Once upon a time, the realm of organ donation was uncluttered by any taint of impropriety. A mere generation ago, single organs (primarily hearts and livers) came from donors who had been declared dead according to whole brain criteria (criteria for which there was broad consensus among those both inside and outside of the medical profession). Kidneys were often donated to patients by both living and non-living family members and friends. Although any shortage of available organs is disturbing, waiting lists were considered to be of reasonable and not excessive length. Unfortunately, the "then" and "now" of organ transplantation constitute two remarkably different eras. Today, a new bioethics vocabulary for organ transplantation has emerged, nurtured by severe organ shortages and characterized by controversy generated through asystolic protocols (which allow organs to be obtained from persons whose hearts have stopped beating and who have been declared dead by cardiac criteria, but who may not meet the criteria for brain death), donation by living persons of up to an estimated 60% of their liver (which has resulted in liver failure in or even death of the donors), and, most recently, the troublesome issue of applying market forces to organ donation.

Simply stated, the question of focus here is whether we as a society should begin paying people for donating their own or their loved one’s organs. In 1984, Congress banned any payment in this context, but the question has since resurfaced (ABCNews.com. June 17, 2002; The Independent Review 2001; 5 (3):373-385; and The Independent Institute, May 5, 2002). The American Medical Association (AMA) is encouraging organ procurement agencies and transplant centers to study whether offering financial incentives would boost the number of organ donations. Given that an estimated six thousand individuals languishing on waiting lists die each year due to unavailability of a needed organ, would the introduction of market forces be wrong? The AMA has suggested that the studies should focus only on incentives of a moderate value that would be paid in exchange for organs obtained from deceased donors. As insignificant as the amount tendered may appear at first glance, it would nevertheless represent a paradigm shift that would
set a very troublesome precedent. Furthermore, if the amount of compensation escalates, the issue may become as serious as any other facing transplantation ethics.

If history qualifies as a teacher, any market force in the area of organ donation—regardless of how negligible—will quickly deteriorate into "black market" commodities trading. The coercion of organ donation has been the rule and not the exception in many countries where money is offered in exchange for transplantable organs. In China, prisoners are executed and their organs are sold to the highest bidder. Yes, this is an extreme example, but it is a real one nonetheless.

There is also no guarantee that initially modest payments would not increase gradually over time, especially if the number of organ donations increases once compensation is provided. The Hepatitis C epidemic and the corresponding rise in the number of patients needing liver transplants are sobering in this regard. In the United States alone, the number of people waiting for livers has skyrocketed from 1,676 to 14,710 in the past decade. During the same period, the number of transplantable livers only increased from 2,931 to 4,480. The most striking result of this disparity is an increase in average waiting time from 65 to 514 days! The human toll lying behind these numbers is tragic, as many people continue to suffer and even die while waiting for an organ that never comes. The suffering and death of each of these patients is terrible, and the numbers will only increase during the next decade. While there is certainly a critical need to solve the organ shortage problem, introducing money into an enterprise that has until now been solely characterized by acts of selfless goodwill is crass and, as has already been demonstrated, can lead to abuse.

Historical precedent, however, should not be the only deterrent to adopting such a system. The hallmark ethic of organ donation has always been informed consent. Informed consent must be free of any hint of coercion. With respect to cadaveric donation, will the promise of remuneration prey on the more palpable needs of the poor? If payment begins to be offered to living donors in exchange for their kidneys, will the unique context of organ donation—and its implications for informed consent—be taken into account? It is important to note that the healthy donor is the only individual for whom surgery is performed without any intended physical benefit. Is valid consent possible when a small but real physical risk is accepted at least in part because financial compensation will be awarded, rather than solely as a function of voluntary giving? The ethics of informed consent are already under serious assault and would likely be further compromised by providing financial compensation for donated organs.

Furthermore, there has been no evidence to date suggesting that financial compensation would serve to increase the number of organ donors. What if offering people money for donated organs had the opposite effect? The success of the organ transplantation system is a direct result of it having found favor in the court of public opinion. Any taint of coercion, profiteering, or organ stealing could do irreparable damage to a system which, though it has its problems, is still remarkably successful as is.

Up to this point, the model for organ donation has aptly been likened to a covenant and not a contract. The contract model, wherein medicine operates under market constraints, is practiced by HMOs and has not been an optimal design from a consumer's perspective. The contemporary application of market forces to the health care arena has added a dimension to medicine that has been pejoratively called the "corporate transformation." The sale of certain health care resources should be prohibited even when those resources are scarce and non-renewable. Human body
parts should never be considered a commodity.

Though the covenant model of giving in the realm of organ donation is not perfect and fails to meet a great need, providing payment for human organs is wrong from an ethical perspective. Offering compensation to organ donors or their families could backfire-actually leading to an even greater shortage of transplantable organs. With the number of patients in need of a transplant steadily increasing, this would be the ultimate tragedy. Wouldn't it be wiser, as well as less risky, to determine why virtuous giving has not kept pace with this critical need? Motivating potential donors or their families with money is certainly not the right solution.

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