COMMENTARY

Imminent Death Donation: Beyond Ethical Analysis and into Practice

Grace S. Lee, Vishnu S. Potluri, and Peter P. Reese

The transplant field must pursue innovative and ethical proposals to alleviate the organ shortage. Imminent death donation (IDD), in the broadest sense, can be defined as a proposed form of organ donation in which procurement occurs prior to the withdrawal of life-sustaining treatment in a living donor. In this issue, Potter provides a thorough ethical analysis of IDD, supporting IDD for donors with decision-making capacity and recommending against IDD for incapacitated donors.[1] While we generally support this assessment, it should be clear that the original conception of IDD and most subsequent analyses of it primarily referred to IDD in the context of incapacitated donors only.[2] Ethical concerns, barriers, and solutions differ in meaningful ways for capacitated versus incapacitated donors. In this commentary, we briefly highlight those differences. We also situate the ethical issues relevant to IDD within the clinical and regulatory considerations that affect the willingness of transplant professionals to pursue IDD among potential donors with capacity.

The United Network for Organ Sharing (UNOS) is the national non-profit organization that facilitates transplants across the US. The UNOS Ethics Committee evaluates ethical issues in transplantation and organ procurement and provides expert guidance to the UNOS Board of Directors, but does not make policy. In 2016, the Ethics Committee provided an analysis that did not support IDD by incapacitated donors.[3] The proposal was passed by the UNOS Board of Directors and made available to the public. Separately, the Ethics Committee completed an analysis of potential donors with life-limiting illnesses, such as those with progressive neurological diseases, and argued that supporting living organ donation in this population is consistent with autonomy and beneficence.[4] However, the Ethics Committee did not specifically address the situation of donors with capacity to undergo living donation immediately prior to the withdrawal of life-sustaining treatment, or capacitated IDD.

When considering ways to advance capacitated IDD, it is important to understand current regulations and what motivates transplant centers. Regulations and center outcome reporting may promote high quality medical care, and are intended to help the public determine which transplant center is best for them. Unfortunately, such report cards may have unintended consequences. Transplant recipient and donor outcomes are scrutinized not only by UNOS, but also by Medicare and private payers. A bad report card or donor death can lead to investigations by regulators or the media, occasionally with costly ramifications that can even result in the hospital having to cease performing transplants. Some transplant professionals believe that center-level reporting impedes innovation and promotes risk-averse behavior in the acceptance of organs, donors, and transplant candidates.[5]

Technically, nothing in the regulatory structure forbids a transplant center from pursuing living donation by persons with capacity who require life-sustaining treatment. However, certain policies and guidelines may lead transplant centers to perceive this practice as an unwarranted risk. First, the center must report

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The Journal of Law, Medicine & Ethics, 46 (2018): 538-540. © 2018 The Author(s)
DOI: 10.1177/1073110518782962

https://doi.org/10.1177/1073110518782962 Published online by Cambridge University Press

living donor outcomes for at least two years and any death within that time period is a reportable event.[6] Donation by a patient with plans to end life-sustaining treatment would likely result in that donor's death within two years. Patients requiring life-sustaining treatment may also be at an increased risk for complications and mortality during organ procurement due to their clinical status. Concern about mortality reporting may therefore limit the willingness of transplant centers to procure organs from capacitated donors requiring life-sustaining treatment, even if the donors have accepted that risk in the context of a larger discussion on end-of-life care.

Second, the current paradigm for living donor selection prioritizes the donor's future health.[7] Screening practices for living kidney donors select against candidates with comorbidities that might increase their risk of renal failure over a lifetime, such as diabetes, obesity, or hypertension. This framework makes little sense for a potential capacitated donor requiring life-sustaining treatment. For example, a 45-year old donor with pulmonary hypertension, a two-year history of diabetes, and excellent kidney function would fall outside living donor guidelines from some professional organizations, including UNOS, due to the history of diabetes, even though the diabetes will not contribute to renal failure before death, regardless of whether capacitated donation occurs.[8] Consequently, guidelines for selecting living kidney donors ought to be adapted to acknowledge that long-term risks of living kidney donation may be irrelevant to the population of potential donors who intend to cease life-sustaining treatment, or otherwise have a life-limiting illness.

Implementation challenges for IDD among incapacitated donors are distinct from those of donors with capacity. One legitimate utilitarian concern for transplant professionals is whether IDD will affect the total number of organs donated. UNOS has committed to "increase the number of transplants" as the organization's top strategic goal.[9] Some IDD proposals involve donating a single organ — one kidney. Yet, IDD candidates may also be eligible for donation after cardiac death (DCD), when multiple organs may be procured. Though a single-center study has projected that IDD could increase the overall number of organs procured, it will be important to first gauge public acceptance of IDD and then empirically compare organ procurement rates between IDD and DCD protocols to determine the true net potential of IDD versus usual practice.[10]

As Potter notes, the requirement for high-quality surrogate decision-making related to end-of-life care is the other substantial barrier for IDD by incapacitated living donors. If IDD causes living donation by those who cannot provide informed consent to become widespread, it is difficult and daunting to estimate how much the general public or the medical community might begin to mistrust the organ donation process. Perhaps the solution lies in future innovations in advance directives. Detailed directives could allow these documents to better represent one's views on end-of-life care, particularly in the context of organ donation. Some ethicists have long supported the notion that individuals should be enabled to choose among plausible definitions of death, including higher-brain definitions of death.[11] By engaging the public with education and improved discourse, individuals could provide a richer and more nuanced context for end-of-life decision-making in advance directives. If more people specified organ donation and IDD as highly-valued outcomes in their advance directives, IDD could be facilitated for individuals after they sustain incapacitating injury with lower risks to public trust. However, the barriers for such improvements include time and substantial investment by the general population.

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Organ transplantation requires a large web of stakeholders and faith in the entire enterprise, which makes changes to organ donation a slow process. However,

The Journal of Law, Medicine & Ethics, 46 (2018): 538-540. © 2018 The Author(s)

https://doi.org/10.1177/1073110518782962 Published online by Cambridge University Press

the many stakeholders and complex regulatory structure also provides an opportunity for the profession to police itself and thoughtfully advance care by grappling with serious ethical questions, as demonstrated by the UNOS Ethics Committee's analyses. While no regulatory statute is an absolute contraindication to pursuing IDD among individuals with capacity, it will take a bold center to write a careful protocol before launching a trial in this realm.

Note

Dr. Reese is Chair (past) and member of the United Network for Organ Sharing Ethics Committee. The other authors have no conflicts to disclose.

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https://doi.org/10.1177/1073110518782962 Published online by Cambridge University Press