Exhibit OO12.bv

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Clinical Staff Executive Committee

MEDICAL CENTERS POLICY NO. 0207

A. SUBJECT: Organ Procurement in Donors after Cardiac Death

B. EFFECTIVE DATE: October 1, 2012 (R)

C. POLICY:

The University of Virginia Medical Center respects the rights of patients to forego life-sustaining treatment and to donate organs and/or tissue if they wish to do so. Donation by persons who die from cardiac or respiratory failure is allowable under Virginia law. Therefore, it is appropriate to consider organ procurement from donors declared dead by cardiopulmonary criteria.[1]

D. PROCEDURE:

1. Identification Of Potential Donors

   a. The contract organ procurement organization, LifeNet Health (hereinafter also referred to as "OPO") shall be contacted to determine potential for donation after cardiac death ("DCD"). See Medical Center Policy No. 0098 "Organ, Tissue, and Eye Donation".

   b. Patients who are not capable and are without appropriate surrogate decision-makers will not be considered for donation after cardiac death (DCD).

2. Approach For Consent

   a. No approach for consent for organ donation shall be made until a definite decision to forego life-sustaining treatment has been reached.

   b. If the OPO determines that the patient is a potential for DCD the OPO Coordinator shall approach the patient and/or surrogate to discuss the potential for organ donation under this policy. The OPO Coordinator shall obtain the written consent of the patient or his/her legal surrogate in the event organ donation is agreed upon.

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[1] Death by cardiopulmonary criteria is defined in the University of Virginia Medical Center as the absence of spontaneous cardiac functions, in accordance with the Virginia statue regarding the diagnosis of death (code of Virginia, Section 54.1-2972), and as reproduced in Medical Center Policy No. 0115, "Guidelines for Determination of Death: Including Death by Neurologic Criteria".

c. The patient or the surrogate maintains the option to withdraw consent for donation at any time without impacting the quality of the patient's care.

d. The patient, surrogate or family shall not be charged for any costs associated with organ procurement.

3. Patient Management For All Personnel

a. The primary responsibility of all personnel is to provide compassionate end-of-life care to the patient and family at all times. Assuring patient comfort and treatment of terminal symptoms is permissible including the use of narcotics and sedatives. The spiritual needs of the patient and family should be addressed through utilization of the Chaplaincy staff or outside clergy at family request.

b. Interventions that directly hasten the patient's death are prohibited.

c. If there is disagreement amongst the healthcare team and/or family members regarding the appropriateness of DCD, ethics consultation should be considered and Medical Center Administration shall be consulted.

4. Patient's Physician

a. The patient's physician must agree to the procedure, and must not be involved with the procurement of organs. The patient's physician must remain in the perioperative suite from the time of withdrawal of support to the declaration of death. The patient's physician shall continue to direct all patient care until death is declared. The patient's physician shall direct the withdrawal of mechanical ventilation and other life-sustaining treatments. The patient's physician shall declare and certify the patient's death.

b. If the patient's physician is unavailable to meet the requirements outlined above in "4.a.", he/she shall transfer care of the patient to another physician who shall take responsibility for the patient.

c. If the patient's physician identifies that he/she has a conflict of interest, he/she has an ethical obligation to resolve the conflict or withdraw from the care of the patient and transfer care of the patient to another physician who shall take responsibility for the patient.

d. The withdrawing physician must continue to provide care until another physician has taken responsibility for the patient.

5. Separation of Responsibility

a. Personnel responsible for organ procurement shall not directly participate in the patient's care prior to death, though they may carry out organ-conserving interventions as outlined below.

b. Personnel responsible for organ procurement shall not direct the withdrawal of mechanical ventilation and other life-sustaining treatments.

c. Personnel responsible for organ procurement shall not declare or certify the patient's death.

6. Care of the Donor Patient

a. No interventions that are injurious to the donor patient or that are actively life shortening are permissible. It may be permissible, in some circumstances, to use interventions that help conserve organs but do not harm the patient. The patient's physician must make a clinical judgment on a case-by-case basis of the advisability of using organ-conserving interventions. Whenever such interventions are proposed, the patient or the surrogate must give consent.

b. If organ ischemia is prolonged i.e. greater than 90 minutes prior to the patient's death, it shall not be possible to utilize the organs for transplantation and procurement shall not be performed. The decision to cancel organ procurement because of prolonged ischemia rests with the organ procurement surgeon. Under these circumstances, the patient's physician shall continue to care for the patient and the patient shall be transferred to an appropriate care location.

c. Procurement of organs cannot begin until the patient meets the cardiopulmonary criteria for death as defined in the Virginia statute regarding the diagnosis of death (Code of Virginia, Section 54.1-2972), and as reproduced in Medical Center Policy No. 0115, "Guidelines for Determination of Death: Including Death by Neurologic Criteria". For the purposes of DCD, the absence of cardiac function will be determined by absence of a pressure wave on a transduced arterial line or absence of heart function observed on echocardiography. To rule out the possibility of auto-resuscitation of circulation, at least two minutes of observation is required; five minutes of observation is required for children under 14 years of age.

d. Immediately after certification of death, organ procurement is to proceed according to the OPO protocol.

7. Special Considerations

a. Procured organs from donors after cardiac death shall be distributed in accordance with United Network for Organ Sharing (UNOS) requirements.

b. The Medical Center shall develop procedural guidelines that shall describe the organizational specifics of successful organ procurement from donors after cardiac death. The guidelines shall be periodically reviewed and updated.

Related Policies: Medical Center Policy No. 0115, "Guidelines for Determination of Death: Including Death by Neurologic Criteria" and Medical Center Policy No. 0142, "Advance Directives"
Ethics Committee, General Counsel & PLT Reviewed

(SUBJECT: Organ Procurement in Donors after Cardiac Death)

SIGNATURE:

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DATE: 9/26/12

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Approved Patient Care Committee
Approved by Clinical Staff Executive Committee