Issues in organ transplantation

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When we scan the history of human civilisations it becomes evident that the evolution of ethical concepts has preoccupied philosophers, ethicists, sociologists, theologians, professionals and indeed all of society. We then have to assume that evolving ethical concepts is deemed as a necessity for guiding individuals and societies with a view to furthering their wellbeing.

To begin with we must be clear as to what we mean by 'ethics', a word often used synonymously with 'morals'. Morals or moral philosophy pertain to the prevailing attitudes, beliefs and rules of behaviour in a given society, are influenced by the thought processes propagated in the environs of the time, and are therefore subject to change. Ethical philosophy is concerned with the analysis of these moral values to offer some guidelines on whether the moral philosophy is appropriate or otherwise.

Ethical value systems and moral principles must be pervasive in all sections of society and particularly in those expected to provide leadership, such as in politics, the administrative services and the professions. A down-gradation in one section can have unwholesome effects on other sections. Witness today the consequences of the low standards of ethics and morals in politics in our country. Medical professionals are a part of society; they cannot stand on a separate pedestal, and must be on their guard against such down-gradations affecting them.

To summarise, ethical philosophy is necessary to evolve principles which aim at preserving those parts of the heritage of human societal structures which have served us in good stead and which further the well-being , integrity and dignity of human beings.

Evolution in medical ethics

We have come a long way from the ethical principles enunciated by Hippocrates. Since then have evolved the Hammurabi Code, the Islamic Code, those laid down by Sushruta and Charaka, and down to the Geneva Declaration of the International Code of Medical Ethics formulated in 1947 and amended in 1968, 1983 and again in 2000.

Medical ethics is closely interwoven with societal morality in each era of civilisation and is influenced by philosophical, theological, and scientific advances. Today we are experiencing an unprecedented explosion in science and technology which in turn influences concepts in medical practice. Whilst they have undoubtedly benefited mankind in many areas, they has often been mis-utilised. Medical professionals have become over-dependent on technology, dehumanising medical practice. These advances then pose dilemmas of an ethical, moral, sociological and theological nature.

By its very definition the word dilemma implies that there can be more than one answer to a specific question. We have then to discern between a technology's beneficial effects and those ineffective, even harmful to the individual patient. It may be argued that concepts of ethical philosophy are too abstruse and generalised and may not be applicable to specific instances in which moral philosophy is causing a dilemma. This is a misconception. The tenets of ethical philosophy can be juxtaposed to such specific instances where moral philosophy needs to be critically analysed. This brings into relief what Peck has described as 'code ethics' versus 'situational ethics'. Application of the tenets of ethical philosophy can then offer an ethically acceptable and practicable solution for society.

It becomes necessary then to keep up a constant review of our ethical value systems without compromising its basic tenets but taking into considerations economic and societal realities. There are four basic pillars on which our concepts of medical ethics rest today. They are:

Beneficence: this entails that whatever treatment we utilise does not harm the patient. It also demands that any intervention must be done with the purpose of preventing, removing or mitigating any harm that may have been caused.

Non-maleficence: this means that in the first place we should not act in any way which may cause harm to the patient.

Autonomy of the individual is today universally a well-accepted doctrine. This autonomy must be respected .The days of 'medical paternalism' are gone.

Society has a vested interest in the profession and expects that our actions will be based on **social justice** and responsibility.

Based on these foregoing introductory remarks, I will venture now to offer some observations on ethics of organ transplant.

Evolution of ethics in human organ transplantation

In 1831 when Jeremy Bentham wrote an essay entitled 'Of what use is a dead man to the living?' he could not have foreseen the advent of modern technology which now makes it possible to transplant human tissues and organs. I mention this to re-emphasise that scientific and technological advances call for a constant re-orientation of prevailing concepts.

Secular and theological thinking has for centuries considered the 'principle of totality' inviolable in order to maintain the total integrity of the human being. Hence any destruction of the human body or its parts is contrary to this principle. However, in the past four or five decades, this principle has been analysed in view of the need for tissues and organs for transplantation, to benefit other human beings. Thus ethical principles have evolved to suggest that transplantation would be within the bounds of ethics of certain criteria are fulfilled, in instances of living

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donor transplantation. These are:

The removal of the tissue or organ does not impair the health or functional integrity of the donor.

