

TRANSCRIPT

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into increasing the number of registered organ and tissue donors

Melbourne—Friday 23 June 2023

MEMBERS

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Annabelle Cleeland—Deputy Chair

Chris Couzens

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Gary Maas

Cindy McLeish

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WITNESS (*via videoconference*)

Dr Beatriz Domínguez-Gil, General Director, Organización Nacional de Trasplantes, Spain.

The CHAIR: Good morning to you in Spain, Beatriz. Thank you for joining us today. We will now recommence our public hearings of the Legislative Assembly Legal and Social Issues Committee Inquiry into increasing the number of registered organ and tissue donors.

This afternoon in Australia, and this morning in Spain, I welcome Dr Beatriz Domínguez-Gil, General Director of the Organización Nacional de Trasplantes in Spain. We are very excited to have an international witness, so thank you so much for joining us today.

My name is Ella George, and I am Chair of this Committee. I am joined by my colleagues Gary Maas; Annabelle Cleeland, Deputy Chair; Cindy McLeish; and Chris Crewther.

All evidence being given today is being recorded by our Hansard team and broadcast live.

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Beatriz, I invite you to make a brief opening statement, and this will be followed by questions from Members.

Beatriz DOMÍNGUEZ-GIL: Thank you very much, in the very first place, for approaching Spain, the Spanish ONT, to share with you our experience in increasing organ donation availability. I hope I can make a very short presentation. I will try to keep it very short.

Visual presentation.

Beatriz DOMÍNGUEZ-GIL: I will try to be very, very short, as requested. This is data from the Global Observatory on Donation and Transplantation. They tell us that in 2021 there were close to 145,000 solid organ transplants carried out in the world. It is impressive activity; however, it barely covers 10% of the global transplantation needs of patients—needs that are expected to be increasing in the upcoming years, particularly as a result of the increasing burden of known communicable diseases.

We have been called to achieve self-sufficiency in transplantation by the World Health Organization. This is a good example of this: the Madrid resolution coming from the Third WHO Global Consultation on Organ Donation and Transplantation. So member states have been called to be self-sufficient and to meet the transplantation needs of their patients by using resources within their own patient population. But there are other ways of looking at organ donation—from the perspective of the dying patient. It is more and more accepted that decision-making at the end of life should not only be based on medical criteria but also take into account social, moral and welfare considerations. Many different professional societies throughout the world from the critical care field, but also the World Medical Association, are stating that donation should be a routine component of end-of-life care. This means that when a patient dies or is about to die in conditions consistent with organ donation it becomes a professional standard to offer donation opportunities, not only because of patients on the waiting list who for sure are delayed waiting for organ donation but because of the overall best interest of the dying patient, and this is a change in the paradigm of donation. It is not only seen from the perspective of patients on the waiting list but also from the perspective of the dying patient. These two principles have been driving the development of deceased donation in Spain.

Here you have the evolution of deceased donation activities in our country. The bars show the absolute number of deceased organ donors, and the circles the rates of deceased donors per million inhabitants. You can see how we have basically four periods in the evolution of deceased donation in Spain. Our very first period, when we started as the basis of the Spanish system, allowed us to increase from 14 to more than 30 deceased donors per million inhabitants in less than a decade. We went through a period of stabilisation of the activity in coincidence with a decline in brain death in our country—so this is something, the declining incidence of brain death, that many countries are witnessing. Likely this is occurring in Australia as well. Then we had a period of further increase in deceased donation rates based on the implementation of some innovative strategies, only interrupted by the impact of the COVID-19 pandemic.

So in this first period what happened is that we established the basis of the Spanish model. This was in coincidence with the creation of ONT. ONT depends on the ministry of health and is in charge of the coordination, organisation and oversight of donation and transplantation activities in our country. We started to work with a transplantation law already enacted, and I know you are curious to learn about some aspects of the Spanish legislation. We also have the technical capacity to perform transplants. We have a public healthcare system which is universal and public, and finally we have the competencies transferred to 17 Spanish regions. They are the ones with direct competence in health care, so ONT coordinated with the regions where we were going to develop our coordination model. This is basically what happened in this first period.

I am going to very briefly talk to you about what happened here and highlight some of the laws that we have developed in this third period, but for you to have an idea, our situation of deceased donation is very outstanding compared with most of the countries in the world. This has been the impact upon transplantation. Along with the United States, we have been able to overcome the rate of 100 transplants per million inhabitants. This is the situation in terms of transplants per million inhabitants in the world.

