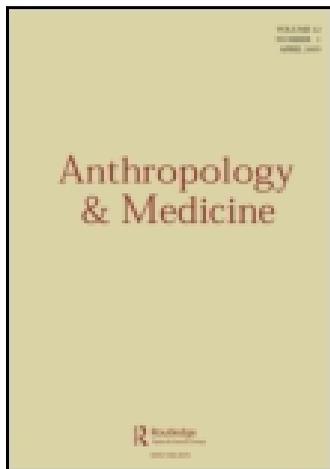


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## The emergence of the ‘ethnic donor’: the cultural production and relocation of organ donation in the UK

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Organ donation is constructed in the UK as a public responsibility, but more particularly as an obligation for members of minority ethnic communities. This paper draws attention to the ways in which ‘ethnicity’ has been made problematic by the allocation practices of transplant medicine, health promotion discourses and policy developments. Taken together, they have served to culturalise and racialise the procurement of organs. As the problem of organ donation is as much made inside medicine as outside it, this paper argues greater attention ought to be paid to these institutional practices and processes. Drawing on ethnographic work in the north of England, and with a specific focus on the organ consent encounter, this paper shows how categories of ethnicity in organ transplantation are an outcome of biopolitical and institutional practices. It argues that organ donation is best thought of, less as a discrete temporally-bounded act of decision-making, and more as a set of variegated situated practices that, in all manner of ways, problematically produce the publics that transplant medicine has come to rely upon so profoundly.

**Keywords:** ethnography; medical anthropology; organ donation; ethnicity; UK

### Introduction: organ donation, moral imperatives and ‘cultural’ differentiation

Organs, from living or deceased donors, provide the raw materials upon which transplant medicine depends; they are the *sine qua non* of this particular area of medical practice. However, transplant medicine’s dependence on organs is not a problem it can resolve for itself. Securing these raw materials has come to be treated as a public responsibility; one fostered through discourses that link donation with gift-giving, altruism and self-sacrifice, all modes of exchange predicated on a biopolitics of scarcity (Sharp 2006). As the technologies bound up with transplant medicine have become progressively more sophisticated and demand for organs has continued to grow, expectations around the public’s involvement have acquired greater intensity. The consequences of this process of intensification have been profound, but also variable, involving subtle shifts from place to place in line with the different ways transplant medicine is practised and organised.

The work of anthropologists has been central in emphasising the complex and situated biopolitical arrangements to which transplantation technologies give rise (Gordon 2002; Gravlee 2009; Hamdy 2010; Kierans and Cooper 2011; Sharp 2006). Of particular significance are the ways in which the technological, organisational and pharmacological developments in transplant medicine, coupled with cross-national differences in preferences for live and cadaveric donation, shape who comes to serve as organ donors, gifters or indeed sellers (Cohen 2002; Crowley-Matoka 2005; Hamdy 2010; Scheper-Hughes

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2002). Furthermore, the moral imperatives that underpin the provision of organs, the emergence of a medical duty obligating both individuals and collectives, has led to the development of new ways of differentiating between those who are required to perform that duty, a process that has served to place organ donors into distinct categories, most notably along racial/ethnic lines (Avera 2009; Gordon 2002; Kierans and Cooper 2011).

The reasons why categories of race and ethnicity – race predominately used in the US; ethnicity the preferred term in the UK (Nazroo 2003) – have acquired salience within transplant medicine are themselves complex. However, in terms of kidney transplantation, the focus of this paper, particular weight is attached to the following. First, kidney disease is prevalent among members of minority ethnic groups. Second, different countries report shortfalls in the supply of organs coming from the same populations. In the US, for example, African-Americans comprise 12.9% of the population, 34% of the kidney transplant waiting list but only 13.8% of deceased donors (Bratton, Chavin, and Baliga 2011). Similar imbalances have been noted in the UK. Third, the practices of transplant medicine privilege organ allocation on the basis of closely matching Human Leukocyte Antigens (HLAs). HLAs vary across humans, however their distributions are represented in transplant medicine as aligning to established racial/ethnic classifications, with ‘black’ and ‘Asian’ populations described as having different HLA distributions than ‘white’ groups. Building on each other in mutually reinforcing ways, the end result is a restriction in the supply of suitable organs to minority ethnic populations. Recognised as raising issues of inequity in transplantation, awareness of these issues has, in turn, driven various health policy and health promotion initiatives specifically targeted at ethnic populations in a bid to increase organ donation, a form of ‘outreach’ that has culminated in bodies of research seeking to identify and explain what are routinely referred to as cultural and social barriers to organ donation (Navaneethan and Singh 2006; Razaq and Sajad 2007).

