

The Independent Living Donor Advocate: A Guidance Document From the American Society of Transplantation's Living Donor Community of Practice (AST LDCOP)

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The independent living donor advocate (ILDA) serves a mandated and supportive role in the care of the living organ donor, yet qualifications and role requirements are not clearly defined. Guidance comes from Centers for Medicare and Medicaid Services (CMS) Conditions for Transplant Center Participation and interpretive guidelines, Organ Procurement and Transplantation Network (OPTN) Policy and CMS and OPTN site surveys, yet interpretation of regulations varies. Herein, the AST Living Donor Community of Practice (LDCOP) offers seven recommendations to clarify and optimize the ILDA role: (a) the ILDA must have a certain skill set rather than a specific profession, (b) the ILDA must be educated and demonstrate competence in core knowledge components, (c) the ILDA's primary role is to assess components of informed consent, (d) centers must develop a transparent system to define ILDA independence, (e) the ILDA should have a reporting structure outside the transplant center, (f) the ILDA's role should be integrated throughout the donor care continuum, (g) the ILDA role should include a narrow "veto power." We address controversies in ILDA implementation, and offer pathways to maximize benefits and minimize limitations of approaches that may each meet regulatory requirements but confer

different practice benefits. We propose a research agenda to explore the impact of the ILDA.

Abbreviations: ACOT, Advisory Committee on Organ Transplantation; AST, American Society of Transplantation; CMS, Centers for Medicare and Medicaid Services; IDAT, independent living donor advocate team; ILDA, independent living donor advocate; OPTN, Organ Procurement and Transplantation Network; UNOS, United Network for Organ Sharing

Received 17 January 2014, revised 18 August 2014 and accepted for publication 30 August 2014

Introduction

The independent living donor advocate (ILDA) is defined by The Centers for Medicare and Medicaid Services (CMS) and the Organ Procurement and Transplantation Network (OPTN) as a person or team who ensures the "protection of living donors and prospective donors" (1). Although protecting donors is critical in the care of the potential living organ donor, specific qualifications and role requirements of the ILDA are not clearly defined. Guidance comes from several sources: CMS Conditions for Transplant Center Participation (1) and associated interpretive guidelines (2), recently amended OPTN Policy (3) and CMS and UNOS compliance surveys (conducted by program auditors every three years). Current regulations are open to a variety of interpretations and implementation strategies, and auditors may not be consistent in their judgments and recommendations. As a result, the ILDA role has been operationalized differently across the United States, as reported by Steel et al in their national survey of programs (4).

In 2012, the American Society of Transplantation (AST) Live Donor Community of Practice (LDCOP) convened an Independent Living Donor Advocate Workgroup, comprised of experts in ILDA clinical practice, research and policy-making from a variety of disciplines, to provide clarification of required components of the ILDA role, outline specific training and role recommendations, and address controversies in ILDA role implementation. During

this interval, Steel et al followed up their survey of transplant programs, which reported variation in ILDA role implementation across the US, with suggestions for the ILDA role. Our manuscript complements and extends these suggestions. We provide seven specific recommendations to help transplant centers incorporate the ILDA role into practice in ways that not only meet regulatory requirements but also maximize the provision of meaningful support to donors (Table 1). We believe that through implementing these recommendations, an effective, compliant ILDA role is in fact achievable.

Our recommendations are one step towards ILDA practice guidelines. We argue that many current approaches to the ILDA are both meeting regulatory requirements and appropriate; however, there are benefits and limitations to each approach. In the absence of data, we do not recommend one approach over another, but advise programs of ways to minimize pitfalls of their chosen approaches. We also suggest areas of research to help define best practices. This manuscript was endorsed by the LDCOP executive committee and by the AST Board of Directors as a guidance document.

History

The concept of living donor advocacy stems from the earliest days of transplantation, when prior to the first living donor transplant case, surgeon Joseph Murray assembled a separate team to care for the prospective donor (5,6). The 2000 “Consensus Statement on the Live Organ Donor” (7) reinforced this philosophy. Recommendations for donor-specific care were formalized following a 2002 living liver donor death and a resulting review of living donor care in New York State, after which the Advisory Committee on Organ Transplantation (ACOT) to the Secretary of Health and Human Services advised that “each institution will provide an independent donor advocate to ensure informed consent standards and ethical principles are applied to practice” (8). In 2007, CMS Conditions for Transplant Center Participation mandated creation of an ILDA or ILDA team (IDAT) to participate in the care of all prospective living

donors; OPTN policies further incorporated this requirement (1,3). Current regulations allow either an individual ILDA or an IDAT, wherein composition of the IDAT must be outlined in a center’s protocol for living donor transplantation, and roles and responsibilities of team members must be clearly delineated (1–3,9–12).

