When organ transplantation is characterized by the covenantal sharing of scarce resources, as it should be under ideal circumstances, it optimally reflects giving to the "least of these."[1] Recently, a Latino man was dying as a result of Sclerosing Cholangitis.[2] This is the untreatable liver disease that claimed the life of Chicago Bears' great Walter Payton. Although on the "waiting list" for a liver transplant, the man ran the risk of becoming another grim statistic?there were only approximately 5,000 livers donated in the last decade for the 18,000 patients who were in desperate need.[3] He was running out of time, yet no organ had been made available. Although the patient's brother volunteered to donate in an adult living liver transplant protocol, someone who was not even a family member stepped forward. The patient's parish priest told the brother, "I can't let you do it, you are the father of four, I'll do it." And he did. Maybe this is not a typical transplantation story, but it is one that nonetheless captures the essence of voluntary sacrifice in the realm of solid organ donation.

Another story highlights a newer side to giving.[4] Two couples in Northeastern Ohio shared similar serious health problems?one of the wives (Debbie who is married to Gary) and one of the husbands (Ron married to Kathy) had kidney failure and were on dialysis. They also shared the same perplexing dilemma. Even though each healthy spouse wanted to donate a kidney to his/her significant other, mismatched blood types precluded organ sharing. Could anything be done to bridge this biologic divide?
Transplant coordinators noticed that Gary could donate a kidney to Ron based on acceptable blood types. To close the loop, Ron's wife Kathy could likewise donate to Debbie. When the information was shared with the two families, they jumped at the opportunity to share. On November 9, simultaneous surgery at two centers successfully accomplished organ retrieval and implantation. A bond has developed between the two families and they call each other frequently.

A happy ending, yes, but is the process ethical? In order to comment in this regard, outcomes, informed consent procedures, confidentiality in sharing privileged information, and the future evolution of this model should be discussed.

The outcome statistics have been good as well as substantial. First, since living kidney donation—as opposed to donations from deceased donors—leads, on average, to 15 years longer graft viability, overall, live donors comprise superior protocols. Secondly, transplanting unrelated organs from living donors (that is, those that do not come from a "blood" relative) in this era of transplantation, as long as there are no blood type mismatches, is safe, successful, and no longer experimental. More than 6,000 people have contributed and benefited this way; serious caveats have not arisen.

Since the couples will have already been through extensive counseling regarding transplantation, donation to another couple is the only "new" discussion?hardly a prohibitive one. The risk and outcome data does not change. A thorough understanding of the pros and cons is achievable and is not complicated in any way.

In regard to confidentiality, there are definitely no insurmountable hurdles. After initial discussion, couples would waive their confidentiality in only a limited way, that is, to transmit critical information solely to the other couple(s) in question. Confidentiality is not an absolute good per se, and since contact would be made only at the behest of those directly affected, it is respected.

Are there potential abuses? It seems that "Occam's Razor," and its demand for simplicity should be operative. The Johns Hopkins' Program is arranging a "swap" involving six pairs and one altruistic donor. It would appear that this level of complexity might stress both the informed consent and confidentiality guidelines. Is there an optimum number, which exceeded would render the process inefficient or unethical? Probably not, but the process could become dicey. Much of the added stress would be logistical, however, not ethical.

The arena that may become critical in the future is a "turf" one. Expanding this model would require sharing across greater distances. Debbie, Gary, Ron, and Kathy live in adjacent communities. Could brokering swaps across states lead to problems? Who will pay travel expenses for donors/recipients who match someone relatively far away? Will geographically disparate programs surrender organs without immediate gratification? What if the patients they identify have their surgery in another state? Time will tell. If sharing is curtailed or those who cannot pay to get to available organs are excluded, necessary adjustments could be made to rectify inequalities. Oversight by independent agencies would be essential. Justice in allocation, continued satisfactory outcomes, and issues related to either informed consent or confidentiality should be monitored.

Designated donation is becoming one way to alleviate the organ shortage. Another model that
features designation is receiving increased interest and has been discussed at an earlier date.[5] As long as donors and recipients are respected equally, and outcomes, consent, and confidentiality policies are acceptable, such programs can represent what is best about organ donation. A covenantal model will always be superior to those proposals relying on a contract.


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