The implications of orienting to group classifications of this kind have been well rehearsed across social science literatures, including the problems that accompany essentialised understandings of race and ethnicity (Hacking 2006). In addition, there is widespread acceptance of the need to problematise the normative treatment of ‘white populations’ (themselves conceived in misleadingly homogenised terms) as providing the standard by which other people’s practices can be judged (Nazroo 2003). However, it is the perseverance of these categories within science and medicine, and their indifference to critique from the social sciences, that makes them of particular significance (Carter and Dyson 2011). Recent developments in genomics, where the ‘return’ to race/ethnicity has initiated new debates among social scientists, have brought these issues back into view (Gravlee 2009; Smart et al. 2008). The persistence of problematic categorisations, and the classificatory practices they rest on, represents a conundrum, one that highlights the need for further examination of the conditions under which race/ethnicity comes to matter, how its attributions are invoked and for what purposes (Bowker and Star 1999; Carter and Dyson 2011).

### **Aim of the paper**

To advance the debate, this paper explores the relationships between subjects, classification and transplant medicine. It will show that the procurement of organs is the product of a complex chain of interlinked biopolitical and institutional practices, played out across a range of sites, settings and points-of-contact. These include policy making, health promotion campaigns, institutional cultures and medical practice. Employing ethnographic

analysis to work across these domains, this paper concentrates on the emergence of ‘the ethnic donor’ as a consequence of health care arrangements and practices that characterise organ procurement in local settings. This is traced through the inter-linkages between (i) changes at policy levels designed to increase the procurement of organs; (ii) the procedures and training put in place to facilitate organ procurement; (iii) the anticipations of medical staff when requesting organs from ethnic donor families; and (iv) the filling out of donation consent forms. Taken together, these interlinked practices are ones in which ethnicity is enacted and made real (Mol 2002). Particular attention is paid to the position of the Specialist Nurse in Organ Donation or ‘donor nurse’. This role is to bridge public and medical domains: to liaise with donor families; to manage and make possible the decision to consent; to mobilise various medical personnel and to make national and legislative policies to optimise the supply of organs work in practice. The donor nurse is pivotal within the complex social, legal, medical, bioethical, human and non-human arrangements upon which organ donation hinges. The donor nurse ‘animates’ these arrangements at the point where transplant medicine interfaces with its publics.

### **Methodological framework**

This paper draws upon multi-sited ethnographic fieldwork conducted between October 2009 and February 2011 in two acute hospital Trusts in the North of England, serving large Indian and Pakistani populations. Data were gathered from ethnographic interviews; observations of donor nurse team meetings, donation training for health professionals, organ donation committee meetings, and in various ‘community’ settings, (e.g. religious temples and community centres); alongside narrative interviews with health professionals involved in requesting organs from these same populations, and wider community members with experience of transplantation. Given ethical, pragmatic and logistical constraints, it was not possible for ethnographic observations to be conducted of the consent encounter itself. In addition, because the study’s focus was primarily on ethnicity, this would have also entailed long delays in order to wait for the ‘right’ kind of person to die in the ‘right’ way. The consent encounter was instead the central focus of narrative interviews with clinical staff. The authors are, however, fully aware that not being present does limit an understanding of the nuances of interaction and the many different ways the practice of requesting might be altered in view of the background of potential donor families. Full National Health Service research ethics approval was granted for the study, along with research and development approval at both Trusts. Assurances of anonymity have been provided, which have restricted the level of ethnographic detail provided on specific clinical settings. The approach the study takes – explicating the situated character of organ donation – is supported by a literature that operates at the intersections of medical anthropology and science and technology studies (Hogle 1995; Knorr-Cetina 1999; Latour and Woolgar 1986; Lynch 1997; Timmermans and Berg 2003).

### **Organ donation and ethnicity: health policy and health promotion perspectives**

Before looking at specific episodes of clinical practice, the paper turns to the wider context in which those episodes are set. In the UK, organs are principally procured from deceased donors. In recent years, efforts to increase organ donation have focused on, what are routinely referred to as, ‘Black and Minority Ethnic’ (BME) communities – specifically, in this case, African Caribbean, Indian, Pakistani and Bangladeshi groups. According to official statistics, patients classified as BME are three to four times more

likely to develop conditions such as End Stage Kidney Disease than those classified as white. They account for approximately 28% of the kidney transplant waiting list, but only 4% of deceased organ donors (NHSBT 2011). Due to the policies of HLA matching within ethnic groups, these patients have a greatly reduced chance of receiving a transplant despite higher levels of aggregate need.