So what did we do in the first period? First it is important to clarify what the legislation is like in Spain. Our law was enacted in 1979. Despite it being a very old law, we can consider it a very good law because it has not changed since then. It has been developed and adapted to the scientific and technical developments in the field through different royal decrees, but the main principles laid down in this act have not changed. We have had a presumed consent policy and an opt-out system since then, since 1979. The law establishes that when a person dies, that person will be considered a deceased donor unless that person has expressed the opposite during their lifetime. There are very good things about having a presumed consent policy, because donation seems to be the normal option in a country where there is universal access to transplantation, so it makes sense. But we have never strictly applied the presumed consent policy, because we feared the state could be seen as the owner of the organs without taking into account the direct views of the individuals if they had not had the opportunity to express themselves and without taking into account the views and the feelings of grieving families. So in practice we do not strictly apply the presumed consent policy. The procedure that we follow is detailed in secondary legislation. So our coordinators need to check, among others, the advance directives registry, which is intended to, among others, specify the willingness of the individual about organ donation, either a yes or a no. That information is presented to the relatives, who will always be approached to confirm the wishes of the deceased, of their beloved one, regarding organ donation and whether donation would be consistent with their principles and values if that will is unknown and has not been registered, and the family always have the final veto. So in reality we are much closer to an opt-in system than to an opt-out system, just to clarify a point that I know you were very curious about.

So if we had to summarise the key principle of the Spanish system when it was established, we would use the word 'organisation'—a good organisation of the process of deceased donation. And here you have the process of donation after brain death, but we could be representing the process of donation after the circulatory death. A good management of this complex and multidisciplinary process is the underlying principle of our system.

The key step of this process—of course all of them are important, but the key one is donor identification because there are very few persons who are going to be dying in conditions consistent with organ donation. You need to die, basically, in an ICU and under mechanical ventilation, broadly speaking. We calculate that in Spain only 1 to 2% of persons who die in a hospital will do so in conditions consistent with organ donation. So if the system is not conceived to routinely identify these exceptional circumstances of death, donation would never happen. And the key for success in the Spanish system is that we have organised the process in a way that we intend not to fail in donor identification and then ensure that the rest of the phases are performed in the best possible manner.

These are the elements of the Spanish system. They have been very well described in the literature, and I will be happy to provide you with some papers describing the elements of the system, but I am going to highlight just three of them. First of all, we have placed intensivists in the midst of that process because these are the individuals, the professionals, who develop their normal activity in those units where those exceptional circumstances of death, those donation opportunities, are going to be appearing. So the intensivist has a key pivotal role in identifying those donation opportunities and making donation possible.

In Spain we have done it this way, but there are other ways to do it. We have created the sphere of donor transplant coordination—donor transplant coordinators who are intensive care physicians. So we have units of

donor transplant coordination in all our hospitals authorised for organ donation—it is at 180 units and hospitals at present—where you can see how most of our coordinators are physicians, 62%. I am sorry, this is the other way around—part-time dedication is 96%, so they are part time dedicated to the activity, and 38% of our coordinators are nurses. And the majority of our nurses but mostly the majority of our physicians dedicated—devoted—to coordination are intensive care doctors.

A second important element is that we have created a system to coordinate coordinators. So of course donation and organ recovery will be taking place in the hospital, but these donor transplant coordination units are supported at the national level by ONT and at the regional level by regional coordination units. We provide coordinators with training, education, guidance, protocols, and of course we continuously evaluate results through what we call our potential donor audit. Remember the Hawthorne effect: everybody who feels observed automatically changes their behaviour.

The third element that I want to highlight of the Spanish system is the great effort that we have made in training all professionals who directly or indirectly participate in the process of deceased donation with governmental funds. So a fifth of the ONT budget is devoted every year to training.

Finally, we take a look to the last period, of the evolution of deceased donation rates in Spain. We had evidently to innovate, and if the first period was defined by the word ‘organisation’, the third period is defined by the word ‘innovation’. And innovation, as I said, has been really driven by the decline in the incidence of brain death in the country, which has been much more profound during the COVID-19 pandemic. We have less and less persons dying in a brain death condition because of the fortunate decline in events leading to devastating brain injury, a better treatment of neuro-critical patients and changes in end-of-life care. For example, in our ICUs, as in many ICUs of well-developed countries, when we reach a point of futility in intensive care, the decision is very frequently made to withdraw life-sustaining therapies that are no longer deemed beneficial to patients. Besides, our potential donors are becoming older and older, so the mean age of persons who die in a brain death condition in Spain is almost 60 years. Most of them die because of cerebrovascular accidents or after a cardiac arrest, and this means they have a very important burden of comorbidity. So we have less potential DBD donors, persons who die in a brain death condition, and they are becoming more complex over time, as you can see.

