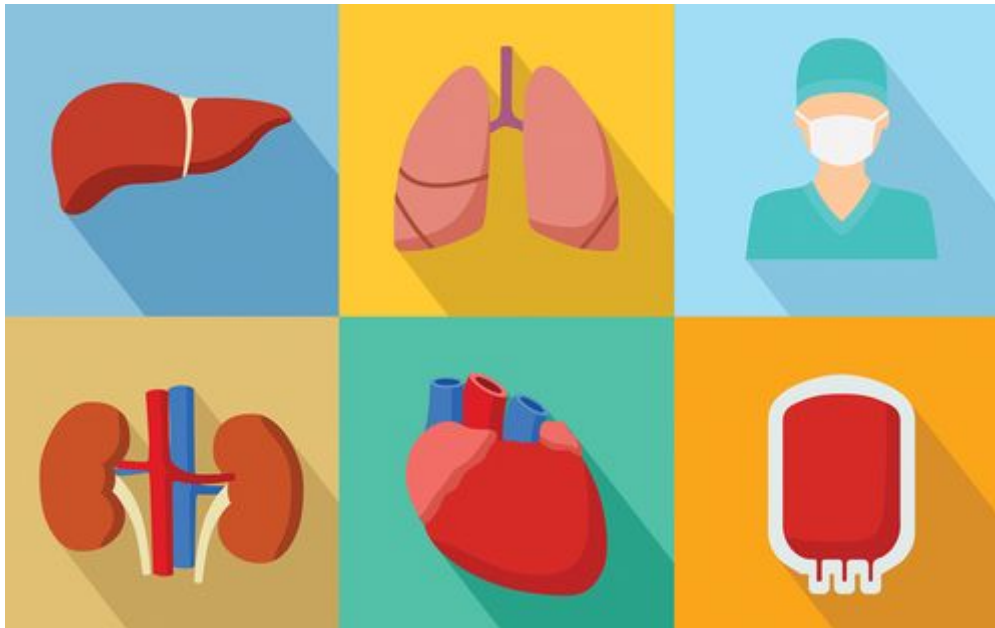


Organ Donation, Transplantation

BAPTIST CENTER FOR GLOBAL CONCERNS

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A Current Moral Issue

Ralph Waldo Emerson once said, “The only gift is a portion of thyself.” He surely could not have foreseen organ donation and transplantation when thinking of a gift, but the sentiment applies well to this pressing issue. There are 128,878 men, women and children currently on the transplant list awaiting an “organ gift,” and 22 people die daily while waiting for a transplant.

An organ transplant is "a surgical operation where a failing or damaged organ in the human body is removed and replaced with a new one." It all seems clear cut—someone has a need for an organ transplant and someone gives—but there are numerous moral concerns in this area, such as: “consent, dead donor determination, for-profit models of organ transplantation, organ trafficking and medical tourism,

synthetic and artificial organs, xenotransplantation [donation/transplantation across species], the possibility of bioengineered and/or 3D printed organs, and even the potential for fetal organ farming” (See Center for Bioethics and Human Dignity)!

The sheer scope of the topic is too broad to cover every aspect of these here, so the focus of this edition of Pathway Ethics will be on the key ethical implications regarding organ donation and transplantation and the key point of "**brain death.**" First, a brief historical background will set the stage for a deeper ethical examination.

The history of organ transplantation is a relatively recent phenomenon with the first successful kidney transplant between identical twins in 1954. Previously, a skin transplant (1869) and a cornea transplant (1906) had been successfully performed. The first kidney, lung, and liver transplants recovered from deceased donors took place in 1962/1963, and the first organ recovery from a “brain dead” donor occurred in 1963. It was the *advent of medical technologies*, however, that allowed medicine to prolong life well beyond its natural limits, and that *gave rise to the need for a shift from longstanding cardiopulmonary determination of death to brain-based criteria*. The shift was already underway at Cape Town (1967), because of pressure for a “viable heart for transplantation.” A successful heart transplant required the moment of death to be determined as precisely as possible.

