Swiss Donation Pathway

Legal basis and requirements for organ donation and donor identification

Module — 1

Version 3.0 — March 2026

CNDO
Nationaler Ausschuss für Organspende
Comité National du don d'organes

swiss transplant

Contents

For the sake of readability, the generic masculine form is used. However, all references to persons apply to all genders. Where applicable, the term "organ donation" also includes tissue donation.

1.0
Summary

The legal basis for the donation and transplantation of organs, tissues, and cells in Switzerland is provided by the Federal Constitution, the Transplantation Act, and the associated ordinances. The protection of human dignity, personality, and health is the top priority. Organ donation is free of charge, organ trafficking is prohibited, organ allocation is fair, and no one should be discriminated against.

The conditions for organ removal from deceased persons are defined by law. Organ removal from a deceased person may only take place with consent and after death has been confirmed.

Death can occur either through brain damage, whereby permanent failure of brain function leads to death (donation after brain death, DBD = brain-dead donor), or by prolonged cardiac arrest, which interrupts blood flow to the brain until permanent brain failure and thus death occurs (donation after cardiocirculatory death, DCD = brain-dead donor after cardiac arrest).

Preparatory medical measures are activities performed exclusively for the purpose of organ donation with a view to transplantation. These may be necessary both before and after the determination of death and are only permissible if the legal requirements are met.

In principle, potential donors can be identified in any department of a hospital. A potential donor is a patient with a grim prognosis, i.e., with no hope of recovery or ineffective treatment options, who will die either from brain damage or disease or from prolonged cardiac arrest and respiratory failure, and who has no contraindications to organ donation.

The scope of these recommendations basically covers all departments in Swiss hospitals, but is aimed in particular at all intensive care and emergency departments due to the increased incidence of patients with a grim prognosis.

2.0
Legal basis

2.1 Federal Constitution and Transplantation Act

The legal basis for transplant medicine in Switzerland is Article 119a of **the Federal Constitution** of the Swiss Confederation. This article stipulates that the federal government shall enact regulations governing the transplantation of organs, tissues, and cells. The protection of human dignity, personality, and health is the highest priority. The donation of human organs, tissues, and cells is free of charge, and organ trafficking is prohibited. The fair allocation of organs, tissues, and cells is of particular importance.

Federal Constitution of the Swiss Confederation [1]
https://www.fedlex.admin.ch/eli/cc/1999/404/en

Based on the Federal Constitution, the federal government enacted the **Transplantation Act**, which came into force on July 1, 2007.

The Transplantation Act specifies the conditions under which organs, tissues, or cells may be used for transplantation purposes. This includes requirements for **consent** to organ donation, **the criteria** for **determining death**, and **preparatory medical measures** (see chapter 3.0 of this module).

The Act also regulates the **non-remuneration of donations** and the **prohibition of trade**. Furthermore, the Transplantation Act stipulates a **duty of care** in the handling of organs, tissues, or cells, which applies to all measures that are necessary according to the current state of scientific and technical knowledge in order to prevent any risk to human health.

The Transplantation Act also contains provisions on **inclusion in the waiting list** and **the allocation of organs**, on **reporting and approval requirements**, on **confidentiality**, and on **penalties** that apply if the provisions of the Transplantation Act are violated.

The **Transplantation Act** defines its scope as the handling of organs, tissues, or cells of human or animal origin, as well as products manufactured from them (transplant products) that are intended for transplantation in humans. Organs within the meaning of this Act are all parts of the body whose cells and tissues form a common functional unit.

Federal Act on the Transplantation of Organs, Tissues and Cells (Transplantation Act) [2]
https://www.fedlex.admin.ch/eli/cc/2007/279/en

2.2 Implementing regulations

The Transplantation Act is supplemented by six implementing ordinances. These are the Swiss Transplantation Ordinance (Transplantationsverordnung), the Cross-Over Living Donation Ordinance (Überkreuz-Lebendspende-Verordnung), the Organ Allocation Ordinance (Organzuteilungsverordnung), the Organ Allocation Ordinance of the Federal Department of Home Affairs (FDHA) (Organzuteilungsverordnung des Eidgenössischen Departements des Innern (EDI)), the Xenotransplantation Ordinance (Xenotransplantationsverordnung), and the Transplantation Fees Ordinance (Transplantationsgebührenverordnung).

