

Establishing an ethical framework for DCD

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Where shall we start?

Some philosophers think that the key to getting things right ethically is to identify what people care about.

Before doing that there is a decision to be made about whose interests count in a particular context or in relation to a particular issue

- Recipients
- Potential donors
- Donor Families
- Health Care Professionals

What did we know would matter when setting out our framework?

- Societal concerns about donation trumping other considerations.
- The challenges of dealing with uncertainty
- Professional concerns about conflict of interest
- Shared concerns about consent to donation

Underlying principles

Unapologetic about donation, seeing it as an opportunity which people should not be needlessly denied, particularly if they have expressed the wish to donate in life

Clear separation between treatment decisions at the end of life and decisions relating to donation

Ultimate goal of making donation 'usual not unusual' and 'part of core NHS business'

End of life care

- Treatment will continue in the hope of saving a person's life unless there is evidence of an advance statement refusing treatment and until further treatment is considered to be counter to the patient's best interests.
- In the case of a known donor there is the possibility that certain treatments may be continued beyond the point at which they become clinically futile because they will contribute towards a successful donation
- This is possible because respecting the wishes of the patient is considered to be an important part of acting in their best interests

Conflicts of interest

- Moving health care professionals towards a more holistic notion of best interests where goals, projects, values etc. become part of the picture
- Engaging them with the idea of managing someone's dying to allow them to become an effective donor
- Presenting the dying patient (who cannot be saved) as a valid recipient of a bed in ITU

Ethically cautious approach

- Having said this, it is rarely appropriate to assume that a good end (in this case securing a good donation) justifies any means necessary, and traditionally we have taken a cautious approach to interventions prior to death when they are undertaken *only* in the interests of donation.
- Maybe we need to be bolder?

What would that entail?

- Perhaps we need to be more explicit in terms of the consent we acquire?
- If not, we may need to reassure ourselves that what we do would be consented to by ‘the average donor’?
- Or could we perhaps ask people to trust health care professionals do what they need to do in order to secure a good donation, whilst at the same time ensuring that nothing is done which works against the donor’s best interests?

So where does this leave us in terms of a framework?

- We are clear on guiding principles
- We are comfortable with the guidance we have offered on donation after circulatory death
- We are now working on what can and cannot be accommodated (ethically) within that framework
- Thus our framework will develop and over time it might allow for changes in practice which would have been untimely at the outset.

What we need to do

- Keep checking in on what people do (and don't care about)
- Listen to professional concerns
- Build public trust
- Ensure that an individual donor's death and dying is ethically acceptable to that person