

# Response from the Nuffield Council on Bioethics to the Scottish Parliament's Health and Sport Committee Consultation on the Transplantation (Authorisation of Removal of Organs etc.) Bill.



October 2015

## KEY POINTS

- Decisions about deceased donation should be based on the known wishes of the donor, so far as these can be discovered.
- We would not oppose on ethical grounds a 'soft opt-out' system, in which families had the opportunity (without pressure) of contributing their knowledge of the person's own views. We do, however, note some practical difficulties in implementation, and some doubts as to the impact of such a change.
- It is important that loss of trust in the system is minimised, for example by ensuring that those seeking family views are not themselves subject to targets that might be seen as leading to pressure on families.
- While we recognise that waiting for evidence from changes to the Welsh legislation will take some time to emerge, we recommend that any change to the system in Scotland should be accompanied by robust research, both on the role of relatives in determining whether organs may be donated, and on the effect that the legislative change has had on the numbers of organs donated.
- The possibility of donating material for research use should be routinely raised with the person's family when authorisation for the removal and use of organs or tissue is sought after death.

## Background

The Nuffield Council on Bioethics is an independent body that examines and reports on ethical issues raised by developments in biology and medicine. It is funded jointly by the Nuffield Foundation, the Wellcome Trust and the Medical Research Council.

In October 2011, the Council published a report, *Human bodies: donation for medicine and research* (available online <http://nuffieldbioethics.org/project/donation/>), which considers how far society should go in encouraging people to donate their bodily material. The report was the result of a two-year independent inquiry led by Professor Dame Marilyn Strathern. In coming to its conclusions, the Working Party held an open consultation to which members of the public as well as academics and professionals involved in transplantation services were encouraged to respond. A deliberative workshop was also held with members of the public recruited to represent a cross-section of the UK community.<sup>1</sup>

<sup>1</sup> Opinion Leader (2010) *Nuffield Council on Bioethics: human bodies in medicine and research - report of deliberative workshop on ethical issues raised by the donation of bodily material*, available at: [www.nuffieldbioethics.org/donation/donationexternalconsultation](http://www.nuffieldbioethics.org/donation/donationexternalconsultation).

We have previously submitted evidence to the Welsh Assembly Consultation on Proposals for Legislation on Organ and Tissue Donation (Jan 2012); the Consultation on the Draft Human Transplantation (Wales) Bill (Sept 2012); and the Health and Social Care Committee Consultation on the Draft Human Transplantation (Wales) Bill. Our responses are available online, here: <http://nuffieldbioethics.org/policy/>

## **Our response**

### ***Ethical considerations***

1. We believe that decisions about deceased donation should be based on the known wishes of the donor, so far as these can be discovered. Such information should, ideally, derive from the person's own expression of these wishes before death (see paragraphs 5.57-5.61 of the full report).
2. In the absence of a record of the deceased's wishes (including the absence of any evidence of objection), information as to their likely wishes should be sought from those close to the deceased person, who are usually best placed to know the deceased person's wishes, and who themselves, in their bereavement, have a stake in how their deceased relative's body is treated.
3. We take this overall view on the basis that there is sufficient evidence that, for many people, the disposal of their bodily material is a matter of significant personal concern, and that to take material without some evidence that this is in accordance with the person's wishes risks treating the person's body as a means to others' ends.
4. Clearly not everyone regards their bodily material – during life or during death – in such a way, but the entrenched and opposing views on proposals for an 'opt-out' approach to deceased organ donation highlight the fundamental lack of consensus on this issue within the UK. However, we make a distinction between what is required for valid consent to an intervention during one's lifetime, and what should be required for valid consent in respect of a deceased person's bodily material. In particular, we suggest that the degree of detail required when providing information about the proposed procedure will differ significantly, and that it should be possible for a person to provide legal authority for donation after death on the basis of quite minimal information, if this is sufficient for them to be clear about their own wishes.
5. Finally, we emphasise the importance of consent in creating and maintaining trust in health professionals and the health care system as a whole. We note that where 'medical mistrust', or mistrust of the system, is cited as a reason for people to hold back from donating bodily material, this may be associated with concerns about consent: both that the terms of the consent may be abused (for example by using the donated material in a different way from that envisaged in the consent) and that additional material may be taken without explicit consent. This is a factor that must be taken into account when considering any changes to approaches to consent.

