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The Ethics of Uncontrolled Organ Donation: Uncontrolled Organ Donation is Ethically Neutral

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With a shortage of donor organs worldwide, measures are needed to improve rates of organ donation. In this paper Prof. David Crippen proposes that preserving organs for organ donation early on while awaiting consent is ethically neutral and reasonable. Prof. Leslie Whetstine argues that uncontrolled donation after circulatory determination of death is ethically and medically specious.

The benefits of organ donation for the purposes of transplantation are many. The media frequently assures us that some worthy person is always awaiting a potentially donated organ. In the USA there are over 100,000 candidates on the waiting list for various organs and 75 people receive organs daily. 19 people die each day waiting for organs. One organ donor can save up to eight lives (National Network of Organ Donors).

See Also: The Ethics of Uncontrolled Organ Donation: Uncontrolled Donation after Circulatory Determination of Death is Ethically Problematic

One of the fundamental problems in the organ donation pipeline is the fact that potentially viable organs must frequently repose on various life support systems for prolonged periods during the ethical journey to assure the “dead donor” rule (patient must be dead according to the irreversibility rule) is followed to the letter. The longer organs so repose, the less viable they are at the end of this journey.

“Uncontrolled” organ donation hastens this process by preserving organs earlier in the game, assuring a bigger supply to meet the demand. This early preservation can be by initiating early CPR, extra-corporeal membrane oxygenation (ECMO) and hypothermia protocols on patients deemed otherwise unsalvageable but not technically irreversibly dead (yet). Consent for donation would be awaited expectantly.

This plan seems ethically reasonable if measures are taken to assure an otherwise moribund patient does not become in some sense more salvageable during the process of organ preservation. There are mechanical modes that would spare the brain from any other organ system resuscitation (Wall et al. 2011).

The intent to re-start circulation in “uncontrolled” donors is only to maintain organ viability, not to actually “resuscitate” the patient. If not technically “dead” by rules set forth long before the advent of modern organ system failure reversal, then these potential donors are beyond harm. All the ethical vectors point toward benefit (Glannon 2013).

The “Dead Donor” rule essentially states that patients may not be intentionally killed to get organs. Therefore, clinicians may not hasten this process (kill the patient by some therapeutic manoeuvre) (Truog and Miller 2008). But the majority of deaths in ICUs now involve planned removal of mechanical ventilation (by consent). The clinical reality is that the actions of physicians to allow patients to die as a direct consequence of their fatal disease still, in the end, result in death. Physicians removing mechanical ventilation directly results in cessation of vital function exactly like they might by turning off a car’s ignition key or turning off a light switch. The end result is directly affected by an action. A fine line, close to, but perceptible from euthanasia.

If it’s ethically acceptable for physicians to actively remove machines that sustain viability, thereby resulting in death with consent, then why is it not equally ethically acceptable to cause death by removing donor organs sustained only by artificial means? (Miller and Truog 2008) If consent is authoritative for organ donation, then why not for pre-morbid procedures that facilitate donation of viable organs?

No patient would die who would not otherwise die. The wishes of patients and surrogates would be honoured more fully and quickly. More viable organs would be made available and the ethics of organ donation would not rest on outdated definitions of death created before the advent of our ability to reverse organ failure.

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