2.2.1 Ordinance on the Transplantation of Human Organs, Tissues, and Cells (Swiss Transplantation Ordinance)

The Swiss Transplantation Ordinance builds on the regulated framework conditions listed in the Transplantation Act and issues specific **implementing provisions.**

With regard to the **determination of death,** the Transplantation Ordinance refers to Section II. 3. and Section III. C-H of the Medical Ethics Guidelines of the Swiss Academy of Medical Sciences (SAMS) on "Determination of Death with Regard to Organ Transplants and Preparation for Organ Removal" [7]. The legislature thus bases the determination of death according to medical practice on the current state of scientific knowledge.

Furthermore, the Swiss Transplantation Ordinance sets out the tasks of hospitals and the "person responsible for local coordination" in the chapter **on implementation**. The tasks of the "person responsible for local coordination" include, in particular, the correct initiation and coordination of organ and tissue donation processes.

Details on the tasks and actors in hospitals and on the structures surrounding organ donation in Switzerland can be found in Module 12, "Quality Management in Organ Donation."

Ordinance on the Transplantation of Human Organs, Tissues, and Cells (Swiss Transplantation Ordinance) [3]:
https://www.fedlex.admin.ch/eli/cc/2007/280/de
(not available in English)

2.2.2 Ordinance on the Allocation of Organs for Transplantation (Organzuteilungsverordnung)

The Organ Allocation Ordinance (Organzuteilungsverordnung) sets out the general criteria and priorities for organ allocation by the national allocation agency Swisstransplant. It also contains guidelines on the waiting list, the Swiss Organ Allocation System (SOAS), and international organ exchange.

Ordinance on the Allocation of Organs for Transplantation (Organzuteilungsverordnung) [4]
https://www.fedlex.admin.ch/eli/cc/2007/281/de
(not available in English)

2.2.3 Organ Allocation Ordinance of the Federal Department of Home Affairs (FDHA)

This regulation lists the detailed allocation criteria specifically for each organ.

Organ Allocation Ordinance of the Federal Department of Home Affairs (FDHA) [5]
https://www.fedlex.admin.ch/eli/cc/2007/282/de
(not available in English)

2.3 Convention on Organ Trafficking

In order to combat organ trafficking more effectively, Switzerland signed the Council of Europe's international convention against trafficking in human organs (Organ Trafficking Convention) in 2016 and ratified it on October 21, 2020. The Organ Trafficking Convention has been in force in Switzerland since February 1, 2021, together with the necessary amendments and clarifications to the Transplantation Act (non-remuneration of donations, prohibition of trafficking, and criminal provisions). Since then, it has been possible to prosecute all persons residing in Switzerland who have committed organ trafficking offenses in Switzerland or abroad.

Council of Europe Convention against Trafficking in Human Organs [6]:
International treaty to prevent and combat illegal organ trafficking
https://www.fedlex.admin.ch/eli/cc/2020/1067/en

3.0
Legal requirements for organ donation

3.1 Consent to organ donation

The requirements for the removal of organs, tissues, and cells from deceased persons are defined in the Transplantation Act [2]. In Switzerland, the **extended consent rule (erweiterte Zustimmungsregelung)** currently still applies**.** The most important provisions are as follows:

- Organs, tissues, or cells may only be removed from a deceased person if they consented to removal before their death and death has been confirmed.
- If no declaration has been made, organ removal is permitted if the next of kin consent. In doing so, they must take into account the presumed wishes of the deceased person.
- The next of kin may only be asked about organ removal once the decision to discontinue life-sustaining measures has been made.
- If the wishes of the deceased person are not known and no relatives are present or can be reached, it is prohibited to remove organs, tissue, or cells from the deceased person.
- The wishes of the deceased take precedence over those of the relatives.
- Relatives do not receive any information about organ allocation or the recipients (principle of anonymity).

