

From the editor

A difficult dilemma

The Welsh Government Assembly, the British Medical Association (BMA) and the National Institute for Health Care Excellence (NICE) have each opined on the details of the approach to procurement of donor organs for transplantation. Notably, the discussions cover – in the case of the first two organisations – the use of ‘opt-out’ provisions, concerning which they come out in favour. The BMA and NICE also discuss details of the usage and the treatment of ‘donors after circulatory death’ – formerly referred to as ‘non-heart-beating donors’ – from whom organs are harvested after death has been confirmed by persistent cardio-respiratory arrest. Clearly this arrest may occur unexpectedly or expectedly, and the latter – when death occurs after withdrawal of life sustaining treatment – offers a substantial opportunity to increase the availability of donor organs. It simultaneously presents difficult ethical issues concerning interventions prior to death. Randall and Downie¹ and Neuberger² present opposing views on these matters in this issue of the journal. Their articles demonstrate that in this as in many current ethical controversies there are no easy answers and this editorial makes no attempt to arbitrate. It does however seek to place the argument in context, and also to reflect on how institutions such as the Royal College of Physicians (RCP) should respond to such contentious issues when there is no unambiguous way forward.

The growth in organ transplantation – one of the 20th century’s great medical achievements – stalled in the UK at the beginning of the millennium. In response to a combination of wholly desirable facts (eg a dramatic reduction in potential donors following a fall in the number of fatal road accidents) with unfortunate events (eg the unauthorised storage of pathological organs at Alder Hey hospital), the number of ‘deceased organ donors’ in the UK fell from 736 in 2000/01 to 609 in 2007/08. At that time the Organ Donation Taskforce of the Department of Health reviewed the field and outlined a set of measures which they suggested could lead to an increase of over 50% in the number of organs donated in the UK by 2013.³ Interestingly, the most recent annual review from NHS Blood and Transplant contends the UK is on track to achieve this. The total number of organ transplants carried out during the

2011/12 period was 3,953 – an improvement on the 3,725 transplants recorded in 2010/11 – representing an increase of 22.2% above the 2007/08 baseline.⁴ Many factors contribute to this, including the increasing number of donations from the living, but it is clear that the greatest increase in organ supply has come from the use of donation after circulatory death, which now accounts for 436 of the 1,087 deceased donors. This is twelve times the proportion in 2001 and is described as one of the highest figures in the world.

It would, however, be wrong to assume that, provided the ethical objections could be countered, this approach represents ‘problem solved’. There is another important aspect and paradox. The National Organ Register carries the names of over 18 million people, approximately 30% of the population. Over 800,000 new names have been added in twelve months. Yet the family refusal rate for organ donation in the UK, at 45%, is one of the highest in Europe and often effectively negates the stated wishes of the deceased. Thus the option of overriding the wishes of relatives is under scrutiny, along with the attribution of presumed consent when an individual has failed to register an opt-out.

There would seem to be a number of potential responses of institutions such as the RCP to this latter issue. Certainly, organ transplantation is part of our remit, albeit in partnership with many other specialties. The RCP has published a moving set of letters from transplant recipients that vividly capture the value of the procedure.⁵ One approach would be for the RCP to debate and formulate a policy on opt-outs, which it would then actively seek to promulgate and would likely involve advocating UK-wide legislation. However taking a stance one way or another would be difficult because it is overwhelmingly likely there is a wide range of opinion among fellows and members. While a ballot of opinion might document the range of views, it would scarcely present a mandate to pursue a campaign to support the majority view. At the other extreme, the issue could be ignored. As a middle course, along which most would probably be happy to travel, the RCP could encourage support for measures which inform and educate the public, not only to opt-in by registering with the Organ Donation Register, but to respect the autonomy of the patient, and thus their stated wishes, even after their death. The latter would contribute to reducing the strikingly high number of family refusals. Such a stance of course enhances not only organ procurement from ‘donors after circulatory death’, but also from ‘donors after brain death’.

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- 2 Neuberger J. BMA and NICE guidance on organ retrieval: neither misguided nor presumptuous. *Clin Med* 2012;12:516–18.
- 3 Department of Health. Organs for Transplants A report from the Organ Donation Taskforce. London: DH, 2008. [Accessed 8 October 2012].
- 4 NHS Blood and Transplant. *Annual Review 2011–12: Saving and improving lives*. Watford: NHS Blood and Transplant, 2012. www.nhsbt.nhs.uk/annualreview/pdf/nhsbt_annual_review_2011-2012.pdf [Accessed 8 October 2012].
- 5 Royal College of Physicians. *Thank you for life – letters from transplant recipients to donors’ families*. London: RCP, 2010.

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