

Best Interests and Potential Organ Donors

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DOI:

[10.1136/bmj.39575.561898.94](https://doi.org/10.1136/bmj.39575.561898.94)

Document Version

Publisher's PDF, also known as Version of record

Citation for published version (Harvard):

Coggon, J, Brazier, M, Murphy, P, Price, D & Quigley, M 2008, 'Best Interests and Potential Organ Donors', *BMJ*, vol. 336, no. 7657, pp. 1346-7. <https://doi.org/10.1136/bmj.39575.561898.94>

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Best interests and potential organ donors

Many potential donor organs are currently lost because of misunderstanding of the law. **John Coggon and colleagues** clarify what is permissible in non-heart-beating donation

The United Kingdom, in common with many countries, faces a shortage of donor organs for transplantation.¹ One of the obstacles to increased donation is the widespread view within the medical profession that it is unlawful to alter the management of a patient who is dying solely to improve or maintain the prospect of that patient becoming an organ donor after death.² Such concerns are particularly relevant to controlled non-heart-beating organ donation, where organs are taken from patients who have a cardiorespiratory death after the planned withdrawal of active support in intensive care units.³ Although this was the original model of cadaveric donation in the UK, it has proved contentious since its re-emergence as an important source of donor organs in recent years.⁴ We explore how the concept of best interests should be understood, and thereby show that apparent ethicolegal objections to controlled non-heart-beating organ donation by patients who are unable to provide informed consent are illusory.

Non-heart-beating donation

By its nature controlled non-heart-beating donation requires the possibility of donation to be considered before death. It is different from perfusion of organs after unpredicted (uncontrolled) death, which we do not discuss here. Consideration of donation before death generates the potential for a perceived conflict of interests with decisions about futility of treatment.⁴ Additionally, some people have challenged the lawfulness of modifications to end of life care that are necessary to support organ donation.⁵ For example, although UK guidance discourages the administration of drugs that might improve the condition of a transplantable organ (such as heparin or steroid⁶),⁷ many units take blood samples before death for virology screening and tissue typing in order to reduce delays in assessing the donor and recipient (and therefore the cold ischaemic damage to retrieved organs). Furthermore, as a minimum, non-heart-beating donation requires withdrawal of medically futile treatment to be delayed by a few hours to allow the surgical retrieval team time to travel to the referring hospital and make necessary preparations in theatre, a delay which some people have considered inappropriate and potentially unlawful.⁵

The recurrent theme in these debates is the extent to which the potential for post-humous donation can be considered in a patient whose death seems very likely but has not yet occurred, and in what way such considerations can be allowed to influence management before death is declared. Common reasoning is that deviation from the normal clinical management if organ donation were not considered would be contrary to the patient's best interests. Some practitioners cite part of the judgment in the case of Anthony Bland, who was in a vegetative state and kept alive by nasogastric feeding,⁸ as legal support for their position. The excerpt from Lord Browne-Wilkinson's speech in the Bland case that alarms clinicians working in intensive care is as follows:

If there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person.⁸

Perhaps understandably, some clinicians interpret this short extract of the lengthy speech as meaning that it is contrary to a patient's best interests, and thus not lawful, to initiate, continue, or escalate cardiorespiratory support that has been judged medically futile in order to maintain or improve the potential for that patient to become an organ donor in the event of his or her death.

This interpretation derives from a misunderstanding of how English law conceptualises best interests. Consider a second quotation from Lord Browne-Wilkinson's speech:

The answer to the question [of whether withdrawal of care is in the patient's best interests] must of course depend on the circumstances of each case and there will be no single "right" answer. Different doctors may take different views both on strictly medical issues and the broader ethical issues which the question raises.⁸

Best interests can be judged only in the context of the particular patient. Later judgments that develop the concept of best interests show that doctors must think beyond that which is immediately clinically beneficial to the patient. The views and values of the

patient, if known, must be taken into account, and, if not known, explored through a timely discussion with the patient's family, friends, and carers.

Courts' approach to best interests

The best interests test in English law derives from *Re F* in 1989,⁹ and is now given statutory force in the Mental Capacity Act 2005. In *Re F*, it was held that neither the family nor the courts had any power to consent to treatment on behalf of an adult patient who lacked mental capacity and that treatments could not be justified solely because they made the lives of others better or easier. Rather it was found that in cases involving adults unable to consent, a proposed medical intervention would be lawful only if it were in the best interests of the patient.