According to the Transplantation Ordinance [3], next of kin are:

a) Wife/husband, registered partner, life partner
b) Children
c) Parents and siblings
d) Grandparents and grandchildren
e) Other persons close to the deceased

In 2022, the Swiss people voted in favor of **extending the opt-out system (erweiterte Widerspruchsregelung** for organ donation. Anyone who does not wish to donate their organs should state this during their lifetime. If the deceased person has not made a declaration, this is generally interpreted as consent to donation. However, the next of kin must always be consulted and may object to organ removal if no declaration has been made and this is in line with the presumed wishes of the person concerned. If no declaration of intent has been made and no relatives can be reached, organ removal is prohibited.

The new regulation will apply **from 2027 at the earliest**. Until the changeover, the extended consent regulation will continue to apply.

3.2 Determination of death

3.2.1 Causes of brain death

The following pathologies can lead to brain death (listed in descending order of incidence):

- Anoxic brain damage
- Cerebrovascular accident (hemorrhagic or ischemic infarction)
- Traumatic brain injury
- Other cerebral diseases (e.g., infections, intoxications)

Brain death is an irreversible loss of brain function, including the brain stem ("full brain death concept").

3.2.2 Requirements for the diagnosis of death

Death must be determined in accordance with the SAMS guideline "Determination of death with regard to organ transplants and preparation for organ removal."

SAMS medical ethics guidelines: "Determination of death with regard to organ transplants and preparation for organ removal" [7]
https://www.samw.ch/dam/jcr:12cfb438-d6cf-4acd-b93c-675f9efd2ff7/guidelines_sams_determination_death_organ_removal.pdf

Death may occur due to the following causes:

1st **Brain damage or disease** leading to complete loss of brain function, including the brain stem, while circulation is still intact. Subsequent organ donation is referred to as donation after brain death (DBD).

2nd **Persistent cardiac arrest**, which interrupts blood flow to the brain until permanent loss of brain function leads to death. Subsequent organ donation is referred to as donation after cardiocirculatory death (DCD).

In the scenario of possible organ donation, the focus is on patients with severe brain damage and those with massive support of vital functions, in whom death is expected to occur rapidly if support is withdrawn.
The **performance of formal brain death diagnostics** is subject to the conditions set out in the above-mentioned SAMS guideline [7].
Clinically, either permanent brain damage of known cause or damage to other organs whose failure leads to death must be assumed. This means that all conditions that make a correct diagnosis of brain death impossible must first be ruled out.

The following clinical conditions must be met for brain death to be diagnosed [7].

- Coma of known cause
- Body temperature > 35°C
- No state of shock
- No effect of neurodepressive drugs
- No effect of muscle relaxants
- No effect of anticholinergic drugs
- No metabolic imbalance
- No polyradiculoneuritis (e.g., Guillain-Barré syndrome)

For further details, please refer to the relevant reference, which also includes a **checklist of clinical signs of death** and provides information on additional technical examinations [7]. The SAMW guidelines cover both DBD and DCD donors and include protocols for brain death diagnosis, which are available for download on the SAMW website (https://www.samw.ch/en/Publications/Medical-ethical-Guidelines.html).

There are also important **technical** and **structural** requirements. It is essential that the physicians involved are independent, i.e., they must not be involved in either the organ removal or the transplantation; furthermore, they must not be subject to the instructions of a medical professional who is directly involved in the organ removal or transplantation. It is also important that the specialist staff caring for the dying person and the physicians performing the death certification are not under time pressure or otherwise influenced [7]. It is necessary that the clinical assessment is performed by specialists with further training in the department of brain death diagnosis and proven sufficient experience.
For brain death diagnosis in adults, completed specialist training in neurology or intensive care medicine is required, and in pediatrics, specialist training in pediatric intensive care medicine or neuropediatrics is required.

3.2.3 Clinical diagnosis of death

a) Death as a result of brain damage
Death is determined by a clinical examination in which the **seven** clinical signs must be **cumulatively** demonstrated and which must be carried out by two specialists in accordance with the "four-eyes principle."

1. Coma (unresponsive unconsciousness)
2. Medium to wide, light-rigid pupils on both sides
3. Absence of vestibulo-ocular reflexes
4. Absence of corneal reflexes
5. Absence of cerebral response to pain stimuli
6. Absence of reflex response to pharyngeal and tracheal reflexes
7. Absence of spontaneous breathing (apnea test)

The **time of death in adults** corresponds exactly to the time at which the clinical examination is completed. If an additional examination is necessary after clinical death has been determined, the time of death corresponds to the time at which the additional examination was completed.