We have devised different strategies to improve. We are now in the midst of the 50 x 22 plan, which aims at reaching 50 donors per million inhabitants. This was intended for 2022, but because of the COVID-19 pandemic this objective has been set by 2023. I am just going to give you a very rapid overview of one of the lines. One of the lines is evidently learning to use organs from very aged donors. You can see here how a very substantial portion of donors in Spain are 60 years or over, so 22 donors per million population are 60 years or over, and you can see here the situation in Australia. Evidently the use of organs from donors of advanced age is a very important area with various room for improvement.

A second important area is DCD. We have developed donations after the circulatory termination of death in Spain. We have different types of DCD programs, but the most important one is what we call controlled DCD, from persons who die following the withdrawal of life-sustaining therapies. In this neat blue line you can see how, since we started this program in 2009 through a pilot, the number of controlled DCD donors and type III DCD donors has increased exponentially. We also introduced a law regulating medical assistance in dying, which I know is a reality in some states of Australia, in 2021, and we have already registered several persons who have donated their organs after dying in these circumstances in our country. So this has placed Spain in a very privileged position in terms of DCD per million population compared to other countries in the world. These are the 22 countries with a DCD program, and this would be the situation of Australia.

Very importantly, we have managed with a very specific system—what we call normothermic regional perfusion, based on ECMO devices—to use basically all types of organs from these donors, even hearts and even the small bowel, which are very sensitive to the effect of what we would call warm ischaemia, to the lack of flow with oxygenated blood. This is, for example, the heart transplant program in Spain, initiated in January 2020. I know Australia has a very powerful DCD heart transplant program as well, but this is based on a completely different preservation strategy. And this is the face of Emma, the first child in Spain and in the world who received a transplant from a DCD donor thanks to this technique of normothermic regional perfusion applied to DCD donors.

To finalise, I would like to say that DCD provides also the opportunity for persons who die of conditions different to a devastating brain injury to donate their organs—for example, persons who die as a result of respiratory diseases, heart diseases or neurodegenerative diseases; persons for whom the decision is made to withdraw life-sustaining therapies because they are no longer deemed beneficial to them and persons who in first person decline to receive life-sustaining therapies. According to our law they have the autonomy to reject those treatments, and since 2021 some of these persons have requested euthanasia—medical assistance in dying—and many of them have requested to be organ donors. So for you to have an idea: in this period of time, we have had more than 150 persons diagnosed with amyotrophic lateral sclerosis who have been able to become organ donors thanks to DCD protocols. It is a very complex process because it is the patients themselves who, when facing the imminence of their own death, request to become organ donors. Because of the regulation of euthanasia in Spain, and inspired by many of the countries who have developed national protocols of donation after MAiD, we initiated and developed our own protocol where the patient is at the centre of the process.

Here you have some hints of the protocol for donation after MAiD in Spain, but as you can see in this slide, we had up to December 2022 many different persons who were able to become donors after their death in this completely new circumstance of death that has arisen in Spain in two years.

I would like to finalise with this sentence from Albert Einstein. He used to say that the people who are crazy enough to think they can change the world are the ones who do. We have two very important responsibilities: meeting the transplantation needs of our patients, but also giving more and more persons the opportunity to donate their organs after death if that is consistent with their wishes and their values. Thank you very much for your attention.

The CHAIR: Thank you. That was a remarkable presentation. I think we are all about to give you a round of applause. I have got a couple of questions for you, and then I will hand over to some Committee Members for their questions. That presentation that you just ran us through, is that something you could provide to the Committee to read through?

Beatriz DOMÍNGUEZ-GIL: Well, I guess basically the idea that I wanted to transfer is that firstly, it is very frequent that many countries looking at this kind of system and for a successful system consider that presumed consent or an opt-out system is something that is worth it. And of course it is worth it if the community and the country are very supportive of a change in legislation, but on occasion what we have seen is that changing or moving from an opt-in to an opt-out system raises a huge amount of debate in the community. It creates a lot of tension and a lot of work, and we know that the key for success is not a change in the legislation but essential changes in the way the system is organised and tackled.