The criteria for HLA matching within ethnic groups have been subject to critical examination in the recent anthropological literature (Avera 2009; Gordon 2002; Kierans and Cooper 2011). They were altered in the US more than ten years ago, due to concerns over inequalities for black recipients and in response to advances in immunosuppression (Cecka 2007). However in the UK, policy change has been slower. Alterations to the national allocation criteria in 2006 attempted to correct this by ‘defaulting’ HLA types less prevalent in the donor population, to more common forms, in the hope of increasing transplant rates for ‘difficult-to-match patients’ (Johnson et al. 2010). However, such changes have not precipitated a rethink of the broader categorisations of ethnicity used by transplant medicine, and the criteria used to determine who may be matched with whom still treat membership of social and cultural groups as proxies for genetic makeup (Kierans and Cooper 2011). Thus, a problem produced within medicine by its own classificatory apparatuses (assigning organs based on ethnic status) has come to be linked to a solution (increasing the flow of organs from minority ethnic communities) that lies firmly outside it, leading to a distinct cultural relocation of whose problem is organ donation.

This cultural relocation can be traced through health promotion campaigns explicitly aiming to increase donation rates among ‘BME’ populations. Starting in 2001, the ABLE campaign (A Better Life through Education and Empowerment), attempted to raise awareness of kidney disease and transplantation within South Asian and African Caribbean communities (Lightstone and Woolnough 2002). This was followed in 2003 by UK Transplant’s (UKT), attempts to mobilise faith organisations to support organ donation. In 2007, NHS Blood and Transplant (NHSBT)<sup>1</sup> produced its first nationwide campaign targeted at black and Asian populations. Entitled ‘Can We Count on You?’ it featured pairs of well-known black and Asian comedians positioned in a reworking of the famous ‘Your Country Needs You’ British propaganda poster of the First World War. This was followed in 2009 by the ‘Prove it’ campaign, which featured, on separate posters, a black male and a South Asian female patient, both in hospital gowns, with connected dialysing catheters, looking extremely ill. To the right-hand side were similarly worded messages: “Black [/Asian] people are three times more likely to need an organ transplant, but less than 1% of people on the NHS organ donor register are from our community”. The public profile of the *mythic* figure (Barthes 1972) of ‘the BME donor’ has further crystallised in recent years through the media.<sup>2</sup>

It would be a mistake to see this stepping-up in ‘recruitment’ activity as an autonomous response. It has, rather, proceeded in close association with wider policy developments (Shore and Wright 2005), such as the introduction of the Organ Donor Register in 1994 and a succession of legislation and policy reports (BMA 2000; Department of Health (2003, 2004). The 2004 National Service Framework for Renal Services made much of the need to increase donation from BME groups and charged UKT with promoting transplantation among South Asian and African Caribbean populations. In 2007, the Organ Donation Taskforce established a Cultural Working Group to look at prevailing cultural attitudes to organ donation.

In 2008, as part of a strategy to increase donation rates by 50% by 2013, the taskforce made recommendations for changes to the organisation of donation services. These recommendations included the following. (1) Embedding those involved in coordinating

donation – the donor nurse – in hospital Trusts to manage all aspects of the organ donation and consent process. Previously, they worked in small centralised teams, attending hospitals only after receiving a donor referral. (2) Creating the role of Clinical Donor Champion, a responsibility assigned to an ICU (Intensive Care Unit) consultant, to promote organ donation and work collaboratively with donor nurses. (3) Efforts to increase ‘donation after circulatory death’ (DCD), previously seen as a less favourable option than ‘donation after brain death’ (DBD).<sup>3</sup> (4) Increased collaborative working between donation nurses and hospital staff to ensure optimal and timely referral of potential donors (Department of Health 2008).