Researchers recognized that patients with “*total brain failure*” (i.e. cessation of cerebral function, “irreversible, unresponsive comas”) *could be “optimal” organ donors*. Circulation was then required to feed the organs, to make possible a successful organ donation. Life support technology entered at this point, making it possible to maintain organ perfusion until a transplant team is assembled and ready to retrieve the organs. However, a key speed bump in the decision-making chain was/is the “**dead donor rule.**” This rule requires patients to be declared dead before the removal of unpaired vital organs like a heart, liver, or two paired organs such as kidneys. (Truog and Robinson, as cited by Potts and Evans, JME, 2016).

A Harvard Medical School (1968) Ad Hoc Committee published a report

for a redefinition of death that encompassed people in irreversible comas. This was a key first step to open a way for obtaining organs for transplantation. Laws would soon follow.

By the 1980s, the growing number of legal statutes regarding brain death in the U.S. led President Ronald Reagan to establish a commission to “clarify the debate and refine and update the criteria put forth by the Harvard group” (cf. UDDA, p. 3). *This became the “Uniform Determination of Death Act”* (UDDA, 1981). The Act clarified as “death” when an individual sustained either: 1) “irreversible cessation of circulatory and respiratory functions,” or 2) “irreversible cessation of all function of the entire brain, including the brain stem.” A determination of death had to be “made in accordance with accepted medical standards.” Although all states, including the District of Columbia, have adopted the UDDA, using the exact wording, some state laws add additional regulations (e.g. Florida, Texas, and Oregon; See [Healthcare Law](#))

Various agencies exercise oversight, and laws provide guidelines, for organ donations and transplantation. Primarily, the Health Resources and Services Administration (HRSA) exercises federal oversight of the transplant system in the United States. Congress passed the National Organ and Transplant Act (1984) to address the nation’s organ donation shortage and improve the matching and placement process. It governs the process of procurement and allocation. *State law*, as reflected in the universal adoption of the Uniform Anatomical Gift Act (UAGA) governs the process of organ donation and the organ registry.

The Acts established the Organ Procurement and Transplantation Network (OPTN) “to maintain a national registry for organ matching.” Fifty-eight regional Organ Procurement Organizations (OPO) oversee the activities of 249 transplant centers. The Acts also called for a private, nonprofit organization to operate the network under a federal contract. The United Network for Organ Sharing (UNOS), in Richmond, Virginia, administers the OPTN under contract with the HRSA of the U.S. Department of Health and Human Services (HHS). There are cultural urgencies, as well, that impact organ donation and transplantation

Current Cultural Urgencies

Most organ and tissue donations are procured from a person who has been declared dead (e.g. “cadaveric,” “non-living,” and “deceased”), but some organs and tissues can be donated while the donor is alive (e.g. one kidney; cf. risks). After death, one person can donate up to 8 lifesaving organs (heart, 2 lungs, liver, pancreas, 2 kidneys, and intestines), *yet while 95% of US adults support organ donation, only 48% have enrolled as donors*. There remains a large gap between supply and demand.

Furthermore, the gap widens substantially when one considers that there are two key steps to gaining access to a transplant. First, one must gain access to a transplant doctor, then one must be selected for a transplant. There are many potential candidates that do not get admitted into a program due to a variety of reasons: too old, not of the right nationality, criminal history, drug abuse or lack of access to a competent primary care physician who can refer a person to a transplant program.

To become a deceased donor, a person must die in very specific circumstances; typically, someone that has been declared brain dead while on life support and while the heart continues to beat (Marquis, "Are DCD Donors dead? *HCR*, 40, no. 3 (2010), 24). Perhaps a person has been hospitalized because of illness or accident, such a severe head trauma, a brain aneurysm or stroke, or a patient has been placed on artificial mechanical support. A medical team does all it can to save a patient's life (whether the person is a registered donor is not considered at this point; yet, see consent below). Only after brain death has been confirmed and the time of death noted can organ donation become a possibility.

One can readily see that the *circumstances are charged with anxiety and emotion* as individuals and their families wait and hope. This situation holds ethical implications. Organ donation and transplantation requires the channeling of various strong currents to flow together into one direction (e.g. biological, medical, technological,

ethical values (e.g. beneficence, nonmaleficence, autonomy, rights, and justice). There are also deeply held moral viewpoints along each of these respective streams, and, indeed, along the new river that is represented in the transplant recipient's life.