So in our view, a very important issue is to focus upon professionals and to support professionals in units that are well trained, that are properly covered from a financial point of view and that are provided with guidance, innovation and continuous evaluation of results rather than investing effort, time and tension in modifying the legislation. That would be my first idea. Second, having very limited knowledge about the Australian system, I would say that we have had visiting Australians on many occasions in Spain and I know that many of the basic elements of the Spanish model that I shared with you have been replicated in Australia. So you have a national transplant agency and you have worked in engaging the intensive care community. I feel there is room for improvement there, but there is engagement of the intensive care community in Spain in deceased donation. You have good organisations at the national or at the state level. You have a potential donor audit system to evaluate performance. You make training. So many of the basic elements are actually there.

But I do believe in the last part of my presentation I have given you some hints on where I think Australia could be improving. For example, Australia should be able to increase the utilisation of complex donors—for example, old donors or donors of advanced age. This requires, of course, being more proactive in the identification of these individuals as possible organ donors but also working with the transplant teams to make sure that they can make the most of these very complex transplants. DCD, donation after the circulatory determination of death, has also large room for improvement in Australia, and I am aware that in some states—I am not very sure if it is in your case—MAiD has become a reality or is becoming a reality. I believe making donation opportunities possible for these patients would also be another important aspect to tackle. In our experience, patients themselves who request euthanasia on many occasions wish at the same time to become an

organ donor, so it also becomes somehow our responsibility to make possible not only euthanasia as requested and permitted by our legislation but allowing these persons to donate organs after death.

The CHAIR: That is really fascinating. We do have voluntary assisted dying laws in Victoria. They are relatively recent. But we have not heard any evidence to date about whether people who have requested euthanasia have also had a conversation around organ donation. So that is something for us to also explore. Annabelle, would you like to ask any questions?

Annabelle CLEELAND: Incredible. Beatriz, could you share your informative PowerPoint with us?

Beatriz DOMÍNGUEZ-GIL: Sure. Absolutely.

Annabelle CLEELAND: Thank you—and any referenced research in your PowerPoint would be terrific to include. It was very quick but amazing. You have got more generous parameters around the organs that are donated, which you mentioned around the age of the patient—or the age of their organ, pardon. I just wanted to know if you had data on the success of those transplants. Did you see a reduction in the success? And the receiver of the organ—did they had any potential detrimental impact from that, or what was the success rate? It would be great if we could have any of that information.

Beatriz DOMÍNGUEZ-GIL: Yes, of course. Firstly, I will be happy to share the PowerPoint presentation and all the publications that we did that might be relevant to this approach to this research. Regarding the outcomes of recipients who receive an organ from an expanded criteria donor or an old donor, of course donor age is highly influential upon post-transplant outcomes. Always it is better to receive an organ from a young donor compared to an old donor. But we do not believe that is the sort of comparison that we should be doing. We should be comparing receiving an organ from an old donor with not receiving an organ and remaining on dialysis or not having an alternative, for example, to a liver or a lung transplantation, for instance.

What we do in Spain, as in many other countries who have been actively transplanting organs from donors of advanced age, is to use what we call an old-for-old allocation strategy. Because the expectancies of survival of those organs are going to be shorter than the expectancies of survival of younger organs, those organs are primarily allocated to recipients of advanced age. So that organ is supposed to be covering the expectancy of survival of that recipient. And yes, the source allowed us to increase the number of persons who are waitlisted of advanced age. Not only are our donors getting older but our recipients are also getting older, so we are able to be more flexible with criteria in terms of the age of persons who are waitlisted for transplantation. It is a strategy that not only embraces donation and transplantation opportunities, globally speaking, but drives a flexibilisation in criteria to be admitted onto the waiting list.

Annabelle CLEELAND: Do you have information on that criteria in terms of even other potential health factors that previously meant they were not considered—say, smokers and lungs. Can you share any of the criteria with us that go into the transplant considerations?

Beatriz DOMÍNGUEZ-GIL: Yes. I would say that the most fascinating example we have is that of liver diseases associated with hepatitis C. In Spain we have a public health initiative which is targeted to the eradication of hepatitis C in Spain, which has been very, very successful to the extent that the waitlist for liver transplantation has declined by 50% since 2015—as a result of the eradication and the treatment of hepatitis C with the new, direct antiviral agents. We were increasing our liver transplantation activity, and at the same time the need for liver transplantation, according to traditional criteria, was declining. So we have the donors to be much more flexible in criteria to admit all types of patients to the liver waiting list—for example, patients with more advanced hepatocarcinoma than in the past; patients with what we call acute alcoholic hepatitis, so not only persons with alcoholic cirrhosis in whom a period of abstinence was required to be included on the waiting list—usually a minimum of six months—but also patients who developed what we call an acute liver hepatitis due to alcoholic consumption who have been of course selected based on a psychosocial study to make sure that these persons will be quitting alcohol consumption; or, for example, patients with more advanced cholangiocarcinoma.