### **The organisational production of consent**

Fieldwork took place in the context of these changes. It was primarily organised around the work of donor nurses: nurses who come into transplant medicine from ICU and Accident and Emergency (A&E) specialities, but also included input from other ICU staff: consultants, anaesthetists and nurses. With respect to donor nurses, training for their role has developed in step with the shift from working in small regional teams to being embedded within ICU teams. This has expanded their remit; from a focus on strategies around obtaining consent to policies for referring potential donors, managing the referral-to-consent process, alongside ensuring greater standardisation in consenting practices. As all requests for donation are expected to be handled in the same way, no specific training is provided for dealing with different types of donor (ethnic or otherwise). It is important to state that their prior experience in IC medicine served to furnish a familiar ground of interaction for the newly embedded nurses, preparing them for an additional role as trainers of ICU staff in new donation procedures. The next section describes the translation of their role into practical action through an instance of staff training for the aforementioned DCD policy. This is followed by a focus on the organ request encounter and the positioning of ethnicity as a specific problem to be overcome. It is through these encounters that the interlinked processes of policy and practice are made real and the category of the ethnic donor worked up as a significant object of medical practice.

### ***Making national standards and guidelines work in local settings: donation after circulatory death (DCD)***

The hospitals of ‘Hillview’ and ‘Lakeland’ served large South Asian populations (mainly of Pakistani heritage), with Lakeland also serving a smaller African Caribbean population base. Both had histories of low donor rates and had difficulties fostering institutional commitment to organ donation, particularly among the Intensive Care Teams. The donor nurses were to drive local policies to increase donation, changes that implied significant shifts in clinical culture. Hillview was in the process of implementing a DCD programme during the fieldwork period. It was launched by ‘Emily’, a donor nurse, working with ‘John’, the Trust’s clinical donor champion. Emily provided training in the new procedures to the ICU nurses, at lunch-time sessions conducted in her office. Using a power-point presentation, she took staff through various aspects of the policy and accompanying guidelines. She was keen to emphasise that they needed to be confident in their judgements, yet flexible to respond to the complexities they would inevitably encounter.

Emily described the procedures of DCD one-by-one. One of the slides stated: **Consent Can Be Revoked at any Time**. She explained ‘that is, until they go through the theatre door’. Responding to the rule that consent could be revoked by the family until

the first incision is made, the nurses raised concerns. They imagined scenarios where they would have to deal with families chasing dead relatives down hospital corridors. They were troubled by the logistics of getting someone who was clearly dead back into a clinical theatre – wondering what this might look like to an uninitiated onlooker. Emily discussed tactics, ‘Okay, so we’ll have someone waiting by the lift to clear the corridors. We may even cover their face with an oxygen mask for sanity reasons so that people don’t ask what you’re doing with that “patient”’. Institutionalising DCD meant ensuring that these new transplant policies fit with the ICU nurses established working practices, expectations and values. It had to fit within their ‘systems of relevancies’ and be translated into locally relevant guides-to-action (Schutz 1962).

Even when new donation policies, like DCD, are formally rolled-out, there is little that those charged with their implementation can do to guarantee adherence. Where ICU teams previously only encountered donation nurses after ‘inviting’ them into the department after a referral, they are now present from the time a terminal patient arrives on the ward. For donation nurses, this shift involves careful management of relations with ICU staff, who are expected to alert them to any potential donors so that requests can be appropriately planned. Securing organs for transplantation needs to be understood against this cultural-organisational milieu and the ways in which it contingently shapes how the subject of consent is broached with those who must ultimately decide: the families of the deceased.

### ***Obtaining consent from BME families: ethnicity as a problem made in advance***

Approaching families to ask their consent was understandably regarded as difficult and anxiety provoking. When that family was from a minority ethnic background, the task was seen as particularly sensitive and problems were anticipated from the outset. Non-white skin colour, the presence of religious objects, dress, language and the gathering of large numbers of family members were treated as foreshadowing possible difficulties. These were managed through a prospective focus on practical, next-step concerns and the local ‘procedural ethics’ they embodied: how should the request proceed?; how much information should be required?; how should descriptions of the parts of the body affected be tempered?; exactly which member of the family should be spoken to?; how long should the process take? Many staff acknowledged that assumptions played a major role in how they prepared for these interactions. One donor nurse admitted being caught off-guard when presented with a black donor family who had an English surname on the referral sheet and whose ‘ethnicity’, therefore, had been ‘invisible’ prior to meeting. While some staff were concerned about upsetting families, for others the presence of a minority ethnic family was an inconvenience, complicating the job. This was manifest in disparaging remarks such as, ‘Asian families, they want everything done by sunset’; ‘I find these families overly demanding’. One doctor, concerned with having large families obstruct and slow down the request process, restricted Asian families to three to a room. He remarked, ‘I approach the conversation with Asian families with a weight on my shoulders’.