An Ethical Intersection

Tragic circumstances very often lead to the possibility of donation and transplantation, so there are ethical considerations that include demonstrating *respect for the life of the person at life's end*.

Considerable discussions take place concerning the moral status of a “person” when there is total brain failure, and what then may be ethically permissible at this stage. The system of donation in America is “opt-in,” meaning a “donor beforehand, or the family at the time of death, must affirmatively consent to the donation of organs” (*Dignitas*, Sept. 2015, p. 4). This *requires an autonomous and informed decision*.

Another key ethical principle in these circumstances is *justice*. Medical resources are costly and this issue holds implications for resource allocation. Since there are limited numbers of available organs for transplantation, then a core ethical challenge for organ transplantation is “rationing”—choosing who receives the “gift.”

There are also *concerns from the perspective of potential donors*. The most common reasons why people state that they want to donate organs are *beneficent*: religious in nature or because they want to help others in need. The most common reasons cited by potential donors for not wanting to donate organs involve: *mistrust* of doctors (inclusive of hospitals and the organ allocation system), a belief in a black market for organs in the US, and issues related to “deservingness.” In the latter case, concern that the potential recipient brought on his or her own illness, or was a bad person was the obstacle to donating touches upon what claim (right) may a person have to receive an organ.

One may readily see that the organ donation and transplantation is fraught with ethical significance. Several core values and moral principles are attached to each step of the process. It is important to

explore some possible steps forward in order to address the realities ethically.

A Way Forward

Finding a pathway forward can be complicated when one considers the complexities surrounding organ donation and transplantation. *A first step ahead* relates to the *language* associated with the "betwixt and between" at the time of death. Confusion often remains among family members about the terms "**brain death**" and "**cardiac death**." In many cases, families believe that the former is somehow not as final as the latter. For example, families may see their loved one with "warm skin, full color, and breathing with the aid of a machine." They believe that that he or she is "alive." *Clearer communication about "death"* will aid family understanding (cf. also the use of euphemisms at life's end).

Secondly, the issue of *personhood* holds moral implications at life's end. The President's Commission mentioned above wrestled with this issue and sought to set strict criteria to "determine its cessation." The conclusion was that "personhood has a direct link to cortical function." This suggests that an individual can acquire and lose personhood at some point in life. This holds implications for a wide range of human beings, not just those at life's end (e.g. persons with dementias, people in PVS, and the unborn). In the case of the brain dead—who by current definition possess no personhood—there is concern that mechanical support might be ended arbitrarily and organ procurement can then take place (Griniezakis, "Legal and Ethical Issues Associated with Brain Death," *Ethics and Medicine*, 23:2 (2007): 116–117). This holds serious ethical implications and is also linked to a wider moral debate regarding doctor's killing at life's end (cf. euthanasia and physician-assisted suicide).

Furthermore, a precise definition of brain death, while important, is not all encompassing at life's end. There is the *important concern* how a "patient" will be dealt with. Some ethicists believe that the new definition has become the "ruling pragmatism of our time"; somewhat

"motivated a definition of death that served the interests of the expanding powers of transplantation" (See above). And it was body-soul dualism, even if in its "new apparition" as the dualism of the brain and body, that allowed us to hold "that the true human person rests in the brain, of which the rest of the body is a mere subservient tool" (Hans Jonas, "Against the Stream," as cited in *On Moral Medicine*, Kindle Edition, at loc. 17890ff.).

Human identity is to be found in the synthesis of the whole organism, even if the higher functions are seated in the brain (*On Moral Medicine*). This view may help to avoid a slippery slope toward commodifying the body by treating it as a "natural resource," or "a source from which resources can be deployed or harvested" (cf. Sleasman & Cunningham, "Exploitation in the Global Medical Enterprise: Bioethics and Social Injustice," *CBHD*, 10/20/2016).

The *ministry of presence in life's most pressing circumstances*, like those surrounding organ donation and transplantation, definitely holds eternal significance (Matthew 25:36). Christ *modeled this truth* and, in so doing, demonstrated that human life has intrinsic value that can never be lost regardless of the circumstances. He showed profound respect for close family friends when their brother Lazarus had died, and He never ceased to address the deceased as a person (John 11; cf. "your brother"). We do well, when we practice this as well.

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