So there are two strategies, but basically the fact that we increased the availability of organs available for transplantation has made it more feasible to be more flexible in admitting more patients onto the waiting list, not only on the basis of age but also on the basis of other conditions that years ago were seen as absolute

contraindications to be admitted onto the waiting list. Of course these are patients for whom we have evidence that they are going to get a real benefit from transplantation.

Annabelle CLEELAND: My final question—sorry, I am so conscious of time. Your data around the recovery after COVID was pretty phenomenal, where you had the dip of donations but then you recovered quite quickly. How was this achieved?

Beatriz DOMÍNGUEZ-GIL: Well, as you know, Spain was one of the countries that was first hit by the pandemic. After China and 15 days after Italy, we were one of the countries which suffered the COVID-19 pandemic much more promptly, so the impact upon donation rates particularly in March 2020 and April 2020 was really very, very profound. We from the very beginning issued very quickly recommendations about how to manage the donation and transplantation programs based on local epidemiology and working with regions according to their epidemiological situation. We rapidly learned how to be adapting every region or even every centre to the different epidemiological situation that they were facing, and that was very variable in time besides variable in terms of geography.

Secondly, we started very, very quickly to compile information about the impact of COVID-19 upon donors and recipients. We were one of the first countries in issuing recommendations about the utilisation of organs with regards to COVID-19 in potential donors and one of the first that started to transplant organs from COVID-19-positive donors where we deemed evidence was appropriate to move forward. So now we have a very large experience, which has been published, on the transplantation—the safe transplantation—of organs other than lungs from donors with SARS COV-2 positivity by PCR.

Finally, I believe that the way the healthcare system tried to recover and the efforts of the entire public healthcare system to recover, which became operant at the end of April 2020, allowed us to slowly recover and of course take over all the lines, innovative lines of work that we had been implementing prior to the pandemic. In fact this year we have increased already by 15% our deceased donation rates compared to the previous years, and this is basically due to the strategic lines of work that I have shared with you—which is basically DCD. DCD has been a revolution in Spain. Of course DCD applies to patients other than those who died as a result of a devastating brain injury. This is very important because you have many patients die following the withdrawal of life-sustaining therapies for lung diseases, heart diseases, neurogenerative diseases, and persons who want to be donors in our country at least. And there are other lines that I do not have the time to share with you, but for example, the cooperation with emergency care. Not only the ICU should be a focus, but we are working basically with expanding donation to the entire hospital, where all units who are caring for persons who can be possible organ donors are engaged. So I think we are basically recovering all our lines of work, and dealing directly with COVID has allowed us to recover.

The CHAIR: Thank you. Cindy?

Cindy McLEISH: I will try and keep it quick. Thank you very much, Beatriz, for your excellent contribution today. You mentioned earlier that there were 180 units at hospitals; is that correct?

Beatriz DOMÍNGUEZ-GIL: 185. We are a 47 million country. Of course in size we are much smaller than you. Though we are a pretty big country, not as big as yours. We have 185 hospitals that are authorised for organ recovery. According to our legislation, to have such an authorisation or accreditation the hospital must have a donor transplant coordination unit. We are also working with the smaller hospitals that are not licensed for organ recovery to work as identifiers of possible organ donors. They may work in cooperation with licensed hospitals to make donation possible as well, but licensed for organ recovery is 185.

Cindy McLEISH: Was it hard to set up? Or was the government fully on board and rolled this out fairly quickly—that you could get such great results, I guess?

Beatriz DOMÍNGUEZ-GIL: I would say that it has been really a donation and transplantation system in Spain that has had institutional support at all levels. So at a governmental level the support has been critical since the start of the system in 1989. In fact the issue that ONT was created as an agency that depends and reports to the Ministry of Health is a way of ensuring that donation and transplantation is on the healthcare agenda—is an item in the healthcare agenda. So our reporting to the government on the basis of what we achieve is basically a way of making sure that donation and transplantation has been something pivotal in the healthcare agenda of the different governments over a long time. And then at a regional level we have the

corresponding authorities, and authorities of course follow the priorities that have been set by the government at a national level—and hence the hospitals follow as well.