For **infants**, which is to say children aged over 28 days but less than one year, or, in the case of preterm infants, more than 44 weeks' postmenstrual age, the determination of brain death

involves two clinical examinations separated by a 24-hour observation period. The **time of death in children** is the moment when the second clinical examination is completed. If brain death is determined via an additional examination, the time of death is the moment when the additional technical examination is completed

b) Death after prolonged cardiac arrest
Death after prolonged cardiac arrest is determined by evidence of permanent failure of brain and brain stem functions due to prolonged interruption of cerebral blood flow. After determining circulatory arrest (lack of cardiac activity) by transthoracic echocardiography (4-chamber view in the subxiphoidal setting) or by transesophageal echocardiography and after a subsequent waiting period of at least 5 minutes without performing resuscitation measures**, the** following **six clinical signs** are **checked,** which must be present **cumulatively** [6]:

1. Coma (i.e., unresponsive unconsciousness)
2. Medium to wide, light-rigid pupils on both sides
3. Absence of vestibulo-ocular reflexes
4. Absence of corneal reflexes
5. Absence of cerebral response to pain stimuli
6. Absence of reflex response to pharyngeal and tracheal reflexes

An apnea test is not necessary, as the five-minute ventilation-free waiting period without resumption of spontaneous breathing is sufficient proof of the absence of the respiratory reflex [6].

3.3 Preparatory medical measures

The topic of preparatory measures is dealt with in detail in the Transplantation Act and in the SAMS guideline "Determination of death with regard to organ transplants and preparation for organ removal" [7]. This guideline applies to physicians and medical professionals who care for patients who are eligible to be organ donors post-mortem.

Preparatory medical measures are those activities that are carried out exclusively for the purpose of possible organ donation for transplantation and are not undertaken for the treatment of the patient. The measures must involve only minimal risks and stress for the donor and may be necessary both **before** and **after** the determination of death.

A distinction is made between **diagnostic** and **organ-preserving** measures. Examples of diagnostic measures include blood typing, serological analyses, and imaging procedures. More invasive examinations such as bronchoscopy or coronary angiography may also be indicated. Examples of organ-preserving measures include the continuation of therapies already begun (ventilation, administration of medication and fluids to maintain circulatory function, maintenance of homeostasis).

Palliative intensive care measures such as symptom-relieving analgesics or terminal extubation are not considered preparatory medical measures.

It is important to divide preparatory medical measures into those taken **before** and **after** the determination of death.

3.3.1 Preparatory medical measures before the determination of death

Preparatory medical measures carried out before death include the continuation of therapies already begun (continuation of ventilation, administration of medication and solutions to maintain circulatory function), laboratory analyses to monitor treatment, and hormone replacement therapy to maintain the "internal environment." Continuing therapies that have already been started is possible and is not considered a preparatory medical measure as long as they still serve purposes other than organ removal (e.g., saying goodbye to relatives, palliative care).
The SAMS guideline also includes a **negative list** [7] that lists the following prohibited preparatory measures prior to the determination of death:

- Insertion of large-bore cannulas (e.g., Gillot probe) for the administration of cooling fluid
- Performing mechanical resuscitation

Preparatory medical measures are also **not permitted** if they could hasten death or lead to a permanent vegetative state. In principle, preparatory medical measures may only be carried out with **the patient's consent** (donor card, living will, etc.). If there is **no written advance directive**, the next of kin must be consulted to ascertain the patient's wishes in this regard, as explained above. If there is no statement from the patient, the measures already taken may be continued until the next of kin can be reached. If **no relatives** can be **contacted** or cannot be contacted in time, no further preparatory medical measures for organ donation may be taken; **organ donation is excluded.** The medical treatment team must respect the patient's decision for or against donation and the decision of the next of kin.

3.3.2 Preparatory medical measures after death has been determined

After death has been determined, measures to maintain organ perfusion (cardiac massage, insertion of femoral cannulas for organ perfusion, extracorporeal membrane oxygenation ECMO). Since these measures cannot harm the deceased (because the person is already deceased), they may be carried out until consent or refusal is obtained from the relatives, as detailed above. The preparatory medical measures may be carried out after the patient's death for **a maximum of 72 hours** [7].

