

ARTICLE

Altruistic Organ Donation: On Giving a Kidney to a Stranger

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Abstract

In the following interview, philosophers Leonard Fleck and Arthur Ward discuss the latter's recent experience of being a nondirected kidney donor. The interview took place in the Center for Bioethics and Social Justice at Michigan State University.

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LF: Today, we want to talk about something you did that many of us would be uncomfortable in doing ourselves. You decided to donate a kidney to a stranger. What prompted you to make this particular choice, and what might have been some of the consequences? Let us start with what comes to mind first: most people would struggle with donating a kidney to a relative, much less a stranger. How did you manage to do that?

AW: Retroactively, it is hard to analyze one's motives after the fact, but the short answer is that I was convinced by an article that I read by Dylan Matthews on Vox.com "Why I Gave My Kidney to a Stranger—and Why You Should Consider Doing It Too." I realize that truly being convinced by something that you read is rare, but to explain my decision, a more nuanced answer is called for. I need to explain why I was in a position to be convinced by this article. As I consider it now looking back, the core element was that previously, donating did not seem like a realistic thing to do—unusual, strange, maybe heroic, or maybe irresponsible, but not something that was likely to be a part of my life.

In describing the main change that happened to me between the time I first read this article, and teaching it in my classes, was that earlier I had a lack of imagination. I did not know anyone who had donated a kidney. (As it turns out, I actually did know someone who had donated a kidney to his father, it is only that we never talked about it.) It was some time after reading and teaching this article that something just clicked in me. What had seemed unrealistic and unimaginable suddenly became realistic and imaginable. As soon as this happened, I had this deep sense of certainty that it was something I wanted to do.

LF: In realizing that donation was something you wanted to do, how carefully did you have to think about it? This is major surgery, and an obvious question is what sort of risk did you expose yourself to in undergoing this surgery?

AW: After reading and being convinced by the Matthews piece, I did quite a bit of research. Matthews is a journalist, not a philosopher, but he has a philosophical background and he presents the argument in a philosophical way, including some of the risks. I continued doing more research; I wanted to know the details of the procedure, the mortality rate, and what effects does this have later in one's life. What I found through my own research, and education provided by the transplant center, was that the surgery itself is extremely safe. I understand the death rate to be 3 in 10,000, about the same for a cesarian section. In

explaining my procedure to others, I often say “The mortality rate is around the same for a cesarian section, do you know anyone who has died from a cesarian section? So far, the answer has always been ‘No.’” Long term, it does elevate the risk of developing end-stage kidney disease, but the elevation rate is small, since those people making it through the screening process are healthier than the general population at large.

My own surgery was performed at the University of Michigan, where they perform many of these kidney donations per week—not altruistic donations—but multiple transplants, for decades, without losing anyone.

LF: I can imagine someone saying to you “Look the folks with end-stage renal disease have an option of dialysis, why not just let them go on dialysis, and you can avoid the risk of donation?”

AW: I understand that view, but for me it was a quality-of-life issue. It is very difficult to live on dialysis. Yes, the service exists, and someone can live on dialysis for many years, and the quality of life is often very poor. Someone on dialysis must typically go to the clinic multiple times per week and endure many hours being hooked up to a machine. There is also the pragmatic concern that it is going to be harder to hold down a full-time job when you are getting dialysis regularly. Additionally, suffering is involved on a daily basis in that patients feel weak and sick. There is also a time horizon; a patient can only be on dialysis for so long before it is going to stop being effective.

It is amazing from a biological point of view that kidneys are so miraculous that we cannot replicate their functionality even with our advanced technology and a big machine; it is not as good as one lousy kidney. There are well-known statistics about the people waiting for a kidney and the number that die each year because there are not enough kidneys to go around, but, as I tell students, there are a lot of kidneys, and they are just in the wrong place—they are in us.¹ After considering my risks, I decided that this was something I really wanted to do to help people.

LF: You have a marital partner that you had to persuade that this was a good thing to do; did she have any concerns about your decision?

AW: Yes, I thought carefully about how to pose this to my family, and I sat on it for quite some time. I thought it might be scary; I wanted to tread lightly. Because it is a big deal, I thought I would ask her permission to look into it more. I co-parent our children, and my body is not just my own business. It took her a little bit by surprise—but not completely—people who know me are aware that as a philosopher and bioethicist, I have been haunted by some ideas for a long time. As an undergraduate, I had written a senior thesis on Peter Singer’s argument for altruism in his paper, “Famine, Affluence and Morality,” and I had had the idea that maybe I should be doing more to help people, I am not sure if I am obliged to do something drastic, but I had always thought that if I had the opportunity to do something big and remarkable, that maybe I would take it, and this was the time. Although she did not give me permission immediately, in the end, after reading the article and thinking about it, she said “OK, I understand your thought process, yes, you can look into it.”

LF: As I remember, and correct me if I am wrong, Singer argues for a kind of altruism and describes a situation where you are walking along and see a very young child flailing about drowning in a shallow pond. You are in your Sunday best clothes and say to yourself, “I do not know if I should jump in and save him at the cost of ruining my shoes.” Singer says that, as a practical matter, there is no great danger to you, the water is not deep, and despite the fact that you do not want to get your clothes wet, you have an obligation to save the child. Is there the same obligation to donate a kidney?

