The Erosion of Ethics in Organ Transplantation

What's a Catholic to Do?

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Caleb Beaver died at age 16 on Christmas Day in 2011 due to a previously undiagnosed congenital malformation of his blood vessels. His devastated parents agreed to the donation of his heart, kidneys, lungs, liver, and pancreas. Several months later, his mother and father were able to meet with the grateful recipient of Caleb's heart and hear their son's beating heart in this new body. While the meeting could not erase their grief, the meeting offered Caleb's parents a small bit of consolation that his death had brought life to someone else.

Organ donation can certainly be a supreme act of generosity. Pope John Paul II endorsed organ transplantation in both his encyclical Evangelium Vitae as well as his 2000 address to the 18th International Congress of the Transplantation Society as a way to build up an "authentic culture of life". However, Pope John Paul II was also careful to insist that this lifesaving technology must be governed by critical ethical principles in order to fulfill its life affirming potential.

The first principle is the donation must be voluntary and free of all coercion. That is why there can be no sale of human organs: the prospect of financial profit would put pressure on the poor to sell their organs for subsistence. A marketplace approach would also unfairly favor those who have the means to pay as organ recipients. Second, the human dignity of both the donor and the recipient must be respected. A potential organ donor must always be seen first as a human being and a patient deserving of optimal medical care. He should never be viewed as merely a cluster of organs waiting to be harvested. With this in mind, respect for human life from conception to natural death prohibits the removal of vital organs for transplant until after a patient has died.

The explosion in organ transplant technology has resulted in a tremendous shortage of available organs. Over 6500 patients died in 2011 while they were waiting for an organ transplant. With so many patients facing death without a transplant, it is not surprising that a black market for human organs has emerged. Organ trafficking has become a major enterprise of organized crime in Latin America, Asia, and the Middle East. Western nations in Europe as well as the United States are not immune from this exploitive trade. According to the European Society of Organ Transplantation, those most likely to sell their organs include the poor, the hungry, the socially marginalized, and illegal immigrants and refugees. Dr. Francis Delmonico, a Harvard transplant surgeon, estimates that 10% of all kidney transplants worldwide are performed with illegally trafficked organs. While many governments have enacted penalties for organ trafficking, few are aggressively seeking to eliminate the black market trade of human body parts.

Perhaps even more worrisome than the deplorable practice of buying and selling human organs are the trends emerging in mainstream medicine. Two of the principles outlined by Pope John Paul II, the expectation that a potential donor is viewed as a fully human patient first, and the requirement that a donor of vital organs be dead before the organs are harvested, have long been cornerstones of transplant programs. The shortages of available organs for transplant have motivated some to question the need for such standards.

Normally, patients are not evaluated as possible organ donors until after a decision to remove life sustaining medical care is made. This ensures that the decision to withdraw extraordinary means of support is made

without coercion from the transplant team waiting for the patient's organs. The United Network for Organ Sharing (UNOS), a nonprofit organization contracted by the United States Department of Health and Human Services (HHS) to administer the nation's organ transplant program, is revising the requirements for organ donation programs in order to allow patients to be evaluated as potential organ donors before any decisions are made about the withdrawal of life sustaining measures. The first attempt by UNOS to revise the guidelines actually designated specific neurological diseases such as high level spinal cord injuries, muscular dystrophy, and Lou Gehrig's disease as conditions to be flagged as potential organ donors on any admission to the hospital. This brought such an outcry from disability advocates that the current revision no longer recommends singling out specific diagnoses for organ donation. Instead, all patients will be evaluated as potential donors, and no consultation with families is required. In fact, UNOS states that it is unnecessary to obtain consent for organ donation from the next of kin or other health care surrogate if a patient has indicated they want to be an organ donor through something like a living will or a check in the organ donor box on their drivers license. This rush to label a patient as an organ donor effectively removes the protective barrier between patient care and preparation for organ donation, thus diminishing the trust between patients and their doctors.

Equally disturbing is the push to remove vital organs from living patients. Since the first transplants were done, there has been a lively debate over what constitutes death, and such discussions are still active today. Some advocate for criteria that rely on the presence or absence of cardiovascular circulation and define death as the absence of a beating heart. Others push for the absence of electrical brain activity to be the gold standard of death. Until recently, the issue was always centered on reaching maximum certainty that death has occurred before harvesting organs for transplant. Now the emphasis is shifting to making sure the patient is "close enough" to dead for transplant.

In their book Death, Dying, and Organ Transplantation, Drs. Franklin Miller and Robert Truog argue that it is not necessary to wait for death in patients who are voluntary organ donors and in whom death is imminent. In Canada, the Canadian Council for Donation and Transplantation markedly loosened the neurological criteria required for organ harvesting, leading critics to question whether the patients declared dead under the new liberalized criterion are really dead.

Standard protocols for donation after circulatory death typically require a two to five minute delay from the time heart function ceases to the time organs are removed. The new UNOS requirements discussed above remove any required waiting period before removing organs after the heart stops. Each transplant center is free to define circulatory death as it sees fit. As a utilitarian ethic becomes mainstream and donor death becomes optional, the need for certainty of death becomes superfluous.

Clearly, these developments are at odds with Catholic ethical principles. The Ethical Religious Directives for Catholic Health Care Services clearly state:

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

So what is a Catholic to do? As with other end of life decisions, it is important to designate a health care surrogate who will make sure your health care conforms to Catholic principles when you are unable to speak for yourself. In light of the increasing speed with which organs are removed from patients who have previously

designated themselves as organ donors, it is wise to consider carefully the possible consequences of making your intentions to be an organ donor public through an advanced directive or a checked box on your drivers license. When possible, know your health care facility. Ideally, your hospital should be able to provide some assurance that any organ procurement protocol will assure quality care to the donor until the time of natural death and no vital organs will be removed before a patient is dead.

Organ transplantation, when done ethically, remains a heroic act of generosity. This legitimate and life-saving practice must not be degraded by turning human organs into commodities, and turning seriously wounded or disabled persons into mere suppliers of organs.