Some encounters had acquired the status of clinical lore among the staff. One particular story involved a woman who had suffered a spontaneous subarachnoid haemorrhage in the ICU. Ellie, a donor nurse relayed it.

This was a Muslim family . . . We went through the whole spiel . . . I was waiting for the husband to say ‘No’ . . . They then started talking in Punjabi. I could hear ‘liver’, ‘heart’,

'kidneys'. I'm thinking they are *actually* going to go with this. Then another family member explained that their nephew, who was sitting in front of me, was waiting for a kidney, could he receive it? So I made enquiries and the answer was yes. I went back and the husband asked if he could have five minutes. When I returned, he'd spoken to his Mullah, who said he couldn't consent. He said, 'donation isn't allowed within our religion.' I said, 'that's not correct. It is how you interpret the Quran, . . . did you tell your Mullah that your nephew was waiting for a kidney transplant?'; 'Yes', he said. Then he added, 'if we had discussed this during her lifetime, she would have been allowed to donate'.

Ellie explained that staff could not understand why the family would not take the opportunity to help their nephew and were disparaging about the decision. A suggestion was made to call in the hospital Imam to broker the situation. This was halted by the Registrar, who was concerned it would be seen as coercion. He insisted the husband's decision had to be respected. In situations such as these, ethnicity provided an explanatory framework and orientation to action. It was called into play when the consent process broke down or explanations did not fit with prevailing forms of reasoning or became over-layered by too many decision makers. Even in situations where donation was agreed, medical practice aligned with the preconceptions of the ethnic donor family. This is particularly visible when it comes to the focus of these encounters, the filling out of consent forms.

### *Formal guidelines; informal practices*

Consenting for donation is a lengthy process, with the donor nurse responsible for ensuring that all requirements are covered and all relevant personnel have been contacted. Depending on the circumstances of death, this can include the police and the coroner, to ensure all legal considerations have been met before consent forms are signed. Obtaining consent takes place in private family rooms, where the family is taken through a standard five-page form; each organ or tissue to be donated is consented for separately. In addition, a patient assessment questionnaire is used to assess the donor's social and medical history to help rule out the risk of HIV and Hepatitis transmission. Questions cover the potential donor's illness history, along with more sensitive questions covering sexual history. The donor nurse must also provide the family with information regarding surgical procedures, the appearance of their relative's body after retrieval and alert them to the possibility that some or all of the organs might be unsuitable for transplantation after their removal. Donation nurses explained that having to accommodate the complexities of ethnicity made this a particularly difficult process, as the following two examples attest.

Stephanie had been nervous on taking an Asian family, who had lost their son, through the consent process for multiple organ donation.

I went through the standard information . . . it was going smoothly until we came to bodily appearances, funeral arrangements, etc. I didn't know how much detail to go into. She [mum] said 'Keep going until I tell you to stop.' I wasn't convinced they knew exactly what they were giving consent for . . . then mum got upset . . . saying 'I don't want to know. It sounds like you're mutilating him. . . . In the end they gave consent but the mother wasn't happy with my description of their son after donation. This was my *first* time and I was shaking because it was an Asian family.

Ruth described taking a 'very large' Hindu family through the patient assessment form, after their daughter, a university student, died after a night out.

... [t]hey had lots of difficulties with the questions ... like smoking, drinking, drugs, sex ... I think they thought she was living by the Hindu faith. Erm ... however, it seemed she was leading quite a Westernised life ... one of the cousins explained she liked an 'occasional drink' and the GP records showed she had been prescribed the morning after pill ... It was very protracted. They kept wanting to get together and discuss things ... certainly the longest consent process I have ever done ... coupled with the family saying [puts on irritated voice]: 'I can't believe you need to ask all these questions. ... can we just say yes or no?' But then they'd want to know more, even though they were having trouble with me giving them information. It was *very* difficult.

Questions relating to drug-taking, alcohol consumption and sexual history were focused on as fissures within interactions. Other authors have indeed drawn attention to the challenges more generally for donor families when faced with alternative truths about their loved-ones (Alneas 2001; Sharp 2006), however, for the donation nurses in this study, this warranted particular attention. Efforts to pre-empt the reactions of families gave way to the development of informal strategies for 'getting through' form-filling procedures and circumventing any awkward exchanges. These included: re-phrasing the required questions in conversational terms; passing over sensitive sections of the forms for families to read for themselves and providing assurances that these are *standard* legal requirements, a necessity for all donor families. Ellie, an experienced donor nurse, explained,

It's very difficult ... what I do is put the forms to one side and have a chat. You find people volunteer information anyway or I'll say 'There's a little section here. I'd like you to read that. If there's anything you'd like to speak to me about afterwards then just come and grab me'.