> In the event of an unnatural or unclear death, the legal authorities must be notified in accordance with the applicable cantonal procedure in order to obtain permission for organ removal.

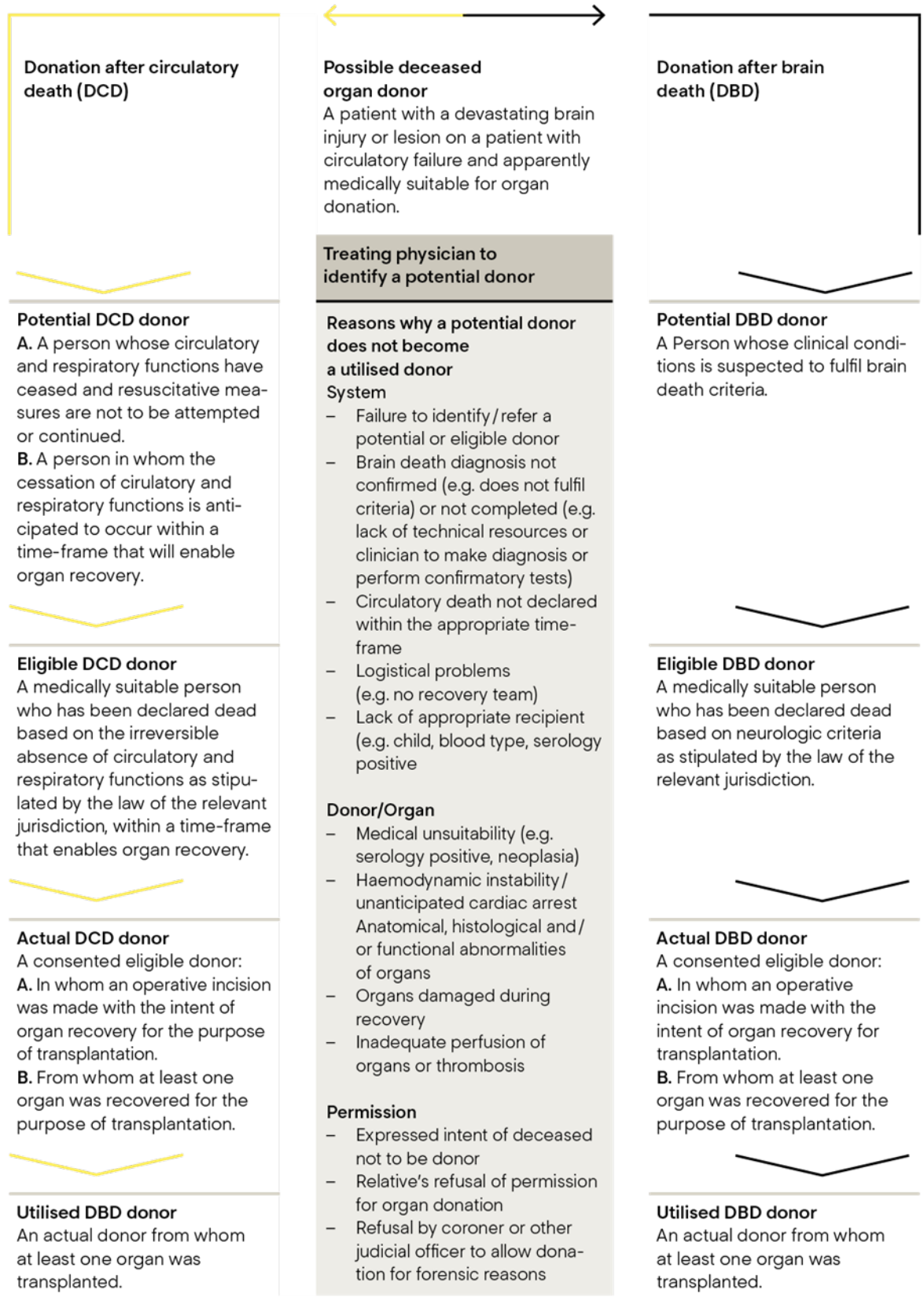
4.0
Donor identification

4.1 Introduction

Countries with the highest transplantation rates and thus the best access for patients to transplantation have well-established donor identification programs [8]. According to the international report on global organ donation and transplantation activity in 2023 by the Global Observatory on Donation and Transplantation (GODT), Spain was the world leader in terms of the number of deceased donations with an absolute total of 2,346 donors per year, corresponding to 48.9 donors per 1 million inhabitants, while Switzerland had 200 donors per year, corresponding to 23 donors per 1 million inhabitants [9].

