Cadaveric organ donation: ethical considerations for a new approach

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We review various organ procurement strategies from ethical and practical perspectives to understand why these strategies have been relatively unsuccessful. We propose that the CMA recommend the implementation of a required-request policy in hospitals. We also propose a possible new approach in which people from the age of 18 years would voluntarily enrol in an organ donation program, agreeing to permit all usable organs to be taken for transplantation at the time of death. In return they would have priority for receiving organs made available by the program. We believe that this program would save lives, respect the donor's autonomy and satisfy the principles of justice and beneficence.

Revue des divers moyens d'obtenir le don d'organes, des points de vue déontologique et pratique, afin d'apprendre pourquoi ces moyens ont eu assez peu de succès. Les auteurs proposent à l'AMC de recommander l'adoption par les hôpitaux d'une politique en vertu de laquelle il serait obligatoire de demander un tel don volontaire. Ils proposent aussi un programme possible dans lequel des personnes âgées de 18 ans ou plus consentiraient volontairement au don de leurs organes utiles lors de leur décès, en retour d'une garantie de priorité comme receveurs éventuels d'organes rendus disponibles par ce programme. On pourrait ainsi sauver des vies tout en respectant l'autonomie des donneurs et les principes de justice et de charité.

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The development of effective immunosuppressive therapy has established cadaveric organ transplantation as an important form of treatment for end-stage heart, kidney and liver disease. Current 5-year survival rates for heart transplant patients exceed 50%,¹ and rates greater than 60% have been reported for liver transplant patients.² One-year survival rates for patients receiving hearts, livers and kidneys are approximately 80%,¹ 70%² and 75%³ respectively, and the patient survival rate for kidney recipients approaches 90%.³

Tragically, people still die while awaiting donor organs. Although an estimated 15 000 hearts could be used in the United States each year, the available supply, determined by current methods, is between 400 and 1100.¹ In the United States about 22 500 patients undergoing dialysis are candidates for kidney transplantation;⁴ in Canada there are 1200 patients awaiting suitable kidney donors (Department of National Health and Welfare: organ transplant and donation statistics, Apr. 1 to June 30, 1988). Patients with functioning grafts enjoy a much higher quality of life than those undergoing long-term dialysis and can be treated at about one-third the cost.⁵

Approximately 20 000 people are thought to die annually in the United States under circumstances that would make their organs suitable for donation.⁶ Therefore, it is important to understand why organ procurement strategies have been relatively unsuccessful, with the result that thousands of lives that could have been extended have been lost. In this paper we briefly examine various procurement strategies that are in use together with their ethical implications and will suggest a possible alternative approach.

The current system in Canada and in the United States is based on the principle of voluntarism. Voluntary donor cards, which are often attached to driver's licences, or familial consent after the person's death permit organs to be removed for transplantation. When this system was first implemented organ transplantation was

just beginning, and the demand for organs was considerably lower than it is today.

Organ donor cards

Organ donor cards constitute an ethically desirable approach to an emotion-laden issue. The donor, who is presumed to be competent and informed, is allowed to freely exercise the altruistic option of donating a body part posthumously to save another human being. If one assumes that no coercion was used when the card was signed, the donor's right to self-determination can be fully respected.

However, organ donor cards have several drawbacks. A US survey revealed that only 14% of people carry a donor card.⁷ When those who did not carry donor cards were asked whether they would be prepared to sign and carry such a card, 19% said No and 53% said they did not know. This finding suggests that there is some resistance to contemplating death and agreeing to donate one's organs. Even if the possibility of death is rationally acknowledged, emotional acceptance occurs less readily. To some people, signing an organ donor card may be equivalent to agreeing to have their deaths declared prematurely or even hastened.^{8,9}

Another problem is that surgeons routinely ask for family approval before removing organs even when there is a valid signed donor card.¹⁰ In Canada the Multiple Organ Retrieval and Exchange (MORE) Program recommends obtaining familial consent even in the presence of a signed donor card,¹¹ although legislation such as that in force in Ontario clearly does not require it.¹² It is not known how many organs are lost as a result of this policy. We do not believe it justifiable that the freely expressed wishes of potential donors can be easily overridden by family members.