## Discussion

What is evident from the above descriptions is that securing organs for transplant is far from a discrete, calculated act of decision-making (Weiss 1986). The provision of a 'yes' or 'no' and accompanying signature on a form is a 'highly stylized [sic] rendition of reality' (Weiss 1986, 223) which obscures the infrastructural, preparatory and interpretive work of which it is a product. It is this work that translates formal donation procedures and bureaucratic forms into cultural artefacts that rework the processes of consent (Knorr Cetina 1999; Timmermans and Berg 2003), while imbuing donor families with 'ethnic' donor status. What is important are the ways in which non-white families are problematised *prior* to any encounter with particular individuals. Such encounters are judged to be complicated in ways that those with white donor families are not. They are prescribed from the outset; primed to look for difficulties, they are found at every turn.

Of course, as the wider literature on cadaveric donation attests, there is no good grounds for thinking that white families do not encounter the same type of problems, have similar complex fears around the death of their loved-ones or indeed present challenging scenarios for those tasked with organ procurement (Jensen 2010; Lock 2002; Siminoff et al. 2001). Instead, the need for differential treatment is simply written in and the particulars of given encounters are then treated as evidence that this differential treatment around ethnicity was already warranted. What can be seen here, in other words, is how the status of a particular kind of organ donor takes on a particular salience and is turned into a problem in the course of organisationally situated interactions, which in turn provide grounds for 'further inferences and actions' (Garfinkel and Sacks 1970).

As a consequence, the category of the 'BME' donor is not simply pre-formed, but acquires its significance through mundane medical work. It is part and parcel of the representation of subjects, which is integral to medicine's epistemic culture (Lynch and McNally 2006). In other words, transplant medicine not only enacts the populations it depends on, it produces them through its own classificatory practices, formal and informal (Ruppert 2011). These are, in turn, driven by the organisational efficiencies of biomedicine, policy making, bureaucracies and a distributional politics that seeks to increase organ donation from different populations – ethnic organs for ethnic bodies. As a result, the status of ethnicity has become established as a category apart: problematic and reified, something to be overcome and managed, a self-fulfilling prophecy. Its stabilisation simultaneously reflects and reproduces the assumptions that underpin the use of the term in health promotion and policy discourses. In tracing its movement from national to local settings, the category of ethnicity is made to work simultaneously across different social, cultural and institutional contexts (Bowker and Star 1999, Hacking 2006).

### Conclusion

Transplant medicine is an important cultural domain, and the disembodied organs upon which it relies are an end point in complex biopolitical, regulatory and institutional practices. To date, efforts to examine the relationship between organ donation rates and ethnicity, and to reconstruct one in terms of the other, have been problematic. This is largely due to the moral imperative tied to organ donation, which has assigned responsibility to members of the public, albeit in different ways. Minority ethnic groups have variously been constructed as unwilling, uninformed and restricted by cultural belief. This paper has focused on the institutional arrangements, which show organ donation to be a complex and unfolding chain of interlinked socially and institutionally situated practices. In so doing, it brings more fully into view the practices that shape how organs-for-transplant are secured, but more importantly – through the situation of the 'ethnic' donor – some of the problematic ways in which transplant medicine itself produces the very publics upon which it relies.

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### Notes

1. UK Transplant was succeeded by NHSBT in 2005, which was established as the health authority within the NHS responsible for maximising the supply of donor organs, along with blood and tissue donations.
2. For example, *Blood for Blood*, BBC Radio 4, 25 February 2010.
3. In DBD – the most common type of deceased donation in the UK – death is diagnosed by neurological criteria and donors remain breathing with the aid of a ventilator until the heart is cross-clamped in the operating theatre. With rates of DBD declining in recent years, DCD has been increasingly focused on as a way of optimising donor rates. A patient is referred for DCD after a decision has been made by the medical team to withdraw care on the grounds of futility. Donation occurs once care has been removed and the patient dies by cardio-respiratory arrest.

DCD is only possible if the family agree to withdraw care from their relative and provide consent for donation *prior to the patient's death*.

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