Worldwide, donations after DBD account for the largest share of deceased donations, although the share of donations after DCD is steadily increasing and already accounted for half of all donations in Switzerland in 2024 [10].

The World Health Organization (WHO) guidelines on deceased donation ("WHO Critical Pathway for Deceased Donation") have proven to be a useful tool for donor identification in everyday practice. The advantage of the guidelines is that they use uniform definitions and process descriptions that cover both DBD and DCD donations (see Fig. 1) [8].



1 : WHO guidelines on deceased donation adapted from [8]

4.2 Identification of potential donors

In principle, potential donors can be identified in any **department of a hospital**, e.g., the emergency room, internal medicine ward, neurology, neurosurgery, pediatrics, etc. However, due to the increased incidence of patients with a grim prognosis, the scope of these recommendations extends in particular to all **intensive care and emergency departments.**

A potential donor is a patient with a grim prognosis, i.e., with no hope of recovery or ineffective treatment options, who will die either from brain damage or brain disease or from prolonged cardiac arrest and respiratory failure, and for whom there are **no contraindications** to organ donation.

It is the responsibility of the treatment team to identify potential donors and arrange for their transfer to the intensive care unit. Competent intensive care treatment is essential in order to enable organ and tissue donation and to ascertain the patient's wishes.

In the respective hospitals, FOGS are responsible for ensuring that the treatment team is familiar with the processes of donor identification and provide appropriate support as explained above.

4.2.1 Criteria for identifying potential DBD donors

A potential DBD donor is a patient with irreversible brain damage for whom donation is being considered. The most important criteria for identifying a DBD donor are as follows:

- Grim prognosis with futile or ineffective therapy
- Irreversible brain damage or deep coma of known cause
- Clinical or radiological evidence that the patient is brain dead or that brain death may occur within 48 hours of consent to organ donation
- No contraindications for organ donation

If a potential **DBD donor** does not die of brain death within **48 hours** of consenting to organ donation, they are subsequently a potential DCD donor.

4.2.2 Criteria for identifying potential DCD donors

A potential DCD donor in Maastricht category III is a patient with a defined change in treatment goal to palliation and an estimated probability of death within 120 minutes after the termination of life-sustaining measures (including extubation).

The most important criteria for identifying a DCD donor are as follows:

- Grim prognosis
- Established change in treatment goal to palliative care
- High probability of death (cardiovascular arrest is expected within 120 minutes after withdrawal of treatment)
- No contraindications for organ donation

4.2.3 Contraindications for organ donation

The following contraindications exist for organ donation:

- Newborns < 28 days old or < 44 weeks postmenstrual age
- Therapy-refractory systemic infections or infections of unknown origin
- Certain degenerative diseases of the central nervous system (CNS) e.g., rabies, prion disease, etc.
- Active leukemia, lymphoma, or plasmacytoma

Regarding **malignant neoplasms**, a highly **differentiated approach** is required nowadays. In principle, malignant neoplasms can be transmitted to immunosuppressed organ recipients from donors with known or unknown malignant tumours, but this risk is small if donors are carefully selected (only approximately 0.05% of organ recipients develop a tumour transmitted from the donor) [13]. A history of cancer – or, in certain circumstances, even an active tumour – is therefore not an absolute contraindication. The expected risk of tumour transmission must be carefully weighed against the benefits of a possible transplant. Advances in medicine and recent findings allow for a more liberal inclusion of donors with neoplasms, especially in the case of early-stage, locally limited tumours; in some cases, a transferred neoplasm in the recipient may even be treatable. However, particular vigilance should be exercised with regard to the detection of malignant neoplasms in the donor. In this context, a detailed medical history of the donor is very important, as are additional laboratory tests including tumour markers, although routine tumour marker screening is not considered to be effective [13]. Imaging techniques should be used carefully, including CT imaging of the thorax, abdomen and pelvis. A tissue biopsy during organ removal can help to rule out malignant tumours. During organ removal, all intrathoracic and intra-abdominal organs should be inspected (including those not intended for transplantation).

