

Organ donation proposals might go too far

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The continuing shortfall of organs available for transplantation has recently prompted a radical rethink of current end-of-life practices in the United Kingdom. The [British Medical Association](#) (BMA) has suggested a possible change in practice for potential donors dying from catastrophic brain injury that leaves them short of brain dead.

Current standard practice is not to admit such patients to intensive care units to provide life-saving measures when they have stopped breathing. Such measures are considered not to be in their best interests since they would only prolong the dying process.

Proposals for change

But it's possible to take steps prior to the patient's death to stop her organs from deteriorating so that, once she has died, her organs are suitable for transplantation. Among other things, this involves inserting breathing tubes to provide ventilation to the patient once she has stopped breathing to ensure her organs continue receiving oxygen.

The changes mooted by the BMA involve admitting people with catastrophic brain injury into intensive care and doing just that. But it would only happen in cases where there has been an expressed wish on the part of the patient to donate her organs.

There's an even more radical proposal being made by the UK National Institute for Health and Clinical Excellence (NICE). They have published a guideline recommending the possible commencement of some of these pre-mortem measures even when the patient's wishes are not yet known. People with catastrophic brain injury would be admitted into intensive care and ventilated (if needed), until their wishes are discovered.

The purpose of this more radical proposal is to prevent the opportunity to donate being lost if the patient stops breathing before doctors have had time to consult the patient's family and find out what her wishes were.

Are these proposals lawful?

There are laws governing when organs can be retrieved from a brain-stem dead patient, whom the law regards as being dead, but they don't apply to these patients because they're still alive. In the United Kingdom, the law that deals with decision-making in these cases is found in the [Mental Capacity Act](#). This Act permits treatment that's in a patient's "best interests".

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A range of factors must be considered to judge whether a treatment is in a patient's best interests, including the wishes and values of the patient to the extent that these are "reasonably ascertainable".

Can non-therapeutic treatment of this kind – treatment that's not for the benefit of the patient but for the benefit of others – be in a patient's best interests? Perhaps. If there's evidence that the patient wanted to donate, either because she has made comments to that effect, or because it's reasonable to deduce this from her values, then it may be possible to conclude that pre-mortem measures to facilitate donation after death are in the patient's best interests.

Best interests under the Mental Capacity Act includes "altruistic wishes" so a patient's desire to benefit others through donation is a relevant consideration. To that extent, the proposals mooted by the BMA might, if they were put into effect, be in the best interests of those patients who have expressed a desire to donate.

But what about the NICE guideline, which contemplates ventilation before the views and wishes of patients are known? [We have argued](#) that this may not be lawful. If we don't know what a patient wanted, it's not possible to argue as a matter of course that it will always be in her best interests to receive ventilation until we find out those views. But this is what the guideline appears to be suggesting.

Some might argue that it is in a patient's best interests for us to discover what her wishes are because otherwise she might lose the opportunity to donate. This might hold if we subsequently discover the patient did want to donate, but it would clearly not work if we discovered that she didn't. Indeed, what if the patient had expressly avowed that she never wanted to be put on life-sustaining measures at all? How would we know, in advance, which patient would be which?

The requirement to consider the wishes and values of the patient doesn't itself sanction providing ventilation until we've had the chance to ascertain her wishes; the legislation only requires wishes and values to be considered if they're "reasonably ascertainable".

The law in Australia is similar. All eight states and territories have guardianship legislation that determines when an adult patient who lacks decision-making capacity can receive medical treatment. There's variation across jurisdictions but most involve consideration of the "best interests" test (often alongside other criteria). So the consideration of similar guidelines in Australia would also give rise to these legal concerns.

Tackling organ donation directly

The proposals in the NICE guideline amount to presuming that it's always in the best interests of a patient to be put on life-sustaining measures if she's a potential organ donor. But doing so stretches the best interests test beyond breaking point.

If the primary goal is to increase the supply of organs available for donation, which is laudable, then that should be tackled squarely. We should be clear that such proposals are really about the societal need to increase donation rates, and that they're thought to be an ethically appropriate way to do this.

If we take that step, we would be in the position to make legislative changes to authorise the measures, and avoid misshaping the general principles of an area of law designed to safeguard the rights of vulnerable people, namely patients who lack decision-making capacity.

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