A POSITION PAPER ON ORGAN DONATION AFTER CIRCULATORY DEATH

AN ACT TO AMEND THE HUMAN ORGANS, TISSUES AND CELL DONATION ACT, CAP. 558.

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Executive Summary

This Position Paper presents a multidisciplinary response to the public consultation launched by the Ministry for Health and Active Aging on proposed amendments to the *Human Organs, Tissues and Cell Donation Act* (Chapter 558 of the Laws of Malta). The amendments seek to extend the current legal framework, which permits organ retrieval following death determined by neurological criteria (donation after brain death, DBD), to include organ donation following the irreversible cessation of circulatory and respiratory functions (donation after circulatory death, DCD).

The consultation provides an important opportunity for public and professional engagement with the ethical, medical, and legal implications of introducing DCD into Maltese clinical practice. Data from countries that have introduced a DCD programme shows an increase in organ donation of up to 50%. Therefore, introducing such a programme locally could considerably improve the prospects of patients on transplant waiting lists, which by the end of 2025 included over 90 individuals for kidney transplants alone.

The Position Paper has been prepared by academics in philosophy, ethics, and theology at the University of Malta, in collaboration with medical consultants and specialists in intensive care, nephrology, and neurosciences. Its aim is to contribute constructively to public policy by offering a critical ethical analysis of the proposed reforms, with particular attention to respect for human dignity, patient autonomy, informed consent, the common good, and the maintenance of public trust in the organ donation system.

The paper focuses specifically on *controlled donation after circulatory death* (cDCD), which applies to patients in critical care who do not meet the criteria for brain death and in whom death occurs following the withdrawal of medically futile and inappropriate life-sustaining treatment. In such cases, death is declared after the irreversible cessation of circulatory and respiratory functions, following a mandatory observation ("no-touch") period intended to ensure both clinical and moral certainty prior to any organ preservation or retrieval procedures.

The ethical principles governing organ donation, as articulated in the 2015 Position Paper and reflected in current legislation, remain fully applicable to DCD. Central among these are the requirement that organ donation remain a voluntary gift, respect for the dead donor rule, and the absolute separation between decisions to withdraw life-sustaining treatment and decisions relating to organ procurement. Consent for organ donation must always be obtained either directly from the patient or most appropriate next of kin.

To avoid conflicts of interest and safeguard patient welfare, the paper strongly recommends a clear separation of roles between: (1) the clinicians responsible for clinical management, end-of-life decisions, and determination of death; (2) the organ donation team members responsible for consent and coordination of the organ donation process; and 3) the retrieval team members responsible for organ preservation and retrieval following death certification.

Finally, the paper highlights the importance of psychosocial support for families, transparency, regular auditing, staff training in ethics, the establishment of clear and regularly updated clinical protocols, and sustained public education. Provided that robust ethical, legal, and procedural safeguards are implemented, the authors support the proposed legislative amendments as a morally permissible and socially valuable means of increasing organ availability while fully respecting the dignity of donors and maintaining public confidence in the transplantation system.

Position Paper

Introduction

1. On 6 December 2025, the Ministry for Health and Active Aging launched a Public Consultation Process proposing amendments to the *Human Organs, Tissues and Cell Donation Act* (Chapter 558 of the Laws of Malta). The proposed amendments seek to extend the current legal framework, which permits organ retrieval from persons declared dead according to neurological criteria (donation after brain death, DBD), to include organ donation following the irreversible cessation of circulatory functions (donation after circulatory death, DCD).[1] This consultation process provides an opportunity for public and professional engagement with the ethical, medical and legal implications of introducing the DCD model into Maltese clinical practice. Data from countries that have introduced a DCD programme shows an increase in organ donation of up to 50%. Therefore, introducing such a programme locally could considerably improve the prospects of patients on transplant waiting lists, which by the end of 2025 included over 90 individuals for kidney transplants alone.[2]

