

letters to the editor

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Patient's best interests and presumed consent in ante-mortem organ preservation in end-of-life care

Editor – Littlejohns *et al* comment on the National Institute for Health and Care Excellence (NICE)'s interpretation of 'best interest', which permits presumed consent to ante-mortem organ preservation (*Clin Med* August 2013 pp 340–3). We argue this interpretation is incompatible with two preconditions established by The High Court of Justice in *Ahsan v University Hospitals Leicester NHS Trust* in 2006: first, the patient's best interests and second, reasonableness of the proposed care regime.¹

Patient's best interests

The Mental Capacity Act stipulates that patient's best interests must include '...the beliefs and values that would be likely to influence his decision if he had capacity...' and '...the views of – anyone engaged in caring for the person or interested in his welfare.'¹ Familial, cultural and religious values determined the best interest of Ahsan, a Sunni Muslim, who was mentally incapacitated, with end-of-life care. Judge Hegarty QC ruled that 'most reasonable people would expect...that they would be cared for, as far as practicable, in such a way as to ensure that they were treated with due regard for their personal dignity and with proper respect for their religious beliefs.'¹ NICE infers that 'best interest' in end-of-life care can include presumed consent to ante-mortem organ preservation for third party interests (recipients). This inference collides with the stipulated 'best interest' in the Mental Capacity Act, when preparation and execution of organ procurement transgress religious values. Major world religions forbid organ donation if surgical procurement itself is the proximate causation of death.²

Reasonableness in end-of-life care

Ante-mortem procedures are continued until the surgical procurement team is available to recover organs which can interfere with optimal end-of-life care.³ Donors failing to meet neurological criteria for heart-beating donation are required to undergo elective withdrawal of life support for a controlled circulatory arrest and non-heart-beating donation.⁴ Circulatory arrest beyond 60 minutes is associated with primary non-function or delayed function of transplanted organs.⁴ Organ donation euthanasia is recommended in those who are unlikely to develop circulatory arrest within appropriate timelines.⁵

In conclusion, the arguments of the patient's 'best interests' and the reasonableness of care regime fail to legally ground presumed consent to ante-mortem organ preservation. Uncorrected, it results in the violation of religious values and human rights of potential donors and surviving families.

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References

- 1 The High Court of Justice Queen's Bench Division. *Ahsan v University Hospitals Leicester NHS Trust*. EWHC 2624 (QB), 2006. lexisweb.co.uk/cases/2006/july/ahsan-v-university-hospital-leicester-nhs-trust [Accessed 31 October 2013].

- 2 Lancet. Religion, organ transplantation, and the definition of death. *Lancet* 2011;377:271.
- 3 Rady MY, Verheijde J, McGregor J. Organ donation after circulatory death: the forgotten donor? *Crit Care* 2006;10:166.
- 4 Rady MY, Verheijde JL. No-touch time in donors after cardiac death (nonheart-beating organ donation). *Curr Opin in Organ Transplant* 2013;18:140–7.
- 5 Wilkinson D, Savulescu J. Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation. *Bioethics* 2012;26:32–48.

Response

Editor – Rady and Verheijde suggest that, uncorrected, NICE guidance could result in the violation of the religious values and human rights of potential donors and surviving families. We disagree with this interpretation. Our position, in summary, is that preserving life in order to determine the patient's best interests with regard to organ donation can be in the best interests of the patient. Where a patient's best interests can be determined without any delay (for example when their wishes are already known) no such delay would be in the best interests of the patient. We agree that the religious views of the patient regarding organ donation are an important component of their best interests. Where these religious views are unknown, stabilising the patient may provide the time necessary to determine and so respect such views. The procedures used to procure donated organs are a matter for a valid, but separate, debate and are not considered in our paper. The Ahsan case referred to by Rady and Verheijde considered the interrelationship between first the need to act in a patient's best interests and second the requirement that a proposed course of action must be reasonable for the court to conclude that the proposed course was an appropriate basis for the assessment of damages in a clinical negligence claim. That question arose in the specific context of a damages claim and does not arise in the context of the NICE guidance or our paper.

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