Overview of ILDA role and function

OPTN policy and CMS regulations and accompanying interpretive guidelines for program auditors must be followed when implementing the ILDA role at each center (1–3). The ILDA must function independently from the recipient team to avoid conflicts of interest, but is not required to be employed or supervised by someone outside the transplant program. If the ILDA is employed by the transplant program, however, he/she must feel comfortable providing the donor with independent representation and have access to an external authority in the event he/she feels pressured by the transplant team.

The ILDA role can be defined around core values outlined by Sites et al: independence, transparency, partnership and advocacy (13). The ILDA works independent of the recipient’s care to focus solely on the prospective living donor’s needs. The ILDA assists the prospective donor in the understanding of the evaluation and donation process. The ILDA is an advocate in promoting the prospective donor’s autonomy, voluntary status and understanding, and effectively communicating the pros and cons of the decision to donate and the prospective donor’s wishes to both the donor and the transplant team (see Table 2). The ILDA role, boundaries and job function should be carefully defined so as to avoid conflicts of interest, as we discuss later.

Foremost, the ILDA should be an effective advocate regarding patient protection, autonomy and readiness and a safeguard for informed consent. In practice, the ILDA role must achieve a balance, in which the advocate is simultaneously independent of recipient services and center-driven pressures around transplant volumes, yet knowledgeable enough of transplantation to promote donor understanding of risks and benefits, the donation process

Table 1: Key recommendations

The ILDA must have a certain skill set rather than a specific profession
The ILDA must be educated and demonstrate competence in core knowledge components
The ILDA primary role is to assess components of informed consent
Centers must develop a transparent system to define the ILDA independence for the program
The ILDA should have a reporting structure outside the transplant program
The ILDA role should be integrated throughout the donor care continuum
The ILDA role should generally include a narrow, defined “veto power”

Table 2: Definition of key terms

Independence	Separation from recipient care and programmatic pressure to increase volume
Advocacy	Assess the relevant pros and cons of donation and ability of donor to give informed consent prior to determination of candidacy. Facilitate donor understanding of candidacy decision
Transparency	Openness and honesty between donor and ILDA about process and information
Partnership	Relationship between donor and ILDA to promote education and guidance
Confidentiality	Donor team and ILDA maintain separation of donor information from recipient team

and expected outcomes for the recipient. We acknowledge this balance is challenging to achieve, but assert that this is the role explicitly mandated by CMS and OPTN. That said, the term “advocacy” as used in ILDA practice is, in fact, ambiguous from a regulatory perspective. Using a literal interpretation, the ILDA would “plead the cause of another” (14), supporting only the prospective donor’s autonomous decision-making. Yet, as defined in OPTN policy, ILDA practice also requires “protecting” the donor to minimize harm (3). To combine both goals allows for dialogue with the prospective donor to resolve conflicts, and to help the prospective donor weigh the risks and benefits of proceeding versus not proceeding with donation (15). Ultimately, an informed, willing individual who has decided without undue pressure and who meets medical and psychosocial candidacy criteria should be able to donate.

Beyond the regulatory guidance from CMS and OPTN, great variability persists in ILDA role definition, and centers’ approach to ILDA employment, education and implementation, and questions remain (4). Practice guidelines for the transplant community have been recommended by many, including Steel et al, who suggested topics to be addressed by guidelines including the ILDA’s professional background, qualifications and delineation of the role, training and continuing education, scope of practice, reporting structure and billing and finances (16). In the absence of data on outcomes of different approaches to practice, the convened AST LDCOP Independent Living Donor Advocate Workgroup, with experience in live organ donation and donor advocacy, offers formal recommendations to define the role and responsibilities to meet regulatory requirements and effectively support living donors and donor candidates. We also recommend a research agenda to further explore the impact of the role (Table 3).