2. This Position Paper presents a multidisciplinary response to the above-mentioned consultation process. It has been prepared by academics in philosophy, ethics, and theology at the University of Malta, in collaboration with medical consultants and specialists from the Intensive Care Unit, nephrology and neurosciences departments. Its purpose is to contribute constructively to public policy discourse by offering a critical analysis of the ethical, medical, and legal dimensions of the proposal reform. In particular, this paper seeks to ensure that the procurement of organs from persons who are certified dead according to circulatory criteria adhere to fundamental ethical principles, including justice, respect for common good, and the protection of human dignity. Central to this concern are respect for patient autonomy and the requirement of free and informed consent, while also recognising the legitimate aim of maximising, in so far as possible, the availability of organs for transplantation.

3. The paper is structured as follows. The first part outlines the current legal and clinical framework governing organ donation in Malta, together with the procedures envisaged under the proposed amendments. The second part examines the principal ethical issues raised by the implementation of donation after circulatory death. The third and final part sets out a series of practical recommendations aimed at ensuring the sound, transparent and responsible implementation of organ donation following circulatory death.

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[1] Ministry of Health and Active Aging, “Consultation process to include Circulatory Death certification for deceased organ, tissue and cell donation,” Public Consultation, 6 December 2025. Available online at https://www.gov.mt/en/publicconsultation/Pages/2025/L-0027-2025.aspx.

[2] Semira Abbas Shalan, “New organ donation model to be opened for public consultation, Health Minister says,” The Malta Independent Online, 17 November 2025. Available online at https://www.independent.com.mt/articles/2025-11-17/local-news/New-organ-donation-model-to-be-opened-for-public-consultation-Health-Minister-says-6736284868; John Paul Cordina, “95 on waiting list for kidney transplant,” Newsbook, 29 November 2025. Available online at https://newsbook.com.mt/en/95-on-waiting-list-for-kidney-transplant/

Part I. Procedures and Legislation: Current and Proposed

The 2015 Bill and Position Paper

4. The present Position Paper builds upon an earlier position paper on organ transplantation published in 2015 by a multidisciplinary group of experts in clinical medicine, philosophy and theology and subsequently endorsed by the Archdiocese of Malta.[3] The 2015 Position Paper was prepared in response to the Government White Paper on human organs, tissues, and cell donation issued at the time.[4] The legislative proposals maintained therein were eventually enacted on 16 December 2016, as the *Human Organs, Tissues and Cell Donation Act* (Chapter 558 of the Laws of Malta).[5]

5. The principal objectives of the 2015 Bill were: (1) to increase the number of organ donations in the Maltese Islands; (2) to respect and safeguard the decision of individuals who wish to donate their organs after their death; (3) to shift the burden of the decision-making of organ donation from grieving relatives to the expressed will of the deceased; and (4) to establish a legal framework that supports organ donation principles in a manner consistent with the Maltese cultural values of generosity and altruism.

6. The discussion concerning the opt-out system of organ procurement lies beyond the scope of the present Position Paper, particularly since the private member's bill drafted to this end[6] has been withdrawn.[7] It suffices to note, however, two important points. First, the ethical principles governing the retrieval of organs articulated in the 2015 Position Paper remain valid and applicable, irrespective of whether organ procurement is carried out following neurological (brain death) criteria or circulatory death criteria. Second, until now, the 2016 *Human Organs, Tissues and Cell Donation Act* has provided that organ transplantation may occur only after the person has been certified brain dead according to the neurological criteria. The Bill currently open for consultation introduces, for the first time, the legal possibility of considering donation after circulatory death.