In the moments that we are living in which one may wonder, ‘Why should transplantation be a priority?’ we have to be very well aware that non-communicable diseases are causing most of the mortality in our countries, particularly in developed countries but also in low- and middle-income countries. Most of our patients are dying as a result of non-communicable diseases, and we should remember that one of the sustainable development goals is decreasing by one-third mortality due to non-communicable diseases. And you will say, ‘Well, then, we need to control hypertension and diabetes,’ and of course we have to do this, but if we want to immediately decline mortality related to non-communicable diseases, we need transplantation. We need transplantation compared with dialysis because it decreases mortality. We need transplantation for patients with cirrhosis and for patients with end-stage lung failure. For all these patients we need transplantation, and if we are able to increase transplantation, we will be able to decrease mortality due to non-communicable diseases in the short term. So transplantation is really transformative in terms of quality of life but also in terms of survival. It really saves a huge amount of lives, and it is really fitting into the goals that have been established by the United Nations. So it should be given priority, and it should be given priority at a governmental level.

Cindy McLEISH: Thank you very much.

The CHAIR: Chris.

Chris CREWETHER: Thank you, Chair. Thank you very much for your excellent presentation, which we look forward to receiving, and your oral evidence as well. Quickly, I guess, noting the experience in Spain—and I note that it just has not been the opt-out system, it has also been a number of other mechanisms—what is your view on us introducing an opt-out mechanism in our jurisdiction, as a general comment? And what is your view on family members having the final say? Because I guess that is something that counters potentially any opt-out system and almost makes it an opt-in system if family members are not very supportive.

Beatriz DOMÍNGUEZ-GIL: Well, I understand it is always very appealing to consider a change in the consent system. All countries have at a given moment discussed whether it is worth it or not. I would say that if there is broad support for that change, well, you can do it. It will raise a lot of attention in the media. It will raise also discussions and sensitivities about the need for organ donors. But I think there are more profound changes that are more critical than changing the legislation. And besides, if you make a critical review of what has happened in countries or states that have changed their legislation from an opt-in to an opt-out system, you will never find results in terms of an increase in deceased donation sustained in time that can be attributable to that change. So if it is not something that creates a lot of tension, debate and work, okay, I would do it. But if not, I think there are many other priorities to do. That is our personal opinion and what we recommend to everybody.

We built our system in 1989. We have had the opt-out system since then. If I had to develop the legislation from scratch, I likely would go for an opt-out system in a country like ours, where everybody has access to transplantation, because everybody should be contributing to organ donation. But making a change in legislation I would not think is going to solve any big problem, and there are more profound changes in the system to be tackled before that in my view.

Regarding families, in our experience if the families are aware of what their loved one wanted regarding organ donation, it is exceptional that they overrule those wishes—exceptional. We never see it. I mean, if the family knows that that person wanted to be an organ donor, they will respect it. If they do not know whether that person wanted to be an organ donor, they will discuss with us their views on whether donation would have been consistent with their principles and values, and if they know that person did not want to be an organ donor, then they will respect that. But even if we have one or two families in which that situation of overruling the known wishes of their loved one occurs, I think going against that family causes more damage to the system than losing a donor. It is very important that we do not harm a family who is in the process of mourning. We believe respecting those families who are going through a very difficult moment is equally important. We believe in really working in training our professionals in communication, and we spend a lot of effort in training not only coordinators but the critical care community and emergency care professionals in communication in critical situations, including approaching families to pose donation opportunities and discuss donation opportunities with them. So I believe taking into account the family’s views, at least in our culture, at

least in our country is something that every country or state should be evaluating, but for us respecting those views and those feelings is very important as well.

Chris CREWETHER: Thank you.

The CHAIR: Thank you, Beatriz, very much, for appearing before the Committee today and for your contribution to this important inquiry. We have learned a lot from your evidence today, and we look forward to receiving your presentation. Thank you so much for your time.

Beatriz DOMÍNGUEZ-GIL: Thanks so much to you for this opportunity, and I hope you achieve the best in your state. Thank you.

The CHAIR: I thank all witnesses who have given evidence to the Committee today, as well as Hansard, the Committee Secretariat and security. The Committee will continue its public hearings over the course of the year. I declare this hearing adjourned. Thank you.

Committee adjourned.