Recommendation #1: ILDA must have a certain skill set rather than a specific profession

Concordant with current regulations, and per the survey conducted by Steel et al, ILDA disciplinary background varies, withILDAs identifying as nurses, social workers, psychologists, chaplains and physicians (4). Our group

Table 3: Areas for research in ILDA practice

Impact of the ILDA’s professional discipline on ILDA performance and on the live donor experience
Donor viewpoints of the impact of the ILDA on the donation experience (e.g. impact on level of donor regret or satisfaction)
Impact of the ILDA on the psychosocial outcomes of potential donors who do not donate
Adequacy of the ILDA training
Impact of the ILDA role on both donors’ and recipients’ trust in the transplant system
Unique feature of the role of the ILDA for paired kidney exchange donation
The benefits and risks of testing prospective donors’ understanding of informed consent components

supports this diversity in disciplinary background, but recommends the ILDA be a professional employee rather than a “lay” volunteer and encourages programs to hire an ILDA who meets program needs. Each discipline brings with it different strengths (i.e. medical disciplines are more prepared to assess understanding of medical risk; psychosocial disciplines are more prepared to assess understanding of psychosocial risk) and no data are yet available to support one model over another. Instead, we delineate skill sets needed (Table 4) and specify key job components and elements comprising a common knowledge base (see recommendation #2), consistent with core competencies and roles as defined in OPTN Policy 14 (3). In this way, we aim to acknowledge the diversity in ILDA background identified by Steel et al and focus instead on key skills that facilitate effective practice.

Critical skills of the ILDA are listed in Table 4. ILDAs must be able to assess and advocate. Motivation, readiness and understanding around donation are complex factors requiring skilled assessment (17–19). ILDAs provide navigation support and effective voice to promote patient autonomy and understanding during all stages of the donation process. Ascertaining that a prospective donor is a ready volunteer requires trust building and eliciting of safe disclosure. The ILDA must be able to effectively communicate his/her findings, conclusions and recommendations to the prospective donor and the team. Just as there needs to be balance between advocacy and protection in the mandated ILDA role, there needs to be balance between respect for autonomy and paternalism in transplant programs. The ILDA should have the skill set and knowledge base to be effective within these nuances.

Recommendation #2: ILDA must be educated and demonstrate competence in core knowledge components

There should be a minimum core orientation program developed for any professional assuming the role of the ILDA at an institution. Table 5 outlines the initial training components considered integral to the ILDA role. ILDA training should include general hospital orientation (even if the ILDA is an outside contractor, who may not be required by some hospitals to attend an orientation) combined with targeted training to clarify the role and a foundation of core knowledge about living donation and transplantation. The ILDA should have at least a basic knowledge base including all concepts that any prospective donor would be expected

Table 4: Skill set for the ILDA

Assessment skills
Communication skills
Advocacy skills
Effective health care systems navigator
Cultural competency
Grounding in medical ethics

Table 5: Education components of the ILDA

Initial education content	Continuing Education
Federal and State regulations regarding donation and transplantation	New data on donor outcomes as they become available
Medical ethics training	Reviewing new regulations as they become available
Hospital orientation including HIPPA training	Quality assurance and performance improvement as it relates to the live donor program
Structure of the transplant program	Participation in list serve and other national ILDA groups
Role of the ILDA within the transplant program	Membership in a professional transplant society
Policies and procedures of the hospital and transplant program specifically how they relate to live donation	Attendance at a national meeting on live donation/donor advocacy for continuing education
Overview of indications, evaluation and outcomes of transplant	Participation in webinars about live donation
Overview of live donation, including inclusion and exclusion criteria, evaluation process and short and long term complications	Obtaining a professional mentor
Importance of donor follow-up	

to understand about donation and transplantation, as outlined in OPTN policy and the OPTN Living Donor Care Evaluation and Consent checklists (20). It is important that the ILDA be able to assess the donor’s reflected understanding of risks and benefits for donor and recipient. Education regarding medical ethics, principles of autonomy and the goal of “avoid undue harm” should be incorporated. The ILDA should understand the structure of the advocate role throughout the continuum of donor care, as implicitly recommended in the CMS regulations, and his/her role (if any) in transplant program activities, including how these are distinct from recipient services. The ILDA should understand the institutional structure of the position, including the reporting and appeals processes. If the ILDA is a transplant center employee, he/she should be instructed in the chain of command available outside the program. Likewise, if the ILDA serves a dual role, either in the transplant program (i.e. transplant coordinator-ILDA) or elsewhere at the institution (i.e., chaplaincy), the ILDA should be oriented in role distinctions and ways to define the ILDA scope of practice for the prospective donor and the donor team.