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[3] Position Paper on the Government's Consultation Document on the Proposal for Legislation on Organ and Tissue Donation, May 2015:
https://ms.knisja.mt/files/article/Position_Paper_on_Organ_Donation.143152137582.pdf
[4] Position Paper on the Government's Consultation Document on the Proposal for Legislation on Organ and Tissue Donation, May 2015:
https://ms.knisja.mt/files/article/Position_Paper_on_Organ_Donation.143152137582.pdf
[5] Laws of Malta, Chapter 558, 16 December 2016. Available online at https://legislation.mt/eli/cap/558/eng/pdf.
[6] See Daniel Ellul, "Opt-out Organ Donation Shift Backed by PN, Health Minister," Times of Malta, 21 February 2024. Available online at https://timesofmalta.com/article/optout-organ-donation-shift-backed-pn-health-minister.1085098.
[7] Giulia Magri, "Organ Donation Opt-out System is No Longer on the Table," Times of Malta, 6 December 2025. Available online at https://timesofmalta.com/article/organ-donation-opt-considered.1120750.

The Proposed 2026 Bill

7. The Bill presently before Parliament proposes the introduction of two amendments to the existing legislative framework:
   i. Deceased organ, tissue and cell donation shall be considered in persons who are certified dead using neurological or circulatory criteria by a clinician.
   ii. The Superintendent shall maintain updated and peer reviewed guidelines for the diagnosis of death using neurological and circulatory criteria for the purposes of organ, tissue and cell donation.[8]

8. The objects and reasons of the proposed Bill are, therefore, to broaden the circumstances under which organs, tissue and cell donation may be donated following death, determined by either neurological or circulatory death.[9] From the outset, it must be reiterated that donation of organs after death is a profound act of altruism – indeed, it is a gift of life – that should always be encouraged. Whether derived from living or deceased donors, organ and tissue transplantation can significantly improve the life expectancy and quality of life of the recipients, enabling them to continue their daily activity and sustain their participation in family and social life. While living donation is an important pathway for kidney, bone marrow and (occasionally) liver transplantation, organs from deceased donors account for the majority of transplants. According to the Health Care Standards Directorate, Malta had just over 27,000 registered donors in 2022, which is equivalent to only 5% of the population.[10] Regrettably, data regarding the number of potential donors are not publicly available, limiting a full assessment of the effectiveness of the current system.

Donation after Circulatory Death (DCD)

9. Until recently, the predominant method of retrieving organs from deceased persons for transplantation — excluding living donation — has been from patients who have been declared brain dead. Such patients fulfil a set of well-defined clinical criteria demonstrating their irreversible cessation of brainstem functions. It is important to note that only a very small minority of people who are declared dead, are certified so using neurological criteria. Over the past decade, however, in response to persistently low organ donation rates and the increasing number of patients awaiting organ or tissue transplantation, several countries have implemented programmes for organ retrieval following circulatory death (DCD) with encouraging outcomes in terms of an increase of organ donations.[11]

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[8] A bill entitled: AN ACT to amend the Human Organs, Tissues and Cell Donation Act, Cap. 558: https://health.gov.mt/wp-content/uploads/2025/12/Human-Organs-Tissues-and-Cell-Donation-Amendment-Act-2025.pdf

[9] Consultation process to include Circulatory Death certification for deceased organ, tissue and cell donation: https://www.gov.mt/en/publicconsultation/Pages/2025/L-0027-2025.aspx?sfnsn=wa

[10] Daniel Ellul, "Opt-out organ donation shift backed by PN, health minister," Times of Malta 21 February 2024. Available online at https://timesofmalta.com/article/optout-organ-donation-shift-backed-pn-health-minister.1085098.

[11] Mar Lomero et al., "Donation after Circulatory Death Today: An Updated Overview of the European Landscape," Transplant International, 33 (2020): 76-88.

In these cases, organs are retrieved from patients who meet established criteria for death, based on the permanent cessation of circulatory and respiratory death, rather than on neurological death. Given the close physiological interdependence between neurological and circulatory functions, the permanent cessation of circulation inevitably results in the irreversible loss of consciousness and brainstem activity.

