Editorial I

A historic opportunity to improve organ donation rates in the UK

Organ transplantation saves lives and improves lives. It trebles the life expectancy of patients with end-stage renal failure compared with dialysis and improves their quality of life immeasurably. For liver, lung, and heart failure, transplantation is often the only alternative to premature death. The very success of transplantation has led to a significant increase in the demand for donor organs over the last decade, but there has not been a similar increase in their availability. In the UK, demand for donor organs now far outstrips their supply and although the relative shortage of donor organs is a worldwide problem, the disappointing aspect of the situation in the UK is that, although many countries have been able to increase cadaveric donation, deceased donation rates in the UK have remained stubbornly static. The current UK rate of 12.8 deceased donors per million of population (pmp) per year was once quite typical, but it is now almost three times lower than that in Spain and half that in Belgium, France, Italy, Austria, and the USA. The net result is that there are currently more than 8000 people in the UK waiting for a transplant, but only 3000 transplants are carried out each year. More than 1000 people die each year while awaiting a transplant, with thousands more arbitrarily denied access to a waiting list.

There are currently two sources of organs for transplantation: living donation and deceased donation. In turn, deceased donation may follow either death defined by neurological criteria, that is, brainstem death, or cardiac death. Controlled non-heart beating organ donation (NHBOD) is the most common form of donation after cardiac death in the UK, although still practised relatively infrequently. Significant investment in living donation has resulted in this form of donation becoming the major source of kidneys for transplantation in the UK. In this regard it should be noted that although heart-beating brainstem dead donors offer the opportunity for retrieval of abdominal and thoracic organs, retrieval after cardiac death is usually limited to retrieval of kidneys, occasionally liver and rarely lungs. Although the total number of deceased donors has remained constant in the UK over the last decade, there has been an increase (from a low baseline) in the proportion of NHBOD from 5% of the total in 2000 to 19% in 2006. This conceals a reduction in the number of heart-beating donors and further threatens the availability of thoracic organs for transplantation.

The shortage of cadaveric donor organs for transplantation in the UK has now reached crisis point. Recognizing that public support for donation after death remains strong, and with the knowledge that other countries, both within mainland Europe and the Americas, have substantially and sustainably improved donation rates, the Department of Health established a multi-disciplinary Organ Donation Taskforce in late 2006 with the remit to identify barriers to organ donation in the UK and to recommend solutions within existing legislative and operational frameworks. The Taskforce focused on three key areas—donor identification and referral, donor coordination, and organ retrieval arrangements—and was mindful of two fundamental principles, namely the primacy now given (after the introduction of the Human Tissue Act) to the wishes of an individual to donate after their death and an emerging view that staff caring for patients when they die should systematically consider, when appropriate, the option of donation as a routine component of end of life care. The Taskforce heard evidence from experts who have successfully led improvements in organ donation in Spain and North America and learned the importance of comprehensive and timely identification of all potential organ donors. In this regard, the Taskforce identified an urgent need to understand the suggestion from the UK Transplant Potential Donor Audit (PDA) that there is a significant cohort of patients—perhaps as many as 600 patients each year—dying a cardiac death on
intensive care units in whom a diagnosis of brain stem death was, in the opinion of those conducting the audit, likely but never confirmed, thereby losing the potential for those patients to donate. Other key features of successful organ donation initiatives elsewhere in the world are the commitment to train and support staff who work in critical care areas at the interface between donor identification and organ retrieval, and the overwhelming impression that organ donation has become core business for all those working in healthcare, from clinicians to national departments of health. The Taskforce wishes to see similar arrangements in the UK and recommends the establishment of functional partnerships between clinicians and the hospitals in which they work, UK Transplant and the Department of Health, with the roles and responsibilities of each being clearly defined, adequately resourced and underpinned by audit, education, and training. In this way, all parts of the NHS can begin to embrace organ donation as a usual not unusual event.

The recommendations of the Taskforce describe a new framework for organ donation in the UK and offer the intensive care community a unique opportunity to drive the shift to more responsive organ donation and transplantation arrangements. None of the recommendations requires any radical change in clinical practice, but rather a universal application of current best practice—every day, everywhere, and regardless of the circumstances. The Taskforce was acutely aware of the crucial role that intensive care clinicians play in the identification and management of potential organ donors and accepted that uncertainties over the current ethical and legal aspects of organ donation, particularly what measures a doctor could or should take in order to facilitate organ donation from a patient who is dying but not yet dead, would prevent some clinicians from embracing the proposed changes and, importantly, identifying potential donors. In recognizing that clinicians have a right to be assured that their actions in relation to organ donation do not present them with a conflict of interest, and that they are clearly lawful, the Taskforce is determined that outstanding legal, ethical, and professional issues should be resolved urgently in a binding and authoritative fashion. Only in this way can clinicians work within a clear and unambiguous framework of good practice.