The benefits expected to be given to the recipient bear an acceptable proportion to the harm likely to the donor.

The donation should be altruistic and is given without any coercion or any other form of external pressure.

The donor must be fully informed of the nature of the procedure and the possible — even if rare — complications. This entails the need for follow-up of the donor's health in the future.

The views of close relatives such as the spouse or adult children are taken into account.

There must be no element of commercialisation or exploitation in the donation.

It is not always easy to establish with any degree of certainty that all these criteria were met in an individual case. However these criteria offer a basis on which we can **compromise?** our ethical principles.

Ethics in genetically-related living donor transplantation

It will suffice here to say in this context that if the criteria for donation enumerated earlier are satisfied, there is ethical justification in accepting the donation. I will still stress that the donor must b emade fully aware of the nature of the procedure. His or her psychological make-up should be taken into consideration, as should be the views of the donor family. We must, to the best of our ability, establish that there has been no undue coercion. All these require communication skills (which, along with concepts of ethics and the history of medicine, are never imparted to us as undergraduates).

Ethics in non-related living donor transplantation

This form of transplantation raises some specific issues of ethics for medical professionals and grave issues of social morality, since it is inevitably connected with the commodification of human organs. The shortage of donor tissues and organs has encouraged 'market forces' and the commerce in human organs. I restrict my remarks to our country and the experiences in live non-related donor transplantation of kidneys.

The question we need to pose is: can the criteria as laid out for live donor transplantation be fulfilled in non-related donor transplantation?

Take the basic criterion of altruism and its negation by commercialisation. Whilst altruism may be a genuine motive in the rare case, we all know that in the vast majority of cases the motivation is the financial reward. As for voluntariness, what greater coercion can there be than dangling the promise of Rs 30,000-40,000 before a poor donor?

As for informed consent, I wonder if illiterate and economically depressed donors are given full details in a language understood by them, and whether their families are taken into confidence. Informed consent consists of more than a signature on the dotted line. Do medical professionals confirm voluntary informed consent through a personal discussion, and is it dully and faithfully recorded in the case papers?

The other important criterion are that there shall not be any commecialisation or exploitation. Commercialisation is self-evident. Exploitation should be a matter of concern to society. The most lurid is that by the middleman or broker who thrives on the gullibility of the illiterate or on the economic strain of the weaker sectors of society. How much of the sum actually goes into the donor's pocket is a matter of guess work. Then there is the exploitation of the donor's poverty by the rich recipient. It is argued that the poor man needs the money which the rich man has with him to give and thereby a little redistribution of wealth is made. I venture to suggest that it is a redistribution of health from the poor — who can ill afford it — to the rich. The inequity of the situation is surely against the grain of social ethics.

It is argued that individuals are free to donate their kidney for a price, as much as they are free to sell their labour or other services. It is also argued that individuals have freedom of action. There are grave dangers to moral values of society in such propositions.

The freedom of individuals to behave as they wish is always circumscribed by the needs of the greater good of social morality. The proposition pits a distorted value system of individuals in need and their methods of obtaining that need against established value systems of organised society. If society accepts the trade in human organs, it will be replacing the concept of the human organism's intrinsic value with the extrinsic value of the human body or its parts, making them a commodity. This destroys individuals' autonomy and dignity. There are also dangers of extortion and even criminalisation, as the recipient' identity may be known to the donor and his family.

In this situation, the dilemma before the medical fraternity is when faced with a patient who has no family donors or chances of obtaining a cadaver donation within a reasonable time, and cannot afford chronic dialysis. Do we let such patients die? Do we refuse them a non-related donor transplantation? Out of sympathy for such patients, I would like to evolve a strategy which separates transplantation from the nexus of commercialisation. But I find myself groping in the dark. I am aware that the latest Human Organ Transplantation Act provides for some safeguards, but there are many loopholes. Non-related donor transplantation can be carried out provided all aspects of the procedure are approved by what an 'approval committee'. But who does this committee consist of besides medical bureaucrats? Does it receive advice from lawyers, ethicists, sociologists, psychologists, etc. to help it make its judgements? I am skeptical of that.