The recommendations published to date classify tumours based on the probable risk of transmission. These recommendations are based on literature references, registry data and expert opinions, and are assessed differently internationally. In general, organ donors with curatively treated tumours who have undergone appropriate careful follow-up care and have been documented as completely tumour-free for a sufficient period of time are acceptable for carefully selected recipients. There is no international consensus on the period of time required to be tumour-free before donation; it varies between > 5 and > 10 years depending on the tumour type and stage [13].

Primary tumors in the central nervous system (CNS) account for up to 1.5% of causes of death in organ donors [8]. The two most important factors in assessing CNS tumors in terms of their transmission risk in the context of organ donation are 1) the histologically determined WHO grade of the CNS tumor and 2) any tumor intervention (surgery, shunt, chemotherapy, and/or radiotherapy). In general, the higher the tumor grade and the more interventions, the higher the risk of transmission [8]. However, a study published in 2023 from England showed that the risk of tumor transmission in transplants from deceased donors with primary brain tumors is lower than previously assumed, even in donors who are considered high-risk. In 778 transplanted organs from 282 deceased donors with primary brain tumors, including 262 with high-grade brain tumors, no transmission could be detected [11].
In **malignant melanoma**, a 74% transmission rate and a 60% mortality rate in recipients have been demonstrated [8]. Published data remain insufficient, so that a high transmission rate for malignant melanoma must still be assumed. In view of this fact, a superficial tumor with a tumor thickness < 1.5 mm after curative tumor resection and a recurrence-free period of > 10 years is considered an acceptable risk with a low transmission rate for the recipient.

There are no contraindications in the following cases:
- Primary basal cell carcinoma of the skin
- Cervical carcinoma in situ
- Local, clearly defined tumor of low malignancy
  e.g., renal cell carcinoma < 2 cm

In **unclear cases**, Swisstransplant should always be consulted for donor evaluation before a potential donor is categorically excluded. The **Donor Evaluation Tool (DET)** is available for this purpose, enabling the Swisstransplant medical advisor to quickly obtain a professional assessment of donor suitability. The medical advisors are familiar with the constantly changing medical exclusion criteria and are also aware of the situation on the national waiting list (if a patient urgently needs a life-saving organ, the transplant centres are also prepared to take certain additional risks, as otherwise the patient will not survive).

In addition, the following general points should be noted:

- Advanced age is not a contraindication for organ donation.
- Hepatitis C virus (HCV): HCV antibody-positive and PCR-negative donors can donate organs to HCV antibody-negative recipients. Organs from HCV antibody-positive and PCR-positive donors may be transplanted to recipients with urgent status. In both cases, the recipient must give their written consent prior to transplantation.
- Hepatitis B virus (HBV): HBV antibody-positive and HBsAg-negative donors may donate organs to HBV antibody-negative recipients. The recipient must give their written consent prior to transplantation.
- Human immunodeficiency virus (HIV): Organs may be transplanted provided that the recipient also tests reactive for HIV. The recipient must give their written consent prior to transplantation.

In all **unclear cases**, it is recommended that a donor evaluation be carried out by Swisstransplant using **the Donor Evaluation Tool**.
The decision as to whether a patient is medically suitable for organ and/or tissue donation is the responsibility of Swisstransplant.

4.3 Opening a SOAS entry

The timing of opening a SOAS entry differs depending on the type of donation.

4.3.1 DBD donors

In the case of a DBD donation, the SOAS entry is opened after brain death has been diagnosed and the donor or their relatives have given their consent to organ donation (see Module 2: "Support for relatives and communication"). The donor is now a qualified DBD donor.

A **qualified DBD donor** is a person who is medically eligible for organ donation (transplantable organs, no contraindications) and who has been diagnosed with brain death in accordance with applicable guidelines.

4.3.2 DCD donor

In the case of a DCD donation, for logistical reasons, the SOAS entry is made before the change in treatment goal to palliation and before the determination of death. Here, too, the consent of the donor or relatives to organ donation must be obtained before a donor entry is opened in the SOAS. At the time of the SOAS entry, the donor is still referred to as a potential DCD donor.