10. DCD is generally classified in two distinct categories, each of which raises significant ethical considerations. The so-called *uncontrolled* DCD (uDCD) is carried out in cases where potential donors have suffered an unexpected cardiac arrest, usually outside the hospital setting.[12] At present, this option is not under consideration for introduction by the Government.

11. By contrast, *controlled* DCD (cDCD) takes place in patients receiving care in critical care settings who do not meet the criteria for brain death. In such cases, death is declared following the irreversible cessation of circulatory and respiratory function that occur after planned withdrawal of life-sustaining treatment judged to be clinically futile. The duration of the "no-touch" period following circulatory arrest varies between countries according to national protocols and must be observed to ensure moral and clinical certainty that death has occurred before any organ-preservation or retrieval procedures begin.[13]

12. It is evident that both uncontrolled DCD and controlled DCD present ethical challenges that go beyond those experienced in DBD. These include concerns regarding the determination of death, the separation between decisions to withdraw life-sustaining treatment and decisions related to organ donation, and the use of interventions that are not directed towards the therapeutic benefit of the dying patient. Nonetheless, the presence of such challenges does not, in itself, warrant the dismissal of the proposal. Given that the introduction of DCD has the potential to increase the number of patients who benefit from organ transplantation, careful ethical analysis and robust public education are required to address legitimate concerns, prevent misunderstanding, and sustain public trust in the organ donation system.

[12] Iván Ortega-Deballon and David Rodríguez-Arias, " Uncontrolled DCD: When Should We Stop Trying to Save the Patient and Focus on Saving the Organs?," Defining Death: Organ Transplantation and the Fifty-Year Legacy of the Harvard Report on Brain Death, special report, Hastings Center Report 48, no. 6 (2018): S33-S35.
[13] Dominic M. Summers, Christopher J.E. Watson, Gavin J. Pettigrew, Rachel J. Johnson, David Collett, James M. Neuberger, J. Andrew Bradley, "Kidney Donation after Circulatory Death (DCD): State of the Art," Kidney International, 88, no. 2 (2015): 241-249.

Part II: Ethical Considerations and Implications

13. As with the established practice of DBD, the procurement of organs in cases of DCD may only be carried out in patients who have "opted-in", and who have, therefore, officially registered their desire to have their organs transplanted in circumstances where this is permissible. However, since the number of persons who have "opted-in" is still very low, the current legislation allows for:

    > The next of kin of a deceased person who is not a registered donor may be approached by a transplant coordinator or a clinician to declare whether they consent to the donation taking place: Provided that this sub-article shall not apply where the deceased has registered his wish not to be a donor.[14]

    It must be kept in mind that even if patients had registered their desire to have their organs transplanted through the "opt-in" process, the next of kin is to be consulted anyway about the retrieval of organs for transplantation. This is particularly critical in the case of DCD since time is very limited. In any case, it must always be established that the patient consented to organ donation, either explicitly or through legally valid surrogate decision-making.[15]

14. A fundamental ethical requirement governing all forms of organ donation is that the donor must be unequivocally dead prior to organ retrieval. This requirement is commonly referred to as the dead donor rule (DDR).[16] Organ procurement in both DBD and DCD must occur only after the patient has been declared clinically dead by a certified clinician, in accordance with well-established international criteria, which, as the amendments indicate, will be updated regularly according to peer-reviewed guidelines. Any failure to ensure that death has occurred before the initiation of organ retrieval would amount to treating the human person merely as a means to an end, which is ethically unacceptable and incompatible with the equal dignity owed to all persons.[17]

15. Certain interventions aimed at preserving organ viability may be undertaken after death has been confirmed, thereby supporting the patient's wish to donate and enhancing transplantation outcomes. However, such interventions must not compromise the determination of death. Particular caution is required in relation to techniques such as normothermic regional perfusion, which carry a risk of re-establishing cerebral circulation and thereby undermining the validity of the

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[14] *Laws of Malta*, Chapter 558, §10 (1).

