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Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within three weeks of receipt of *Clinical Medicine*. Letters should ideally be limited to 350 words, and sent by email to: clinicalmedicine@rcplondon.ac.uk

Legal and ethical implications of NICE guidance aimed at optimising organ transplantation after circulatory death

Editor – Samuel Littlejohns *et al* assert that the NICE guidance on improving donor identification and consent rates for deceased organ donation provides a 'legal, ethical and clinically relevant way forward in a complex and developing public health issue', namely 'increasing the number of organ transplants' (*Clin Med* August 2013 pp 340–3). It is our contention that they have failed to provide justification for the NICE guidance.

Firstly, they do not respond to our (ethical) criticism of the use of scarce intensive care unit beds to 'stabilise' irreversibly dying patients purely for the purposes of exploring their wishes (if any) regarding donation and their 'clinical potential' to 'donate'. The overwhelmingly likely consequence of this policy is that other patients who could benefit from intensive care would be denied access to it.

Secondly, they fail to justify the absence of public information explaining the major interference, much more than taking 'minimum steps', in patients' care in the last days of life, including the change in time and place of their death, which organ donation after circulatory death would require. Thirdly, they make no reply to our criticism that this NICE guidance apparently contradicts previous NICE guidance on patient choice regarding place of death. Fourthly, they see no need to justify the extraordinary NICE recommendation that doctors give relatives blatantly false assurance that 'donation is a usual part of end of life care'.

Rather than responding to our criticisms above, Littlejohn *et al* attempt a legalistic defence of making a decision which both overrides the existing decision that continuing life-sustaining treatment is not in the patient's best interests, and also radically alters the dying process. This radical alteration is merely to ascertain if the patient would (or would not) have wanted their organs retrieved for transplant in these circumstances and their organs' clinical potential for transplant.

More debate is also needed about whether this NICE guidance might promote infringement of the Human Rights Act (Article 3), namely the right to be free from inhuman and degrading treatment, since employing invasive means to prolong dying might be regarded by many as inhuman and degrading.

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Response

Editor – Randall and Downie assert that we did not respond to four of their criticisms. Taking them in turn:

1 There is a valid debate to have on the availability of intensive care beds, but deliberations on the prioritisation of their use must include consideration of the best interests of every patient under their care.
2 We agree that increased information is important in facilitating decision making at the end of life.
3 Regarding place of death, there is no contradiction with previous NICE guidance. The patients we are referring to are likely to be admitted through the accident and emergency department and are unlikely to have a choice about place of death. If there has been a chance to determine the preferred place of death, this of course should be taken into account.
4 The guidance recommends that doctors should, when speaking to those close to a patient, discuss that donation is a usual part of end-of-life care. Given that almost 20 million people or one-third of the total UK population are on the organ donation register, this is an appropriate recommendation to make. It is not suggesting that donation occurs in all, or even most, cases. Rather that it is a usual part of the end-of-life care to consider whether organ donation is appropriate.

Finally, it is not at all clear to us how medical intervention in a patient's best interests could interfere with the patient's rights under Article 3 of the European Convention on Human Rights. We understand that Randall and Downie might dispute that such intervention would be in the patient's best interests, but this is a different point. We would note further that this is not an issue raised during the extensive consultation and consideration of the draft guidance.

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