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INVITED COMMENTARY

The right to refuse*

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

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The clinical success of organ transplantation started with live donor kidney transplantation more than half a century ago. Living donation was originally limited to kidney donation – a paired organ whose removal is usually tolerated by the donor with certain risk that is rarely life threatening. Partial liver transplantation was originally developed for pediatric liver transplantation, where a parent would donate part of the liver to his or her sick child. In many countries, especially in Asia, cultural traditions have hindered the development of recovery of organs from deceased donors. In these regions, living liver donation among adults has become the de facto standard of care. In contrast to kidney donation adult-to-adult liver transplantation (mostly utilizing the right liver lobe) carries with it considerable risks to the donor including a mortality of 0.2–0.5% – which may even seem to be an underestimation, and a morbidity risk of around 50% in the immediate perioperative period. In the early days, and in part ascribable to limitations of immunosuppression, living donation was limited to family members and blood relatives. While blood relation is not a prerequisite for donation any more, donation between individuals who have some sort of personal relation is the rule. In many countries this relationship between potential donor and recipient is scrutinized by specially designated, usually multiprofessional committees to rule out commercial donation. In comes so-called ''Samaritan donation'' where a healthy person donates part of his or her body anonymously into the pool of waiting recipients and the organ is allocated following standard allocation rules to a patient unknown to the donor. Today the term ''Samaritan donation'' is widely used but perhaps misleading: according to the scriptures the good Samaritan, ''moved by compassion'' took care of a road side robbery trauma victim by providing him oil, wine, wound dressings, transportation, and prepayment for in-patient treatment – only time and valuables, but not part of his body (Luke 10:30–37).

Against this complex background Hilhorst *et al.* describe the case of an individual who had previously donated a kidney anonymously and now wishes to donate another part of his body i.e part of his liver [1]. The question whether or not ''we'' can turn down this wish starts with the definition of ''we'' – it may imply *we* as physicians, *we* as hospital employees in a transplant center, *we* as a professional society or *we* as a society of the whole. The easiest answer is: yes, of course we can turn down this offer *individually* as a physician – however, we

then have the duty to hand over the case to a colleague [2]. In a recent Expert consensus statement of the European Heart Rhythm Association Padelletti *et al.* have elegantly summarized that ''individuals should not be compelled to participate in a clinical activity that they find morally objectionable. If such a situation occurs, the attending physician must find another physician … to carry out [the patient's] request'' [3].

Hilhorst *et al.* in introducing their case and arguments ''presuppose … for the sake of argument, that the outcome of the screening, regular for all Samaritan donors, does not disclose any contraindication''. But – the devil is in the details which must not be overlooked: Trotter *et al.* have drawn our attention that there may be hidden severe psychiatric disorders in live liver donors. Suicide rates after seemingly uncomplicated living donation may be increased compared with the general population [4]. The wish to donate may originate in financial gain, *per se* this is ruled out in anonymous donation. However, both in related, nonrelated, or anonymous donation the individual wishing to donate may have underlying undisclosed psychiatric morbidity such as feelings of low self-esteem or depression leading to the wish to donate as an act of as-it-were self aggression. Jendrisak *et al.* have reported their experience with evaluation for nondirected kidney or liver donation where they particularly looked at a temperament and character inventory (TCI) measuring novelty seeking, harm avoidance, reward dependence, and persistence [5]. In the current ''Guidelines for psychosocial evaluation of living unrelated kidney donors in the United States'' one of the key required components is evaluation of motivation including ''explore the rationale and reasoning for volunteering to donate, i.e. the voluntariness' including whether donation would be consistent with past behaviours, apparent values, beliefs, moral obligations or lifestyle, and whether it would be free of coercion, inducements, ambivalence, impulsivity or ulterior motives (e.g. to atone or gain approval, to stabilize self-image, to remedy psychological malady)''[6]. Thus, when looked at closer the seemingly easy presupposition of the paper by Hilhurst that no such contraindications exist becomes much more complicated. Despite these failings it is an elegant paper which clearly delineates many fault lines of ethical conflicts. While today autonomy of the patient is a principle that overrides paternalism (the principle that the physician knows best what is in the interest of the patient) even autonomous patients have no right to have any treatment delivered according to their wishes irrespective of clinical need [3]. This should be scrutinized even more carefully in the situation of living donation where the fundamental Hippocratic principle of ''primum nil nocere'' [first – do no harm] is regularly being violated by performing surgery on a healthy human being. Finally, as is often the case, theoretical ethical arguments often follow the reality: a case similar to the one so elegantly presented by Hilhorst *et al.* was recently published by the Toronto Liver Transplant Unit – the group describes an anonymous liver donor who later went on to become a kidney donor [7]. Thus, progress in transplantation will always confront us with new ethical questions and the group of Weimar from Rotterdam is to be highly commended for their efforts in clarifying this field.

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