[15] Bernardette Haase, *et al.*, "Ethical, Legal, and Societal Issues and Recommendations for Controlled and Uncontrolled DCD," *Transplant International*, 29 (2016): 771-779.

[16] Lainie Ross, "The Dead Donor Rule Does Require That the Donor Is Dead," *The American Journal of Bioethics* 23, no.2 (2023): 12-14.

[17] We are aware of the debate among a small group of scholars who insist that patients in DCD protocols do not fall within the dead donor rule as, they believe, they are not yet dead. See for example, A.R. Joffe et *al.*, "Donation after cardiocirculatory death: a call for a moratorium pending full public disclosure and fully informed consent," *Philosophy, Ethics, and Humanities in Medicine* 6, no. 17 (2011): art 17. We disagree with their conclusions as long as the protocols followed are rigorous as outlined at the end of this paper.

declaration of death. Clear protocols and effective safeguards are therefore essential to ensure that these practices remain ethically and legally acceptable.[18]

16. Life-sustaining treatment is withdrawn solely on the basis that continued treatment is deemed futile, burdensome, or disproportionate and must never be influenced by considerations of organ retrieval or transplantation. Futility of treatment is established, for instance, after recognition of massive devastating brain injury or after failure of various treatments over a certain period of time. Withdrawal of life-sustaining treatment is a medical decision guided by clinical judgment and ethical considerations. These decisions should be discussed with the patient, where decision-making capacity is preserved, and with the next of kin; however, responsibility for the decision rests with the treating clinical team. Conversely, consent to organ donation should always be obtained from the patient where possible, or otherwise from the next of kin. Ideally, such decisions should be made in advance through organ donor registration. For this reason, all healthcare professionals involved in end-of-life care must be aware that this decision to withdraw treatment was made chronologically prior to any consideration of organ donation. This ensures that the withdrawal of treatment is not influenced by considerations of organ retrieval.[19]

17. Conflict of interest might arise when the intention of procuring organs takes precedence over the best interest of the patient. For this reason, the issue of donation should not be raised by the treating physicians until the potential donor or the patient's family and caring physicians have agreed to discontinue life-sustaining treatment. The determination that further treatment is futile and should be withdrawn must precede, and remain separate from, any discussion of organ donation. This sequencing is essential to avoiding real or perceived conflicts of interest and to preserving the integrity of clinical decision-making. To safeguard patient welfare and avoid conflict of interest, DCD protocols require, as much as resources permit, a clear separation between the clinical team responsible for the patient's treatment and care, including management of the withdrawal of life support and confirmation of death, the team that coordinates the transplant and the clinical team responsible for organ retrieval. For this reason, investing in human resources, training, and technology remains a priority if ethical standards are to be safeguarded. Indeed, the primary obligation of the treating team must remain the patient's comfort, dignity and the provision of appropriate end-of-life care, until an agreement has been reached independent of any consideration related to potential organ procurement.

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[18] See Nicholas B Murphy *et al.*, "Ethical Issues in Normothermic Regional Perfusion in Controlled Organ Donation After Determination of Death by Circulatory Criteria: A Scoping Review." *Transplantation* 109, no. 4 (2025): 597-609. See also Matthew DeCamp, Lois Snyder Sulmasy, Joseph J. Fins, "POINT: Does Normothermic Regional Perfusion Violate the Ethical Principles Underlying Organ Procurement? Yes" *Chest*, 162, no. 2, (2022): 288-290.

[19] See Pablo Pérez Castro, and Sofía P. Salas, "Ethical Issues of Organ Donation after Circulatory Death: Considerations for a Successful Implementation in Chile." *Developing World Bioethics* 22, no.4 (2022): 259-266. See also Jean-Pierre Graftieaux *et al*. "Contribution of the Ethics Committee of the French Intensive Care Society to Describing a Scenario for Implementing Organ Donation after Maastricht Type III Cardiocirculatory Death in France." *Annals of Intensive Care* 2, no. 1 (2012):23.