Familial consent

The most common method for procuring cadaveric organs in Canada and the United States is to obtain the consent of family members after the person has died. There are several difficulties with this approach. First, many health care professionals in intensive care units (ICUs) and emergency departments find it difficult to approach grieving families, particularly when they are not trained to do so. Second, these staff are often busy with the care of other seriously ill patients, to which, understandably, they assign higher priority. Staff have to be sensitive enough to ensure that encouragement to permit organ retrieval does not become pressure or coercion¹³ during this painful time. Finally, family members do not necessarily know what the patient would have wanted and therefore may not be morally valid substitute decision-makers.

Required request

A method of obtaining organs that has increasingly been advocated is required request. A law mandating required request has been enacted in over 40 US states,¹⁴ and Manitoba has a law requiring consideration and request when appropriate.¹⁵ In general these laws oblige the health care institution or physician to ensure that the family is asked whether they are willing to donate the organs of the deceased. The rationale is that if more requests were made, more organs would be donated. It is an impression at the MORE Program that physicians' failure to request donation is an important factor in inadequate organ retrieval in Canada (Robert Smith, chief transplant coordinator/administrator, MORE Program: personal communication, 1989).

A serious difficulty with legally mandated required request, however, is that there may be a lack of genuine cooperation by health care professionals who resent an obligation that has been imposed on them.¹⁴ For instance, the legal obligations may be fulfilled in a way that does not bring about the desired result. From an ethical perspective, difficulty in obtaining genuine informed consent from bereaved families and the issue of patient autonomy remain. Nevertheless, this method represents a reasonable and more effective method of increasing the number of donor organs.

We believe that it would be opportune for the CMA to recommend that a policy of required request be instituted in hospitals. This would be a logical extension of the current CMA position supporting, "in principle, the concept of recorded consideration for organ donation".¹⁶ This approach would have the advantage of peer-group encouragement of cooperation and would avoid the distastefulness of a legal imposition. Adequate training of designated personnel or more widespread use of experienced organ procurement teams should prevent avoidable trauma to families. Several hospitals in Canada have already implemented a policy of required request (Robert Smith: personal communication, 1988).

Routine referral

Routine referral was recently suggested by Prottas¹⁷ as a way of bypassing the resistance of ICU and emergency department physicians to required-request policies. Prottas proposed routinely requiring hospitals to inform organ procurement teams of all admissions that could lead to organ donation, arguing that this approach would require only minimal involvement of medical staff and "would reverse the present unfair — indeed, perverse — balance that expects a proactive response from people outside the organ-procurement system while it relegates the system itself to a reactive role".

This strategy does not seem to offer significant

advantages over required request and could give rise to serious problems. It is not clear how the patients could be identified without the involvement of the medical staff. Involvement of organ procurement personnel, who would be following the course of both potential donors and other patients, might be experienced as an unnecessary intrusion that interfered with the health care team's primary goal of patient-centred beneficence. Identified patients or their families, should they become aware of the involvement of the procurement team, could become quite distressed and might wonder whether the best interests of the patient were still the priority. Furthermore, this approach would necessitate further erosion of confidentiality about diagnoses and prognoses of hospitalized patients.

Presumed consent

In several countries the doctrine of presumed consent is the standard policy. There are two forms of presumed consent. In the first form the person who has died is presumed to have consented to organ donation unless he or she expressly forbade it before death or a family member forbids it. In the second form the state grants physicians complete authority to remove organs regardless of the previously expressed wishes of the deceased or the wishes of family members. Various countries, such as France and Switzerland, have laws mandating the latter form of presumed consent.¹⁸ In France, however, this second form exists only on paper, as doctors are not willing to remove organs without familial consent.⁶ In the United States only 7% of people polled stated that doctors should have the power to remove organs without consent of either the deceased or the next of kin.⁷ Sadler and Sadler¹⁹ argued that such a law would be excessive. They felt that an acceptable balance that facilitates organ donation without infringing on deeply held values is needed. The lack of support for presumed consent reflects the strong US tradition of respect for the individual and the right to self-determination even when it is not in the interests of the larger community (especially those who would benefit from organ transplantation). Although it is not yet entirely clear to what extent a person continues to have "property rights" to tissues or organs once they are removed from the body (e.g., cells or specimens removed at operation), there is consensus that in both life and death a person has the right to the integrity of the intact body.