In the issue of the journal, Thomas and colleagues provide an intelligent, detailed, and thoughtful description of how they have improved deceased donation rates through the introduction of a controlled NHBOD programme in a regional neuroscience intensive care unit that also provides general intensive care. They describe the steps taken to establish the programme and the results for the 5 yr after its implementation. The importance of this publication is three-fold. First, and most obviously, the authors demonstrate how critical care staff can successfully offer patients and their families the option of organ donation after cardiac death. The relatives’ refusal rate of 29.6% for NHBOD identified by the authors compares favourably with a refusal rate of around 44% for heart-beating donation, suggesting that NHBOD is acceptable to families. In fact, NHBOD is likely to be more acceptable than donation after brainstem death to those who wish to witness cessation of their relative’s heartbeat. Their conversion rate of 40.8% (of potential donors to actual donors) also compares favourably with the national conversion rate of 45% in heart-beating donation, thereby supporting early indications from the PDA that a nationwide adoption of NHBOD would lead to the identification of an additional 150 donors each year.

The second important feature of this paper follows on from the first. Although NHBOD is not new—the first cadaveric kidney transplants in the UK were carried out using organs retrieved from asystolic donors—its re-introduction has met with considerable opposition from elements of the intensive care community in the UK who have forcefully expressed their anxieties over some of the practical, ethical, and legal aspects of NHBOD programmes. Although heart-beating donation after brainstem death is supported across the whole of the country, only a minority of intensive care units currently offer the option of donation after cardiac death. Although the failure to provide NHBOD programmes can be related to inadequate organ retrieval facilities, it can equally reflect the unhappiness or unwillingness of local critical care staff to accommodate the process. Thomas and colleagues have provided compelling evidence that with care and attention, and a willingness to define potential obstacles to NHBOD and tackle them head on, a programme for donation after cardiac death can be successfully introduced and supported by all members of the team. Furthermore, they demonstrate that once established, it is a process that is likely to be adopted in other units in the area when staff, through focusing on patient autonomy, have also come to recognize that the impediments to NHBOD appear to lie primarily with clinicians rather than with potential donors or their relatives.

Finally, and perhaps most importantly, this study is timely. The recommendations of the Taskforce call for a complete overhaul of the relationship between critical care units and organ retrieval services, based on the fundamental principle that donation should be a consideration, where appropriate, after every death, but with a clear recognition that the opportunities for solid organ donation remain uncommon. Thomas and colleagues demonstrate how motivated critical care staff can work constructively in partnership with local organ retrieval teams to give more families the opportunity to ensure that the wishes of their relatives to donate after death are honoured. Their work demonstrates that organ donation can become an automatic consideration whenever irreversible asystole is anticipated. It also clearly shows that donor transplant co-ordinators are most effective when working as part of the critical care team rather than being external agents.
whose apparent motivation is solely to increase donation rates. The authors recognize the benefits from early involvement of a donor transplant co-ordinator and the expertise that they bring. The Taskforce also recognizes the importance of this relationship and recommends that donor transplant co-ordinators should work more closely with critical care teams to support and develop approaches to organ donation that are professionally, ethically, and legally acceptable, as well as providing more general support within the team. 6

The Prime Minister has recently called for a wide public debate about presumed consent, adding that a different consent system could ‘serve to increase donation levels significantly’. 11 Many patient groups oppose a move to presumed consent and, despite support from some areas of the medical profession, such as the British Medical Association, 12 there is considerable uncertainty in other quarters that a change in the consent arrangements would actually bring the increases in organ donor numbers that some suggest. Whatever the conclusions of the ongoing debate, the issue of presumed consent must not be allowed to divert attention away from the other changes that are so urgently required to improve organ donation arrangements in the UK. Even were consent rates in the UK to match those in Italy, France, and the USA and nowhere near approach donor pmp per year and would still fall short of those in the level of public support for donation (of between 80% and 90%), donation rates would only rise to around 19 quarters that a change in the consent arrangements would actually bring the increases in organ donor numbers that some suggest. Whatever the conclusions of the ongoing debate, the issue of presumed consent must not be allowed to divert attention away from the other changes that are so urgently required to improve organ donation arrangements in the UK. Each of the Taskforce’s 14 recommendations has an important contribution to make in building the organ donation service that is so urgently needed in the UK. 6 These recommendations are radical and wide-ranging and the involvement of all key stakeholders is essential to their successful implementation. The Taskforce believes that their implementation will save the lives of at least 1000 patients each year and dramatically improve the quality of life of countless more. The proposed changes will ensure that organ donation is considered every time a potential organ donor dies, that the wishes of the potential organ donor or their family are ascertained and respected, and that every opportunity is taken to maximize the number of organs that can be transplanted successfully. The recommendations represent a coherent and bespoke framework for organ donation in the UK, and are founded on a determination to pursue the clarification of outstanding legal and ethical issues that will crucially allow clinicians to embrace the proposed changes with confidence. The experiences of Thomas and colleagues 9 are an important contribution to the process of change, demonstrating that an NHBOD can be successfully introduced into an intensive care unit. We must now all play our part in ensuring that the wishes of our dying patients to donate their organs after death are identified, respected, and honoured by embracing the recommendations of the Taskforce.

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Declaration of interest

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References

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