Transplant International

Transplant International ISSN 0934-0874

INVITED COMMENTARY

Making an offer you can't refuse? A challenge of altruistic donation*

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Keywords
altruistic, donation, ethics, kidney, liver, non-directed, transplantation.

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Conflicts of Interest
There are no conflicts of interest; the views expressed here are personal and do not represent the views of NHSBT nor the Queen Elizabeth Hospital.

*Commentary on 'Can we turn down autonomous wishes to donate anonymously?', by Medard Hilhorst *et al.* [Transpl Int 2011; **24**: 1164].

Received: 31 August 2011
Accepted: 12 September 2011
Published online: 8 October 2011

doi:10.1111/j.1432-2277.2011.01367.x

Summary

Living donation is becoming increasingly used to help fill the gap between the needs of potential organ recipients and the availability of organs from deceased donors. The last few years has seen a small, but increasing contribution from altruistic (or good Samaritan or nondirected) donors. However, use of organs from such donors is associated with ethical as well as practical issues. The rights of the well-informed and consented donor to donate must be balanced against the rights of the surgeons to decline to offer such a service.

Altruistic, Samaritan or more accurately nondirected organ donation is becoming an increasing source of donated organs. This has arisen primarily as a consequence of the failure of donation from deceased donors to match the needs of those awaiting a transplant. For example, in the UK, over the last decade, the number of donation from donors after brain death has remained broadly static (Fig. 1a). The number of kidney transplants from donors after circulatory death and living donors increased between 2001 and 2006, but has remained stable in the second decade whereas the number of living donors has now overtaken the number of deceased donors and the number of altruistic donors has increased from 6 in 2007/8 to 28 in 2010, and is likely to continue to rise. As kidney transplant chains become increasingly sophisticated, altruistic donation has allowed expansion of this approach to increasing access to transplantation [1]. Living liver donation is common in those countries where deceased donor rates are low, but both in Europe and North America, living donation represents a very small part of the donor pool. Altruistic liver donation does occur, but is uncommon and lung donation has been rarely reported.

Any surgical intervention is associated with risk and donor deaths have been reported even in the most highly regarded units [2,3]. The risks of surgery can be reduced,

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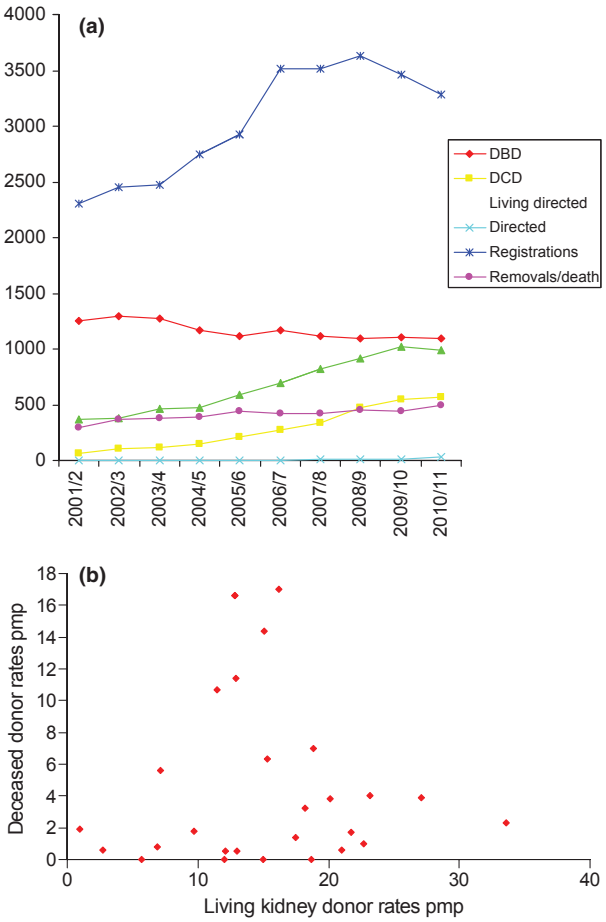

Figure 1 (a) Kidney transplant activity in the UK over the last decade (data from NHS Blood and Transplant. (b) Deceased donation rates and living kidney transplant rates in countries of the European Union) (adapted from Council of Europe, http://ec.europa.eu/health/ph_threats/human_substance/oc_organs/docs/fact_figures.pdf).

