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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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].
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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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The impact of consultant-delivered multidisciplinary inpatient medical care on patient outcomes

Editor – We read with interest the article by Fielding *et al* which assessed the impact of consultant-led multidisciplinary team (MDT)-delivered care on length of stay (*Clin Med* August 2013 p344–8). Taken together with the earlier study by Ahmad *et al*,[1] there appears to be mounting support that increasing consultant-delivered ward rounds is associated with shorter length of stay. However, at our own institution we found that the introduction of two extra consultant 'winter pressure' ward rounds by the respiratory and general internal medicine (GIM) teams was associated with only a very modest saving in average length of stay when compared to the non-respiratory/GIM teams, who continued with two formal ward rounds per week (Table 1). Furthermore, an earlier start time of 8am did not appear to influence the time of TTO ('to take out' prescription) printing or the time of discharge.

While the data presented by Fielding *et al* are encouraging, we urge caution before widespread implementation of daily consultant-delivered care. As stated in the conclusion, their study was not a randomised controlled trial (RCT) and is open to considerable selection bias. Furthermore, they do not include a formal health economic analysis in their report, nor do they comment on the experience of the consultants concerned in terms of the sustainability of such high intensity work.

Despite the strongly worded conclusion of the Academy of Royal Colleges report[2] recommending daily consultant-delivered care, to our knowledge there have been no RCTs performed in this area. The cost of employing sufficient consultants to deliver a consultant-led ward service will be substantial and persuading new consultants to sign up to delivering care without trainees will be challenging. While we support the concept of early and regular patient access to senior clinical decision makers, we advocate the collection of more robust data before the widespread introduction of daily consultant delivered care on general medical wards.

References

1 Ahmad A, Purewal TS, Sharma D, Weston PJ. The impact of twice-daily consultant ward rounds on the length of stay in two general medical wards. *Clin Med* 2011;11:524–8.
2 Academy of Medical Royal Colleges. *The benefits of consultant-delivered care.* London: Academy of Royal Colleges, 2012. aomrc.org.uk/component/docman/doc_download/9450-the-benefits-of-consultant-delivered-care.html [Accessed 27 September 2013].

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Table 1. Impact of additional ward rounds and 8am start.

	Average length of stay (median (IQR) days)		TTO printed before 1pm (%)		Discharged before 1pm (%)	
	Four rounds at 8am	Standard care	Four rounds at 8am	Standard care	Four rounds at 8am	Standard care
Pre-intervention*	7.0 (9.0)	9.0 (16)	29.5	27.0	16.8	19.9
Post-intervention*	7.0 (8.0)	10.0 (21)	32.6	29.3	18.0	20.2
p-value†	ns	0.012	NS	NS	NS	NS

IQR = inter-quartile range; NS = not significant; TTO = to take out [discharge prescription]. *Intervention = two additional ward rounds and 8am start.
†Mann-Whitney U test

A trainee's guide to surviving ePortfolio

Editor – This is a follow up to Dr King's paper on the ePortfolio (*Clin Med* August 2013 pp 367–9). The Foundation Programme, workplace assessments and local faculty groups (foundation process) were implemented to accelerate foundation doctors' progression to expertise sufficient for full registration with the General Medical Council (GMC) and then into higher training. Vance *et al* reported trainees' considerable dissatisfaction with the processes.[1] In the August edition of *Clinical Medicine*, Dr King wrote 'whether or not you like online portfolio systems, ePortfolio seems here to stay as a tool for assessment and advancement'. I believe the ePortfolio system may require swift changes to make it 'fit for purpose'.

In July 2013 I ran an online survey promoted on Twitter, which attracted responses from 36 consultant supervisors and 88 current foundation year (FY) doctors (32 FY1, 56 FY2). 75% of supervisors and 58% of trainees were not confident that the foundation process was 'fit for purpose' in supporting and accelerating training. 75% of supervisors were not confident that the process provides valid information to recommend full GMC registration at the end of FY1 or progression into higher training from FY2, a view shared by 62% of trainees. Only 33% of supervisors and 36% of trainees found the ePortfolio easy to use. 67% of supervisors felt irritation or dread when asked to complete an online assessment. 31% of supervisors had not read any of the foundation curriculum, whereas 30% of trainees had read all and 65% some of the curriculum.

This was a small survey and participants were probably sceptical. However, the results mirror Vance *et al*'s findings. Full registration with the GMC is a weighty matter, as is assessment of FY2 to progress into higher training. Supervisors, trainees and the public must have confidence the processes are 'fit for purpose'. Swift changes are required to restore supervisors' and trainees' confidence in the foundation training process.

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