It is critically important that the ILDA know the history of live donor advocacy and the laws and regulations governing live donor practice (Table 6). This includes the policies and associated guidance documents for the ILDA role as outlined by CMS and OPTN (1–3,20). The ILDA must remain current in the literature on live donor outcomes and modifications to policy (21–24). Seeking mentorship from an experienced ILDA can be a valuable resource, as well as national listserves available to discuss complex advocacy issues. It is important that the transplant program have a plan for continuing education so the ILDA stays current in a rapidly changing field. This may require travel to national meetings or time for online education. Given that donor care practices (and acceptable risk thresholds) vary between transplant centers, ILDAs may benefit from a basic understanding regarding controversies in living donor care (such as differences in candidacy guidelines, or impact

of emerging data on the donor evaluation process), and ways for prospective donors to learn more and seek second opinions (25). The new ILDA may find it useful to shadow a prospective donor through the evaluation or hear living donor testimonials (26).

Recommendation #3: The ILDA’s primary role is to assess components of informed consent

Several consensus statements and OPTN policy describe basic ethical principles underlying living donation (7,27,28), and provide the bedrock for ILDA activities. Although the entire transplant team has this obligation, only the ILDA role is created specifically to avoid conflicts of interest for the donor, separated from the provision of recipient care or the promotion of transplantation (10,27). The ILDA thus assesses whether a prospective donor meets standards of informed consent as defined in OPTN policy (3). The ILDA must assess a potential donor’s understanding of the process and his/her ability to make an informed, un-coerced decision to donate. Given the extant literature on presence of pressure in living donor decision-making (both internally felt and externally imposed), the ILDA pays particular attention to the potential donor’s status as a volunteer and desire to proceed (17–19). Further, the ILDA assesses

Table 6: US laws governing living donation

Law	Main outcome
1984 National Organ Transplant Act	Banned acquisition or transfer of human organs for “valuable consideration”
1999 Organ Donor Leave Act	Federal employees guaranteed paid leave for organ donation
2004 Organ Donation and Recovery Improvement Act	Grant program to reimburse donor travel and subsistence expenses
2007 Charlie Norwood Living Donation Act	Paired kidney donation determined not to constitute valuable consideration

whether the prospective donor has a realistic understanding of expected outcomes, alternative treatments available to the transplant candidate, and that the sale or purchase of organs is a crime (7,17–19,27–31). Our group recommends the ILDA utilize a structured interview process to assess consistency of the donor's description of motivation and expectations, and ask the donor to reflect back required knowledge base components (as defined by OPTN) and express explanations of risk (17–19,30). The ILDA honors prospective donor confidentiality with respect to the recipient team, and helps the donor and the transplant team navigate the separation between donor and recipient, protecting the prospective donor's rights should he/she choose not to proceed with donation. The ILDA assists when the prospective donor wishes to be declared not a candidate. These activities help ensure that donor autonomy is preserved and safety is maximized, and it is here that ILDA distance from recipient care offers a unique perspective and opportunity for independent assessment.

Recommendation #4: Centers must develop a transparent system to define ILDA independence for the program

In order to maintain transparency, we advise that each transplant program be prepared to demonstrate how the ILDA role designation limits conflict of interest in the independent evaluation and service provision for potential donors. The transplant center's approach to structuring ILDA independence must balance local institutional factors with regulatory requirements—there is benefit to building a system that meets an individual transplant center's culture, while also providing for independent ILDA practice. Regulations state the ILDA "must not be involved in transplantation activities on a routine basis"(1), defined as routine participation in activities involving transplant recipients (e.g. waiting list management, organ allocation or transplant patient care). It is not considered "routine" if there is unscheduled, occasional participation on a contingency basis (e.g. to cover for the on-call transplant coordinator in case of unexpected absence) (2,3). We note that some program auditors have interpreted this strictly, to mean that a professional participating in the care of any organ recipient cannot be an ILDA; others have accepted a lung transplant social worker as a kidney ILDA. We would support the latter as appropriate and recommend clarification and consistency in future regulatory guidance.

We recommend that ILDAs describe the nature of their "independence" to potential donors. Each ILDA should be able to describe how his/her work is distinct from recipient care. Given that the ILDA assessment is a required component of the donor evaluation, and results in recommendations about candidacy, we do not anticipate ILDA findings will be kept confidential from the rest of the donor team, and we advise explicit discussion of this process so donors understand that while the ILDA functions separately from the rest of the team, the findings

are in fact integrated into donor care and into the donor medical record (though kept distinct and protected from the recipient's medical record, as required by HIPAA). To protect ILDA independence, the role must include a reporting structure that limits ILDA exposure to center pressures around recipient access to living donor transplantation, volumes or approving specific donors.