but not abolished. The only certain way to avoid deaths is not to carry out the procedure. When donor deaths are reported, it can have a major impact on living donation. The short and medium term risks to the healthy donor are not negligible for liver donation, but are very small for kidney donation: robust figures are hard to come by, but current estimates suggest a risk of death of 1 in 250 for right liver lobe, but around 1 in 7000 for kidney donors [4]. Furthermore, there are few recorded cases where living liver and kidney donors require a graft themselves as a direct consequence of their donation. Long-term consequences of donation are uncertain, but are unlikely to be significant. Living donation, in my view, must be considered a second-best option and should not be a substitute for efforts to increase deceased donation. There is a crude inverse correlation between deceased and living donor rates (Fig 1b) which suggests that living donation is being used to make up the shortfall.

Nondirected donation brings with it many challenges. In medicine, the concept of autonomy and self-determination is well accepted, provided the person is adequately informed and fully consented. Yet, these concepts ignore the restrictions that most societies place on personal freedom. For example, most states prohibit driving without seat-belts: earned income is taken by the state to support others in society irrespective of the wishes of the individual (interestingly this concept is not applied to organs which are no longer needed when the 'owner' dies). Part of the justification for this restriction is that 'society' may have to bear the consequences of the individual's actions: whether through state or insurance-run schemes, someone will need to bear not only the financial and other costs of the surgery but also any possible consequences, should the donor come to harm. The assumptions that patients do give fully informed consent, understand the full implications of the consent forms, and have a rational comprehension of risk is not always borne out in practice [5,6].

Not all clinicians support the concept of living donation and some may question the motives of the donor. Although many may doubt the sanity of altruistic donors [7], those who are involved in assessing altruistic donors have been impressed by the truly generous and selfless approach of these so-called supererogatory altruistic donors [8]. Mostly these donors appear motivated by a single inspiration and do not have religious or self-seeking characteristics [9] although Mueller described one instance where members of a religious community presented en masse and offered to be kidney donors [10]. Psychosocial and functional outcomes of directed and nondirected donors appear to be similar, although numbers are relatively small and follow-up limited, but slightly more altruistic donors regretted their decision [11,12]. Centres will have clear processes for ensuring potential donors are truly motivated by voluntariness, but exclusion of coercion is difficult [13]. Financial incentives for donation are banned by convention and by law, yet the validity and practicality of this ban has been questioned. Recent calls for students to be financially rewarded for the sale of a kidney to allow their student debts to be cleared [14] were not well supported, but even with safe-guards, any system of donation is open to abuse as seen by the recent case of the 17-year-old who sold a kidney for around £2000 to buy an iPad (the suggested rate for a kidney in the UK was £28000) [15]. Kidney donors appear to have divided opinion about the use of financial incentives when compared with recipients, although most had donated without wishing financial

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reward. In contrast, just under two-thirds of recipients supported the use of financial incentive [16].

If a person comes forward for altruistic donation, can the transplant team refuse the offer, assuming the potential donor is considered physically well enough to donate and understands the risks? This question has been very carefully considered by the group in Rotterdam [17] who added a twist by considering the donor who has already donated a kidney and now wishes to donate part of the liver lobe. The team concluded that the request of the donor must be respected. However, the authors do acknowledge that doctors do not have a duty to perform unrelated donations, but are ethically allowed to do so (presumably this applies not just to the surgeons but anaesthetists and other health care professionals who will care for the donor). Although surgeons do have a professional obligation to carry out procedures in the interests of the patient even if this puts the surgeon at physical risk, they do have a right to decline to participate in some procedures (such as termination) although in such cases, they have an obligation to ensure that the patient is referred to another doctor. At the extreme end, no one would argue that a clinician should not be allowed to refuse to participate in any way in supporting suicide even in those jurisdictions where this is legally permissible. Thus, allowing clinicians to make decisions not to comply with the patient's wishes, to some extent, negates the wishes of the would-be donor. If the unit does not wish to support unrestricted donation, then they have this right, but should not impede the wishes of the would-be donor and refer them elsewhere.

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