Payment for organs

Other alternatives such as systems based on payment for organs carry the obvious risk of exploitation of the disadvantaged and fortunately have not been accepted.

A proposed organ donation program

What, then, can we do? People are dying because of a lack of organs, and the strategies described have been only partially successful. Perhaps it is time to consider a new, ethically defensible approach to organ procurement.

We propose that people from the age of 18 years be allowed to enrol voluntarily in an organ donation program. Any person joining this program would agree to permit all usable organs to be taken for transplantation at the time of death. In return he or she would have priority for receiving organs generated by the program that might be needed at a future date. Detailed information about the program would be widely available, and those wishing to join would be expected to sign a consent form after it had been ascertained that they understood the program. Such a consent form could be witnessed, as is done currently in obtaining passports. People initially hesitant to join the program would be permitted to join later on, perhaps with an equivalent delay before eligibility to receive organs; that is, a person who waited 5 years to join the program might have to wait 5 years before being eligible to receive organs collected through the program. There would be provisions to allow people to withdraw from the program. Children under the age of 18 years would not take part; the process of consent for donation of their organs would remain what it is now. People who joined the voluntary organ donation program would have priority in the distribution of all types of organs generated by the program. Any excess supply would be distributed to nonmembers through existing organ retrieval programs.

We believe that such a system would help increase substantially the supply of organs because there would be a strong personal incentive to participate and to confront the irrational resistances to organ donation. The detailed information provided, which would include an explanation of the concept of brain death, would help dispel various myths that currently prevent people from voluntarily donating their organs.

Ethically such a system seems equitable because it would distribute the benefits equally to those willing to share the responsibility of post-mortem organ donation. Those who did not wish to participate would continue to receive organs obtained through conventional methods or surplus organs generated by the program. Most important, the proposed system would respect individual choice and autonomy by allowing people to study the available information and make an informed decision.

This system would serve an educational purpose because everyone would be eligible and encouraged to enrol in it. It is hoped that it would engender a sense of community and shared purpose concerning organ donation and transplantation. Health care professionals would have to decide whether to join, and through this process

they could be expected gradually to become more comfortable with the concept of cadaveric organ procurement. They would also learn that it is not necessary to obtain familial consent to remove organs when the deceased has had the opportunity of exercising the option to donate organs.

There are some potential criticisms of such a program. It could be argued that joining the program would not satisfy all the requirements of informed consent because it would not be entirely voluntary. That is, if one chose not to join the program, one would sacrifice priority of access to organs generated by the program should a transplant become necessary. We feel that the proposed system would strike an acceptable balance in facilitating organ donation by creating an incentive. We do not think that this is undue coercion, because all that the system would do is give priority in the distribution of organs to those who show a willingness to contribute to increasing the supply. Furthermore, it is hoped that the program would increase the supply of organs for all people. In addition, there would be no attempt to penalize unhealthy people, because one would be permitted to join even if one's organs were not suitable for donation.

Another possible criticism is that the proposed system would stress self-interest and thereby erode altruism in health care. Role-related altruism — the commitment to help people in need of medical care — is among the oldest of the core values of the physician, and we agree that it must not be eroded. But in our view such criticism would miss the point with respect to the retrieval of organs for transplantation. The current system in North America is essentially one of familial consent and does not necessarily reflect the donor's altruism. The roots of public health were based on enlightened self-interest, not altruism, when it was realized that infectious diseases endangered everyone and therefore had to be contained.²⁰ We believe that shared interest and purpose form a more solid basis for an organ retrieval system than does altruism. Finally, we expect that people who donate organs for altruistic reasons would continue to do so. There would simply be an additional reason for organ donation.

For any real progress to be made in closing the gap between demand and supply of organs a new approach is needed.²¹ We propose an alternative system that could save lives by making more organs available, that would respect the individual donor's autonomy and that would also satisfy the principles of justice and beneficence. We feel that this proposal should be subjected to debate and compared with a policy of CMA-sponsored required request, which is the system we would like to see implemented at this time in Canada. Finally, the cost and administrative feasibility of the voluntary organ donation program will have to be carefully analysed to determine whether the program is practical as well as ethically acceptable.

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