Recommendation #5: The ILDA should have a reporting structure outside the transplant program

We recommend the ILDA's reporting structure include someone outside the transplant program, though this could function in an as-needed, secondary capacity. CMS interpretive guidelines do ask auditors to consider: "Is the supervisor someone whom a reasonable person would determine does not have a vested interest in the transplant taking place?" (2). An ILDA reporting solely to the Director of Transplantation may raise concerns; a second supervisor outside the transplant program would allow the ILDA to maintain independence. For example, the ILDA might be jointly hired and supervised by the Directors of Transplantation and Social Work. From our perspective, the disciplinary background, or credentials, of the supervisor is less important than their standing in the institution, and his/her ability to help resolve any differences between the ILDA and the transplant team. In addition, we recommend that the mandated appeals process available to address disagreement between ILDA and the transplant team (3) be clear. We believe such disagreements are rare, especially in programs with skilled donor teams, and discussion will usually resolve disputes. The identity of the third party who would be sought for assistance with an appeal is left to individual programs, and we support this flexibility. Options include the director of the ILDA's second affiliation (eg Director of Nursing, Chair of Medicine), the local ethics committee or members of hospital leadership.

Recommendation #6: ILDA role should be integrated throughout the donor care continuum

Despite a wide range of implementation strategies, common themes for ILDA best practice can be identified. The ILDA should be integrated into the prospective donor's evaluation to assess motivation and voluntary status, determine understanding of donation-related risks and benefits of follow-up, and either confirm the individual's desire to proceed or assist with withdrawal from donation. The ILDA explores donor informed consent beyond the psychosocial assessment interview, if the psychosocial assessment takes place before completion of medical testing and teaching. Timing of ILDA assessment is crucial to role effectiveness: it must occur late enough in the evaluation process to assess donor understanding of process and risk, but early enough to support donor decision-making (32). As such, the ILDA may not always function optimally with a one-time encounter, given that prospective donor readiness, understanding and advocacy needs may vary and may change over time. We support a

best practice model in which the ILDA conducts follow-up with the potential donor following the evaluation visit by phone or in person if there are unresolved issues or decision-making is not finalized. After donation, the ILDA may provide supportive services as needed, including advocating for provision of follow-up care, helping ascribe meaning to the donation process, or assessing donor satisfaction with care.

In cases involving coercion, or inducement, or if a prospective donor wishes to withdraw, the ILDA should assist in the withdrawal process. The ILDA protects the donor's right to withdraw and explains options (including discussion with the donor team) regarding what to share with the transplant candidate. In complex cases of the ambivalent donor, or a donor experiencing internalized pressures around donation decision-making, best ILDA practice includes recommendations for additional assessment, normalization of decision-making process or support for a "cooling off" period. In the event a candidate is not allowed to donate, the ILDA may provide support and help in processing this information, and may assist him/her in learning more about the reason for denial.

Recommendation #7: The ILDA role should include a narrowly defined veto power

The issue of ILDA "veto power" regarding donor candidacy remains controversial, without regulatory guidance. After much deliberation, our authorship group concluded that the "ILDA veto" is essential to ILDA practice. If the ILDA's fundamental role is to assess components of informed consent, when a prospective donor is identified as unwilling, at high risk of coercion, or is uninformed about risk, he/she should not be cleared to donate. In most such circumstances, we believe other members of the team would concur, but in the event this is not the case, the ILDA should be able to veto candidacy. In this model, an ILDA's veto should be confined to ILDA informed consent-related assessment components only (not the medical and/or psychosocial assessments). Opponents of this viewpoint favor a team-based approach, in which the ILDA voice does not outweigh others. Benefits cited include the ability to supplement the ILDA knowledge and experience in living donation, as other donor team members may base candidacy decision-making on additional information, such that these recommendations should not be overridden by the ILDA. In either approach, an institutional appeals process should be established for the rare cases involving intractable differences. If this process does not resolve disagreement, programs should have a protocol defining whether the ILDA will have the power to veto donor candidacy.