### ***Research on effectiveness of opt-out systems***

6. We are aware of the ongoing discussions in the research literature as to whether increases in organ donation in countries such as Spain that have introduced opt-out legislation can be ascribed to the legislative framework, or whether other systemic factors in the way organ procurement is managed are the main contributing factor to

the increase. A systematic review of studies comparing ‘before and after’ donation rates after legislative change in a number of countries, published in 2009, concluded that changing to an opt-out system of consent alone was unlikely to explain the variation in organ donation rates between countries, with many other factors identified as relevant. These included both factors affecting the total number of potential donors available (for example rates of motor accidents, the population’s age distribution, and the country’s definition of death), and factors affecting how many of those potential donors in fact went on to donate (for example the organisation and infrastructure of the transplant system, wealth and investment in health care, and underlying public attitudes and awareness).<sup>2</sup>

7. Another study, published subsequently, concluded by contrast that opt-out systems are associated with relatively higher rates of deceased donation – but also with relatively lower rates of living donation.<sup>3</sup> We are also aware of research modelling the possible effects on organ supply of an opt-out system, based on differing levels of individual and family opt-out.<sup>4</sup> We note that, while such models demonstrate a potential increase in the number of available organs (and hence lives saved) on the basis of particular assumptions about numbers opting out, such assumptions clearly remain to be tested.

### **Our recommendations**

8. In our opinion, **the importance to be attached to the person’s own wishes rules out absolutely any consideration of introducing a ‘hard’ opt-out approach to deceased organ donation**, given the impossibility of ensuring that everyone would be sufficiently well-informed to have the opportunity of opting out during their lifetime.
9. However, **we would not oppose on ethical grounds a soft opt-out system**, in which families had the opportunity (without pressure) of contributing their knowledge of the person’s own views and, where appropriate, of determining that the person would not have wished to become a donor, or indeed that donation would cause the family significant distress. We do, however, note some practical difficulties.
10. First, we suggest that **initial assumptions as to the numbers of additional organs that might be obtained in such a way should be modest**, if families do indeed continue to feel genuinely free to express any objections they feel. It does not automatically follow that families who currently refuse consent to the use of their deceased relative’s organs would take a different view under such a system. Indeed, if families in such cases felt coerced in any way, then this would potentially render their role meaningless. On the other hand, if the effect of any policy change were to change attitudes so that donation were seen as ‘natural’ or ‘normal’, hence increasing the likelihood that families would conclude that donation would be in line with their deceased relative’s wishes, this would be ethically unproblematic. Similarly, if families felt relieved from the requirement actively to make the decision, this too might lead to fewer refusals.

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<sup>2</sup> Rithalia A, McDaid C, Suekarran S, Myers L, and Sowden A (2009) Impact of presumed consent for organ donation on donation rates: a systematic review *BMJ* **338**.

<sup>3</sup> Horvat LD, Cuerden MS, Kim SJ *et al.* (2010) Informing the debate: rates of kidney transplantation in nations with presumed consent *Annals of Internal Medicine* **153(10)**: 641.

<sup>4</sup> Bird SM, and Harris J (2010) Time to move to presumed consent for organ donation *BMJ* **340**: c2188.

11. Second, given the strong opposition in some quarters to the notion of any form of opt-out scheme, and the associated concerns that the state (acting through health professionals and the health care system) would be intervening to ‘take’ organs rather than facilitating their being ‘given’, there is at least a risk that some degree of trust in the system could be lost. In such circumstances, **it would be particularly important that systems should be designed in such a way as to minimise such loss of trust**, for example by ensuring that those seeking family views are not themselves subject to targets that might be seen as leading to pressure on families.
12. As we have already shown, there may be a significant difference between how people think or say they will act in particular theoretical situations, and what they actually do if that situation arises (see paragraph 6.19 of the full report). We are therefore hesitant to rely on research reporting on how people say they would respond to the introduction of a soft opt-out system including all the protections described above. At the time of writing our report, we noted that the Welsh Assembly was considering a soft opt-out system of organ donation, due to be implemented in December 2015. Post-legislative scrutiny of the impact of the Human Transplantation Act in Wales will provide useful evidence of the effectiveness (or otherwise) of a soft opt-out system. **While we recognise that waiting for evidence to emerge from the changes to Welsh legislation will take some time, if an opt-out system is introduced in Scotland, we recommend that this is accompanied by robust research**, both on the role of relatives in determining whether organs may be donated, and on the effect that the legislative change (as opposed to any confounding factors such as system changes) has had on the numbers of organs donated. Such research would provide a clear evidence base for any proposals for change elsewhere in the UK, or indeed further afield.

#### ***Donation of organs for tissue for research***

13. We note that current proposals in Scotland will apply to the donation of organs and tissues for the purposes of transplantation only, and not include the donation of organs and tissues for other purposes, such as research, display or commercial use.
14. We consider that it is crucial that any change in the systems used to obtain consent should take fully into account the implications for the donation of organs and tissue for research purposes. In the context of the current ‘opt-in’ system to organ and tissue donation, our report recommends that **the possibility of donating material for research use should be routinely raised with the person’s family when authorisation for the removal and use of organs or tissue is sought after death**. We also suggested that routine information about the Organ Donor Register should include explicit reference to the potential research uses of organs and tissue, and that potential donors should have the option of authorising such uses in advance.