Can legal amendments unintentionally complicate donation services?

Organ donation and ethics

Transplantation is an integral part of the treatment programme for certain organ diseases. This presupposes organ donation, from living as well as deceased donors. The need for organs exceeds the supply, and increasing the availability is a goal. The definition of death in the Transplantation Act is brain death. Prevailing practice is to raise the issue of organ donation when all treatment opportunities have been exhausted and brain death is imminent or already a fact. Might some of the conditions in the Transplantation Act be amended, so as to simplify implementation of organ donation? Proposals for amendments would in any case need to be based on the fact that nobody wishes for uncertainty as to whether the hospital doctors give priority to effective treatment above organ donation in case of life-threatening injury/disease.

What attitudes do Norwegian doctors have with regard to terminal treatment and organ donation? This is the question asked by Foss and collaborators in this issue of the Journal of the Norwegian Medical Association (1). In 2008–2009, they conducted a survey among doctors in intensive-care units and specialists and junior registrars in neurosurgery. Altogether 435 doctors (55 % of the recipients) completed the questionnaire. A total of 315 out of 420 responded that they could imagine initiating organ-preserving treatment «when there is no hope for the patient», while 18 % were uncertain and 7 % responded that they would not consider this option.

The authors use the term «when there is no hope». Many aspects of the course of a critical brain injury/disease may rob the health personnel and the next of kin of hope. For the treating doctor responsible, this is not a matter of hope, but of clarification of treatment opportunities and the further critical development of the disease. The authors have not discussed their findings in light of the proposals put forward in the public report *Når døden tjener livet [When death serves life]* from 2011 (2).

The study elucidates whether conventional cerebral angiography should remain the only radiological method for diagnosing cessation of cerebral circulation. Respiratory and cardiac arrest as a criterion of death before organ donation was also reviewed. One of the proposals was that the law should permit initiation of organ-preserving treatment (intensive care) in case of severe brain injury/disease, even when there are no indications for initiating life-saving treatment. Common practice is to initiate organ preservation once life-saving treatment has been attempted.

It may be problematic for the treating doctor to explain to the next of kin of a patient with a life-threatening brain injury/disease that there are no indications for initiating treatment, but that the hospital would like to take steps to preserve and use the patient's organs. Oslo University Hospital is conducting a project in which the precondition for organ donation is not brain death, but serious brain injury/disorder complicated by respiratory and cardiac arrest at the end of treatment.

Activities related to organ donation require substantial resources in an intensive-care unit. A candidate organ donor may possibly displace another seriously ill patient. An enhanced emphasis on organ preservation and consequent transplantation activity will necessarily require additional resources.

Almost certainly, no one has deliberately intended to reduce the integrity of donors as patients. This notwithstanding, the proposals in the study *Når døden tjener livet* may give rise to ambiguities. Recent signals from the Ministry of Health and Care Services regarding a possible future legalisation of euthanasia (3) pull in this direction. In a hearing memo on the GP's right to conscientious objection to referrals for abortion, the Ministry proposed an amendment to Section 3-2 of the Health and Care Services Act. The amendment would authorise regulations on the opportunity for doctors to object in case of serious conflicts of conscience, including «objection to euthanasia in the event that this should be made legal» (3).

Some countries permit euthanasia administered by a doctor (4). However, this does not imply that doctors are obligated to participate. A statutory right (including for hospital doctors) to object to euthanasia would be required only if the doctor could be instructed to provide such help. Euthanasia is intended for groups of patients other than those whom we are treating in an intensive-care unit. Though not exclusively, however – this would depend on possible guidelines for euthanasia. Only very few intensive-care doctors would be in favour of euthanasia. Could it nevertheless disrupt the relationship between the doctor and the next of kin in an intensive-care unit with donation responsibility if euthanasia was permitted?

Terminal treatment must be based on trust, one precondition for which is provision of understandable and exhaustive information to the patient and the next of kin. There must be absolutely no doubt that the doctor's role is to treat the patient (5). Terminal treatment must take place in accordance with established guidelines (6). Organ donation should not compete with the purpose of treatment, but will arise as an opportunity wherever the treatment has failed and the patient is terminal/dead. Legal amendments that give broader permission for organ preservation with a view to donation in cases where life-saving treatment is pointless, but not attempted, and the patient's imminent death is highly likely, presuppose a new set of regulations that strike a balance between these concerns.

The Ministry of Health and Care Services is preparing a revision of the Transplantation Act on the basis of the proposals in the public report from 2011 (2). A new set of regulations that permits alternatives to conventional angiography for diagnosing brain death is expected (7). The proposals for amendments are likely to trigger a debate. Even though the hearing memo on conscientious objection was withdrawn, the Ministry has unintentionally created ambiguities regarding the future role of the treating doctor in terminal treatment – which in some cases may be related to organ donation (3).

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