For patients receiving life support, Bland provided an important point in analysis of best interests. But since that case, the English courts have developed a clearer and more coherent picture, with one common theme being pre-eminent: best interests demands that decision makers look beyond purely medical considerations. The then president of the family division made this clear in the cases of *Re A*,¹⁰ when she held that "best interests encompasses medical, emotional and all other welfare issues," and *Re S*,¹¹ when she stated that a decision on best interests asks not only what is medically indicated, but also "broader ethical, social, moral and welfare considerations."

Best interests are informed by the patient's own values. Recently, the High Court was asked to consider whether a patient in a persistent vegetative state should have anything other than her physical requirements considered when assessing her best interests.¹² It held that, even with such a severely incapacitated patient, it was necessary to consider intangible benefits, such as familial, spiritual, and religious benefits, that the patient would have considered important when she had capacity. Consequently, it judged that this devoutly Muslim patient should be cared for in an environment commensurate with her faith, even though this was a benefit that she would never consciously appreciate.

The courts have made it clear that patients' wishes and values count. Their best interests



“Best interests includes facilitation of organ donation”

are not just to receive what is medically indicated, but are also served by considering their ethical, social, moral, spiritual, and religious values. An express wish to be an organ donor is such a value. Case law supports a broad approach to assessing best interests,¹³ and this principle extends to the protection of those who would wish to be posthumous organ donors. If their values support it, their best interests are served by preparation for it while they are still alive.

Mental Capacity Act

The Mental Capacity Act 2005 reinforces this interpretation. Section 4 elaborates on how we should understand best interests, and there is extensive discussion of the concept in the Code of Practice,¹⁴ which endorses the broad means of understanding best interests. Section 4(6) obliges decision makers to consider so far as is reasonably ascertainable:

- The person's past and present wishes and feelings
- The beliefs and values that would be likely to influence his decision if he had capacity, and
- The other factors that he would be likely to consider if he were able to do so.

So it is mandatory to inform any assessment of best interests with notions of good and bad that extend far beyond that which is clinically indicated. Hastening patients' deaths to access their organs is clearly unlawful, falling foul of the laws on homicide. Equally, elective ventilation is morally and legally problematic because doctors are intervening in a course of events with the attendant risk of creating a persistent vegetative state.

However, extending the time a patient is ventilated after an agreed withdrawal of treatment is not analogous with either of these situations. Provided the decision to withdraw is not influenced by transplantation considerations, the ethical and legal objections do not arise. Taking steps to improve the prospects of patients becoming organ donors

when there is evidence that that is what they would have wanted promotes, not violates, their best interests. A doctor's duty of care can thus lawfully include a modest prolongation of existing cardiorespiratory support pending the necessary preparations of the surgical retrieval team.

Conclusion

As far as the law is concerned, we have said nothing new in arguing that a potential organ donor's interests include being considered for donation while still legally alive. Nevertheless, fears of the law that have no solid foundation are needlessly costing the lives of patients who die awaiting transplantation. The UK General Medical Council guidance on withholding and withdrawing life prolonging treatments reflects the legal principles that we have highlighted.¹⁵ For clarity and reassurance to practitioners, we suggest that it should add a clause to cover decisions to prepare a patient for organ donation after death. The law is clear: treating a patient in accordance with his or her best interests means more than doing what is medically indicated. It requires us to explore the patient's values and to choose the course of action that accords best with them. Where a patient would wish to donate, measures such as those described here are not unlawful if they are necessary for organ donation to proceed. They serve, rather than deny, the best interests of a patient.

SUMMARY POINTS

The law requires that patients who have lost mental capacity be treated in their best interests

Best interests is not limited to clinical considerations but includes the patient's values and wishes

These wishes can include the desire to donate organs

When such a patient's death is imminent and inevitable, interventions to improve the prospects of donation that carry no harm are lawful

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Accepted: 30 March 2008

Competing interests: None declared.

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Provenance and peer review: Not commissioned; externally peer reviewed.

See FEATURE p 1342, PRACTICE p 1374 and REVIEWS pp 1377, 1378

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