Part III: Practical Recommendations

18. The following recommendations are based on established protocols taken from countries where DCD has been implemented successfully and in view of the ethical considerations mentioned above.[20] The consistent application of these measures tends to foster trust within the population and make organ donation socially acceptable. This would, in turn, lead to more persons officially registering their desire to donate their organs should they find themselves in situations where this is permitted.

19. In order to ensure the accurate determination of death and its irreversibility, and to safeguard both the dignity of the donor and ethical standards, the following measures are essential: (1) the implementation of a mandatory observation or waiting period ("no-touch period") following the cessation of circulatory function, the duration of which is to be established in accordance to current established criteria in order to confirm irreversibility; (2) confirmation of death by an independent team of clinicians who are not directly involved in organ procurement, thereby avoiding conflicts of interest; and (3) the application of clearly defined medical criteria for declaration of death, ensuring that organ retrieval does not occur prematurely or in circumstances where resuscitation remains clinically possible.

20. *Separation of medical teams.* Conflict of interest is avoided by the setting up of three distinct teams but which work together: (1) *the treatment team* in the intensive care unit which is fully responsible for the wellbeing of the patient including the decision to continue or withhold life-sustaining treatment as well as CPR and also for the determination of death; (2) *the donor team* that coordinates the whole process, checks whether the patient is a donor, and who contacts the next of kin to obtain the necessary consent; (3) and *the receiving team* which carries out the organ preservation procedures and the organ retrieval itself after death has been declared by the treatment team.[20]

21. *Informed Consent and Family Involvement:* Clear protocols must be established to ensure open, honest and compassionate communication with the next of kin. In cases where the person is already receiving life-sustaining treatment, the possibility of DCD should not be introduced during discussions related to the withdrawal of life-sustaining treatment, unless the subject is first raised by the relatives or next of kin themselves. Once a medical decision to withdraw or withhold life-sustaining treatment has been made by the treating team and accepted by the family, it is appropriate to subsequently initiate discussions regarding organ donation. In all cases, the establishment of trust, rapport, and transparent communication is central to ethically sound practice.[21]

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[20] See for example, Antonio Ríos and Andres Balaguer, "Social and ethical-moral considerations in cardiopulmonary death donation," *Transplantation Reports*, 8, no. 1 (2023).

[20] See Bernardette Haase, *et al*., "Ethical, Legal, and Societal Issues and Recommendations for Controlled and Uncontrolled DCD," *Transplant International*, 29 (2016): 771-779.

[21]See NHS, "Consent and authorisation: the family approach," *ODT Clinical.* Avilable online at https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/consent-and-authorisation-the-family-approach/. See also UK Donation Ethics Committee, *An Ethical Framework for Controlled Donation after Circulatory Death: Consultation*, (London: Academy of Medical Royal Colleges, 2011). Available online at https://www.aomrc.org.uk/wp content/uploads/2016/05/Controlled_donation_circulatory_death_consultation_0111.pdf, and https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/consent-and-authorisation-the-family-approach/

22. *Respect for the Donor and Avoidance of Harm.* Although the donor is clinically dead at the time of organ procurement, the donor's body must still be treated with utmost respect. Organ retrieval procedures should therefore be performed in a way that minimises unnecessary trauma and preserves bodily integrity to the greatest extent possible, thereby honouring the donor's dignity.

23. *Psychosocial and Emotional Support for Families:* Decisions regarding organ donation, especially in the context of DCD, are often made during periods of profound grief and emotional distress. Family members may experience ambivalence or conflict when invited to consider organ donation following the death of their loved one. Providing timely access to appropriate psychosocial support is therefore essential to safeguard the emotional and psychological well-being of the family members throughout this difficult process. The availability of compassionate and professional support also helps maintain trust in the organ donation system.