Controversies in ILDA Implementation—Pros and Cons to Each Approach

Interestingly, our authorship group concluded that flexibility in implementation strategies for transplant centers is

important to effectively utilize the ILDA towards best practices. Steel et al identified many areas lacking consistency in ILDA practice (4). We concur, and suggest that without outcomes data, one model should not necessarily be recommended over another, but each considered with their benefits and limitations. As such, we hope to help programs minimize limitations in their selected approaches.

The ILDA as a member of the donor team—or not

How separately the ILDA functions from the rest of the donor care team is open to interpretation within current regulatory guidance. In the Steel survey, 18% of respondents identified "not being part of the donor team" as a necessary characteristic of independence (4). Some argue the benefits of an ILDA fully incorporated into the donor care team, describing a collaborative approach focused on prospective donor interests and understanding throughout the evaluation and donation process. Benefits to this approach include ability of the ILDA to assess emerging concerns/questions in real time, and participate in intervention and follow-up. Others argue that this dilutes the independence of the ILDA, may lead to reduced discussion about concerns and increases the risk of conflict of interest. Some programs identify the risk of conflict of interest, or blurry role identification, as outweighing the benefits of more frequent, in-depth assessment and understanding of donor care issues. Most at issue are ILDAs who serve a dual role (e.g. donor nephrologist-ILDA or donor social worker-ILDA).

Each approach has merits, and programs should choose consciously, adapting structure and implementation to reduce the limitations of their chosen approach. Risk of conflict of interest, for example, may be reduced with narrow ILDA role identification, separate ILDA documentation and description of the dual role to prospective donors. Conversely, an ILDA independent of the transplant center will require additional training, and perhaps supervision, to ensure competency in the required knowledge base and understanding of risks for specific living donor candidates.

The ILDA at donor selection meeting—or not

Current guidelines do not address ILDA participation in donor candidate selection meetings, and anecdotally, it is our understanding that some program auditors have opposed this practice while others have encouraged it. 53% of respondents to the Steel ILDA practice survey described attending donor selection(4). Benefits of ILDA participation in selection meetings include ensuring concerns about donor readiness are addressed, as well as directly voicing donor questions to the donor team. ILDA participation also allows the ILDA to identify discordance between team and donor understanding of risk profile. Presence at selection also enables an ILDA veto (Recommendation #7). Disadvantages of ILDA participation include risk of reducing ILDA independence, and increased risk of conflict of interest, if recipient interests are discussed at the

same meeting (this could be avoided where recipient and donor case discussion are separated to allow the ILDA to exit). ILDA presence at selection meetings involves additional resource allocation to cover ILDA time, a factor weighing more heavily for small programs or for programs that have an externally contracted ILDA.

Conclusions

Members of the living donor transplant community (regulatory bodies, professional organizations, centers and ILDAs) have struggled to define the scope of ILDA practice (4). ILDAs come from varied disciplines, and to fulfill their role in the donation process, they must gain a standard knowledge of living donation. Clearly, the ILDA role is evolving. We provide recommendations essential to donor care, that follow regulatory requirements, including guidelines for ILDA training, skill set and core knowledge base and delineation of fundamental elements of the role. We acknowledge controversies in ILDA practice. By recognizing different approaches, transplant centers can ascertain benefits and liabilities in their own settings, and take steps to maximize benefits of their approach.

At a minimum, centers must implement the ILDA role to meet CMS and OPTN requirements while providing center-specific functions that best assess potential donor understanding, and support donor decision-making. Clearly, standardized education, competencies and data about best practice are needed. We recommend professional societies undertake development of a standardized ILDA curriculum. We look forward to outcomes studies exploring the impact of various ILDA approaches. Specifically, we outline a research agenda (Table 3) to identify the ILDA implementation strategies that create measurable improvements in living donor and recipient trust in donor care; informed consent process and satisfaction with care. We also encourage process improvement research to identify impact of various ILDA approaches on transplant center resources, donor candidacy and quality of care. Once a core base of knowledge is identified, the professional societies will need to decide whether or not to offer an ILDA certification process to demonstrate competency.

Acknowledgments

We thank the AST Living Donor Community of Practice Executive Committee, including David Cohen, Kenneth Newell, Robert W. Steiner, James Rodrigue and Cathy Garvey for thoughtful review of this manuscript, and Jason Polinsky of AST for administrative support.

Disclosure

The authors of this manuscript have no conflicts of interest to disclose as described by the *American Journal of Transplantation*.

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