

Organ donation — two new proposals

Organ transplantation and donation has been a perennial topic of discussion in medical ethics since transplantation first became possible. In this issue there are two articles discussing ways in which the number of organ donations could be increased in an ethically acceptable way.

De Wispelaere and Stirton identify the *de facto* 'family veto' as one major problem in cadaveric organ donation (*see page 180*). They suggest that one way of overcoming this problem would be through a specific advance commitment device which can increase the chance that a person's prior commitment to donate is actually acted upon when the person has died. Their concrete suggestion is that potential donors who register with organ donor registries should not only register their intention to donate but should also appoint a designated second consentor (DSC). The DSC would be a person that was committed to upholding the donor's decision after the death of the donor. The DSC could be a family member or a friend, and in a situation where donation became an option the local donor coordinator would contact the DSC and the donation would go ahead unless the DSC objected. The authors argue that introducing a DSC will have several positive effects: (1) it will increase the likelihood that the donor's wishes are acted upon, (2) it will simplify decision making after death, and (3) it will reduce donor and family distress.

The proposal by Phedias Diamandis is much more radical (*see page 155*). He suggests that we should implement a universal living donor programme for kidney donation—that is, a programme where we are all potential universal living kidney donors. According to his analysis such a program is prudentially warranted and ethically mandatory given our current

knowledge concerning the risks to live kidney donors, the benefits that accrue to recipients of kidney transplants and the extra costs to society in providing dialysis and other treatments to persons who could have been transplanted if enough kidneys had been available. It is argued that such a scheme would have to be voluntary, but that everyone ought to sign up to it. In a significant departure from standard bioethics writing, the author does concede that, even though he is convinced by his own argument, he still remains 'uncommitted with regards to my status as a living organ donor.' The Editors of the JME applaud his commitment to honesty!

Assisted suicide — is helium the way to go?

One of the many ways in which a person can commit suicide is by oxygen deprivation through the use of helium as the oxygen excluding gas and some sort of face mask or other device for delivery of the helium. Some assisted suicide organisations, including Dignitas in Switzerland, have used this method. It is also described on the web. The paper by Ogden *et al* analyse four videos of assisted suicide by this methodology (*see page 174*). The researchers obtained the videos from Dignitas. In all four cases the suicide succeeded, and consciousness was lost in less than 1 min, but in one of the cases death did not occur until more than half an hour had elapsed. Given that complete exclusion of oxygen should result in loss of consciousness in 5–10s the authors conclude that the face mask methodology used is less than optimal. They suggest that a more effective way of achieving oxygen deprivation is by use of a large hood instead of a face mask.

They also point out that their research was only made possible because of the

transparency promoted by some Swiss right-to-die groups.

Shameless self promotion

Finally I would like to point you to the very interesting paper on the ethics of quality improvement (QI) in general practice by Tapp *et al* (the *et al* includes one S Holm) (*see page 184*). This paper discusses under what circumstances quality improvement projects in general practice should undergo formal ethical review. Such projects often fall in a grey zone between research and audit and often raise data protection issues. It is suggested that whether formal review should take place depends primarily on whether the QI activity is more than minimal risk, and six factors are proposed as aids to risk assessment

QI activities that could be viewed as more than minimal risk

1. Projects that provide untested interventions.
2. Projects that provide less care than the current standard.
3. The risk involved for patients is greater than minimal.
4. Treatment of care is assigned by a protocol and not physician judgement.
5. The intentions are unclear, and reducing costs is an over-riding factor.
6. Data sharing is not confidential.

Tweet with us

For those of our readers who are Twitterati we wish to point out that JME blog entries can now very easily be re-tweeted to all your followers.