A rather novel concept has been floated, of 'rewarded gifting'. I consider this merely a terminological subterfuge. It represents the commodification of human organs while placating professionals. I did not realise that one gives a gift and expects a reward! I find the arguments of protagonists of this concept specious and am unable to

find an ethical compromise which safeguards social morality.

Obligation to the recipient and family

Recipients must be fully informed about the nature of their illness. They must be given a choice in the modalities of treatment, namely haemodialysis and transplantation. They must be given a clear picture of the nature of the operation and its likely sequelae, both immediate and long term. Recipients and their families have to be informed of the economics of the treatment, particularly the need for post-transplant medications which can be expensive. It is distressing to see families face economic ruin on account of a transplant, with the liquidation of all their assets and the compromise of other family members' future. In this context, professionals must exercise extreme judgement in advising transplantation for patients with contraindications to the procedure. They must estimate the chances of success. They must take the moral responsibility of advising the family clearly on the issue.

Ethics in relation to cadaver organ transplantation

It might seem that that there are no serious ethical problems in this form of organ transplantation But there are some issues.

There are many theological and religious concepts expressing the inviolability of the human body even after death, in the belief that the body should reach the other world as a whole. However, it has been argued that if we believe in the concept of reincarnation, we are concerned only with the 'spiritual passing away' of life, leaving our physical bodies as empty shells. It would then be within the bounds of ethical principles, both theological and sectarian, to allow such bodies or their parts to be used for the benefit of humanity. Today many theologians of various religions share this view. Still, there will be groups and families who adhere to the stricter religious concepts. Professionals are ethically bound to respect their sentiments when approaching the subject of organ donations.

This brings us to some of the ethical dilemmas in cadaver donation programmes, namely of establishing priorities in the choice of patients to receive a cadaver kidney, as the demand will far outstrip the supply. This will be all the more applicable when one donor matches more than one potential recipient. The question is: what parameters should we employ when excluding so many in need? Is it age? Should a judgement of whether the patient's economic resources will allow for for long-term success be made? Is it dictated by the need of the family to have an earning member restored to health? Is it by the importance of the individual to society? Should it be purely on medical grounds? Or shall we make the final choice by drawing lots?! Such dilemmas cannot be easily resolved but need to be addressed.

Ethics in relation to society

Throughout the history of medicine we observe that the practice of medicine has been closely intertwined with the social, economic and moral texture of society. All advances in medical science have always promised an impact on society. But the medical technological advances of the past two or three decades have been so phenomenal that society is often left bewildered. There is always a time lag between the advent of such advances and the time required for society to absorb their impact. This places a moral and ethical duty on the professionals to be explicit in our approach and explanations. We have to help society make what Illich calls 'social assessment of technological progress'. We are an integral part of society and we cannot isolate ourselves on a pedestal by assuming a posture that we are only concerned with our technical perfections and service without reference to social needs and morality. Morality in medical practice has no different dimensions than morality in other sectors of society. The finger that points to lack of morality and ethics in other sectors may also be pointing at us.

The concept of brain death — or more precisely brain stem death — has created problems for society to understand. This places two types of ethical and moral burdens on professionals. They must convince society of the ethics of brain stem death, and if the concept is accepted ensure that the criteria of brain stem death are clearly articulated and scrupulously enforced.

If society expects — and rightly so — medical professionals to maintain high levels of ethical and moral standards in the execution of organ transplantation programmes, professionals will expect that society will also undertake to bear its responsibilities — to mobilise its economic, man-power and other resources for the purpose. It must promote awareness of the issue and the need. It must reorient social ethics on these issues. Society will have to foster and sustain such activities and thereby also act as a watchdog. If society shirks its responsibilities today, it may not have a second chance tomorrow.

I would like at the end of this article to say that the views expressed in this article arise from my personal perceptions of the issues. Let them be debated by society as a whole and medical professionals in particular.