24. *Transparency, Accountability and Regular Auditing:* Maintaining public trust requires robust transparency and accountability at every stage of the donation process. All phases — from the determination of death to organ retrieval and transplantation — should be subject to clear oversight and thoroughly documented. Independent audits, routine evaluations, and appropriate public reporting of outcomes are essential to ensuring adherence to ethical and professional standards and to facilitating continuous quality improvement. Regular disclosure of donation rates, identified challenges, and corrective actions undertaken reinforces public confidence in the system and strengthens ethical governance. Such transparency is integral to the legitimacy and sustainability of DCD practices.

25. *Establishing an Organ Donation Team:* The aim of this team is to identify and engage all key stakeholders involved in the development of clinical protocols, frameworks and guidelines and support their implementation. This team should include leaders with appropriate cross-departmental representation, ideally individuals with experience in implementing change or healthcare improvement, to influence attitudes and behaviours. This team should also be responsible for identifing the potential local barriers and solutions to the development of a successful transplantation programme.[22]

26. *Training in ethics.* Staff in ICU, ED, operating theatres, and medical specialities with primary responsibility for patients likely to become DCD donors would require training in ethics specifically on the issues they encounter, since they are the ones facing the decisions.[23] This is important so that decisions are not merely the following of a protocol or a tick-box exercise, but rather part of a holistic approach towards both the donor and the recipient of the organ transplant.

27. *Implementation protocol.* The protocol should include guidance on the following key steps: How the decision to withdraw active treatment is reached, and by whom; the criteria for and the timing of notification to the donor co-ordinator and

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[22] A.R. Manara, *et al.*, "Donation after Circulatory Death," *British Journal of Anaesthesia* 108 (2012): i108-i121.
[23] Manara, *et al.*, "Donation after Circulatory Death," i108-i121.

checking of donor registers; when the family are approached for authorization, and by whom; information given to relatives; pre-mortem interventions; process of withdrawal of treatment, including airway management and the use of sedative drugs; timing and location of treatment withdrawal; organization of operating theatre; diagnosis of death (who and where); arrangements if patient does not die in a time frame compatible with organ donation; post-mortem interventions (including tracheal intubation to facilitate lung retrieval); criteria and management of standing down retrieval team; and arrangements for family after organ and tissue retrieval.[24]

28. *Regular review of cases, dissemination of public information and education*. It is imperative that cases are documented and reviewed regularly in order to learn lessons and improve the DCD programme. Review of the first few cases allows an opportunity to learn lessons and further improve the DCD programme. Moreover, coordinated engagement across healthcare institutions, public health authorities, educators, and civil society, is essential, including the ascertainment that the proper and correct information is being disseminated. Adequate professional training, institutional readiness, and digital infrastructure, such as that concerning donor registries, are essential. The proposed change in legislation needs to be accompanied by appropriate funding, changes to the school curriculum and increasing involvement of faith and community groups. It is also important to monitor and evaluate the impact of any changes to the system as well as to share and compare the findings with those of other countries. This will help inform ongoing refinement.

29. *Support for Living Donation.* All efforts should be made to encourage donation from living persons, as well as to facilitate this process without decreasing the high standards used in the selection of appropriately motivated donors.

[24] These points have been adapted from: Manara, *et al.*, “Donation after Circulatory Death,” i108-i121.

Conclusion

30. In response to the public consultation on organ donation, we, as academics and healthcare professionals, express our support for initiatives that expand opportunities for individuals to donate their organs to those in need, provided that respect for human dignity is upheld at all times. Organ donation after death constitutes an act of generosity and solidarity when undertaken freely and in accordance with the wishes of the individual. We have emphasised that robust ethical, legal and procedural safeguards are essential in any system of post-mortem organ donation in order to protect patients, support families, and sustain public trust.

31. In this paper we have shown that we support the amendments that are being proposed in the Bill in order to make DCD possible in Malta, since this can significantly increase the number of organs available for transplant. If the appropriate ethical safeguards that have been outlined in this paper are put in place, the wishes of the patient (or next of kin) and the dignity of the patient are ensured at all times.

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