A **potential DCD donor** is a patient whose heart function and respiratory function have ceased and who is not undergoing resuscitation measures. Or a patient in whom the failure of heart and circulatory function and respiratory function occurs after withdrawal of therapy within a defined time interval in which it is possible to resume organ function in the recipient.

4.4 Transfer of potential donors

If, due to the structural conditions of the hospital, organ removal is not possible on site, the patient (potential DBD or DCD donor) is transferred to a removal hospital with the consent of their relatives.

For further information on this topic, see Module 8, "Transport Logistics."

Authors

Contributing experts since the first edition (in alphabetical order)

- Prof. Dr. med. Christian Benden
- Dr. med. Christian Brunner
- Dr. med. Edith Fässler
- PD Dr. med. Franz Immer
- Dr. med. Nathalie Krügel
- Dr. med. Renato Lenherr
- Dr. med. Mathias Nebiker
- Vera Nobs
- Dr. med. Deborah Pugin
- Juliane Skierka
- René Waser

References

[1] Bundesverfassung der Schweizerischen Eidgenossenschaft, SR 101 vom 08. April 1999, Stand März 2024

[2] Bundesgesetz über die Transplantation von Organen, Geweben und Zellen (Transplantationsgesetz); SR 810.21 vom 8. Oktober 2004; Stand Februar 2021

[3] Verordnung über die Transplantation von menschlichen Organen, Geweben und Zellen (Transplantationsverordnung), SR 810.211 vom 16.März.2007, Stand September 2023

[4] Verordnung über die Zuteilung von Organen zur Transplantation (Organzuteilungsverordnung), SR 810.212.4 vom 16. März 2007, Stand Januar 2024

[5] Verordnung des EDI über die Zuteilung von Organen zur Transplantation (Organzuteilungsverordnung EDI), SR 810.212.41 vom 02. Mai 2007, Stand April 2024,

[6] Übereinkommen des Europarats gegen den Handel mit menschlichen Organen, SR 0.810.3, Stand August 2025

[7] Schweizerische Akademie der Medizinischen Wissenschaften SAMW. Medizinisch-ethische Richtlinien. Feststellung des Todes im Hinblick auf Organtransplantationen und Vorbereitung der Organentnahme; November 2017

[8] European Directorate for the Quality of Medicines & HealthCare (EDQM), Guide to the quality and safety of organs for transplantation, 9th edition; 2025

[9] Organ Donation and Transplantation Activities 2023 Report. Global Observatory on Donation and Transplantation (GODT), https://www.transplant-observatory.org/wp-content/uploads/2025/02/2023-data-global-report-20022025.pdf

[10] Swisstransplant. Jahresbericht 2024 https://www.swisstransplant.org/fileadmin/user_upload/Jahresbericht_2024_DE.pdf

[11] Greenhall G., Rous B., Robb M., et al. Organ Transplants from deceased donors with primary brain tumors and risk of cancer transmission. Fama Surg. 2023; 158(5): 504 - 513

Changes

Date	Version	Changes
March 2026	3.0	Chapter 3.2.3: Changes to the diagnosis of brain death in infants / children have been reversed. The revised SAMS guideline on the determination of death with regard to organ transplantation has not yet come into force; the version dated 16 May 2017 remains in force.
February 2026	2.0	Merging of the content previously available in two parts (Module 1 Basic Version + Module 1 SOP) Module title adjusted. Entire module: New chapter structure and changes/corrections to improve readability Chapter 2.2: Further information on Swisstransplant, organ donation networks, and the CNDO removed; reference made to the corresponding chapter in the new Module 12 instead. Chapter 3.3: Maastricht classification table removed as already included in Module 9. Subchapter on costs in the organ donation process removed as now mentioned in Module 12. Chapter 4.1: Introduction shortened and updated with the latest available figures. Chapter 4.2.2: DCD schemes removed as they are now integrated into Module 9. Chapter 4.4: Information on the transfer of potential donors shortened and referred to Module 8. References: Updated
February 2023	1.1	Correction
December 2020	1.0	Initial version

Swisstransplant
Effingerstrasse 1
3011 Bern
T: +41 58 123 80 00

info@swisstransplant.org
www.swisstransplant.org

CNDO
Nationaler Ausschuss für Organspende
Comité National du don d'organes

swiss transplant