Best interests and potential organ donors

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Best interests and potential organ donors

Many potential donor organs are currently lost because of misunderstanding of the law.

John Coggon and colleagues clarify what is permissible in non-heart-beating donation

The recurrent theme in these debates is the extent to which the potential for posthumous donation can be considered in a patient whose death seems very likely but has not yet occurred, and in what way such considerations can be allowed to influence management before death is declared. Common reasoning is that deviation from the normal clinical management if organ donation were not considered would be contrary to the patient’s best interests. Some practitioners cite part of the judgment in the case of Anthony Bland, who was in a vegetative state and kept alive by nasogastric feeding, as legal support for their position. The excerpt from Lord Browne-Wilkinson’s speech in the Bland case that alarms clinicians working in intensive care is as follows:

If there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person.

Perhaps understandably, some clinicians interpret this short extract of the lengthy speech as meaning that it is contrary to a patient’s best interests, and thus not lawful, to initiate, continue, or escalate cardiorespiratory support that has been judged medically futile in order to maintain or improve the potential for that patient to become an organ donor in the event of his or her death.

This interpretation derives from a misunderstanding of how English law conceptualises best interests. Consider a second quotation from Lord Browne-Wilkinson’s speech:

The answer to the question [of whether withdrawal of care is in the patient’s best interests] must of course depend on the circumstances of each case and there will be no single “right” answer. Different doctors may take different views both on strictly medical issues and the broader ethical issues which the question raises.

Best interests can be judged only in the context of the particular patient. Later judgments that develop the concept of best interests show that doctors must think beyond that which is immediately clinically beneficial to the patient. The views and values of the patient, if known, must be taken into account, and, if not known, explored through a timely discussion with the patient’s family, friends, and carers.

Courts’ approach to best interests

The best interests test in English law derives from Re F in 1989, and is now given statutory force in the Mental Capacity Act 2005. In Re F, it was held that neither the family nor the courts had any power to consent to treatment on behalf of an adult patient who lacked mental capacity and that treatments could not be justified solely because they made the lives of others better or easier. Rather it was found that in cases involving adults unable to consent, a proposed medical intervention would be lawful only if it were in the best interests of the patient.

For patients receiving life support, Bland provided an important point in analysis of best interests. But since that case, the English courts have developed a clearer and more coherent picture, with one common theme being pre-eminence: best interests demands that decision makers look beyond purely medical considerations. The then president of the family division made this clear in the cases of Re A, when she held that “best interests encompasses medical, emotional and all other welfare issues,” and Re S, when she stated that a decision on best interests asks not only what is medically indicated, but also “broader ethical, social, moral and welfare considerations.”

Best interests are informed by the patient’s own values. Recently, the High Court was asked to consider whether a patient in a persistent vegetative state should have anything other than her physical requirements considered when assessing her best interests. It held that, even with such a severely incapacitated patient, it was necessary to consider intangible benefits, such as familial, spiritual, and religious benefits, that the patient would have considered important when she had capacity. Consequently, it judged that this devoutly Muslim patient should be cared for in an environment commensurate with her faith, even though this was a benefit that she would never consciously appreciate.

The courts have made it clear that patients’ wishes and values count. Their best interests
are not just to receive what is medically indicated, but are also served by considering their ethical, social, moral, spiritual, and religious values. An express wish to be an organ donor is such a value. Case law supports a broad approach to assessing best interests, and this principle extends to the protection of those who would wish to be posthumous organ donors. If their values support it, their best interests are served by preparation for it while they are still alive.

Mental Capacity Act

The Mental Capacity Act 2005 reinforces this interpretation. Section 4 elaborates on how we should understand best interests, and there is extensive discussion of the concept in the Code of Practice, which endorses the broad means of understanding best interests. Section 4(6) obliges decision makers to consider so far as is reasonably ascertainable:

• The person’s past and present wishes and feelings
• The beliefs and values that would be likely to influence his decision if he had capacity, and
• The other factors that he would be likely to consider if he were able to do so.

So it is mandatory to inform any assessment of best interests with notions of good and bad that extend far beyond that which is clinically indicated. Hastening patients’ deaths to access their organs is clearly unlawful, falling foul of the laws on homicide. Equally, elective access their organs is clearly unlawful, falling foul of the laws on homicide. Equally, elective

Conclusion

As far as the law is concerned, we have said nothing new in arguing that a potential organ donor’s interests include being considered for donation while still legally alive. Nevertheless, fears of the law that have no solid foundation are needlessly costing the lives of patients who die awaiting transplantation. The UK General Medical Council guidance on withholding and withdrawing life-prolonging treatments reflects the legal principles that we have highlighted. For clarity and reassurance to practitioners, we suggest that it should add a clause to cover decisions to prepare a patient for organ donation after death. The law is clear: treating a patient in accordance with his or her best interests means more than doing what is medically indicated. It requires us to explore the patient’s values and to choose the course of action that accords best with them. Where a patient would wish to donate, measures such as those described here are not unlawful if they are necessary for organ donation to proceed. They serve, rather than deny, the best interests of a patient.

SUMMARY POINTS

The law requires that patients who have lost mental capacity be treated in their best interests. Best interests are not limited to clinical considerations but includes the patient’s values and wishes. These wishes can include the desire to donate organs. When such a patient’s death is imminent and inevitable, interventions to improve the prospects of donation that can carry no harm are lawful.

“Best interests includes facilitation of organ donation”