AW: I wrestled a lot with that question. I do not want to tell people they have an obligation to donate. It would certainly be a good thing if there were more kidneys available, but I do not want to take the position that people are a moral monster if they do not make the decision to donate. It is up to them. Nevertheless, Singer’s argument haunts me, and I want it to haunt others. In Singer’s scenario with the drowning child, he offers a simple argument. Premise one is that certain qualities in life cause suffering and suffering is bad (a drowning child, or having to live on dialysis because of end-stage kidney disease). Premise two is if you have an opportunity to prevent something really bad without sacrificing much

yourself, you should do it. Singer concludes by posing a question to the reader: should you be doing something more than you are to help people? People confronted with the drowning child example almost always say you should save the child.

Singer's agenda is to juxtapose the drowning child in a pond to a child suffering in Africa from malnutrition. His argument is that your obligation to the distant child is equally strong to the nearby child. There is a lot of philosophy that we need not go into here, but when considering Singer's contrast, it prompts the question whether it could be the case that distance alone determines moral obligation. Could it be that morality is like magnetism, the farther away you are the weaker it becomes? And when you reason through it, what is the relevant moral difference between the person you know right in front of you and the distant person you do not know?

LF: Like you, I am a philosopher, which means that now and then I have to play the role of the devil's advocate. If I were walking along by that pond and saw the child who had foolishly gotten himself in water out of his depth, I would still feel obligated to save him, no question about it. But the people you are talking about, as you have said, are people with kidney failure as a result of diabetes because they have eaten poorly, not exercised, and who have failed to take responsibility for their health. So, why should I have to take responsibility?

AW: Diabetes is not the only cause for kidney failure; there can be other reasons. As someone who thinks about bioethics and teaches bioethics, I think the right approach to take when considering policy is to close off other considerations and just deliver good healthcare to every patient. We do not want doctors second-guessing the motivations or responsibilities of their patients. We want them pushing aside everything except what is best for the patient, and I thought that was probably the best stance for me to take as well. If, for example, I knew someone with diabetes brought on by drinking too many sugary sodas and we could say they were partly responsible for their health (as we are all partly responsible for our health), I would still be thrilled if someone donated a kidney that extended their life another 10 or 15 years, which is the norm. So, I thought if I could save someone who had been partly responsible, I would want to do it. The more you read stories about people who need kidneys, they are really heart-wrenching and it is pretty hard to come upon a case and be so cold-hearted to say "Well, they deserve it."

LF: In explaining this whole process, I have heard you use the term "daisy chain." Could you explain for readers what this means?

AW: This was a really big factor in my decision to do this. Not only does it turn out that I can benefit someone pretty tangibly, but also the chances are that a so-called altruistic donor (or what is more precisely called a "nondirected donor," meaning there is no particular person you want to donate to) can improve or save many lives and this is a really exciting thing for philosophers. The way it works is, if you needed a kidney and a loved one of yours was willing to donate, they may or may not be a match. What you might be able to do is that the two of you could be paired up with two others who also want to match. You could crisscross in that the other person's loved one could donate to you and your loved one could donate to the other. That happens sometimes, and it is called "paired donation." However, because of other biological considerations, it does not always work out for a pair to match with a pair. So, if you have someone like me who is an undirected donor and was just willing to donate to anyone, what can happen is that I donate to somebody and then their loved one becomes the undirected donor and they can donate to anyone and that person has a loved one who can then become an undirected donor who can donate to anyone. In this way, my donation can result in several transplants in a row by linking up, a sort of connecting the dots, and closing a circle for a couple of open-ended paired donations.

The longest chains have been in their 30s. So far as I know, my chain was three people. The morning that I donated, which was about 7 weeks ago, three transplants happened simultaneously, all in the same hospital. I do not know any of them, and they do not know me; it was all anonymous. It is possible that my chain may become longer in the future. I was told, after a little delicate inquiring, that the potential donor at the end of the chain was not in the required health condition to donate right away. But it may have been

only a small temporary disqualifier, and I would like to think in my heart of hearts that this chain can grow even longer and this person will yet donate in the future.

LF: For me, there would be the worry about someone at the last minute changing their mind and disrupting the whole chain.

AW: Yes, someone backing out would disrupt the whole chain; however, it is very rare for that to happen. There is nothing binding someone to this decision. We want this to be completely voluntary. We would not want some informed consent document to bind your future self to the irreversible promise of donating. It was made very clear to me—as it is to everyone—that I was totally free to change my mind at any moment. Five minutes before surgery, when they are wheeling you down the hall, you can back out. It is true that someone could be involved in this paired program and their loved one could benefit from receiving the transplant, and there is the possibility that they could shirk their own promise to donate. But I am told that is an exceedingly rare occurrence.

LF: We have to stop there; thank you Dr. Ward for joining us in this conversation.

An Alternative (Interior) Conversation Regarding Organ Donation

Some time after finishing this conversation with Arthur Ward, I began to reflect a bit on the emotional complexity associated with kidney donation and related ethical complexities. I started out imagining a hypothetical situation situated more than 10 years ago. I imagined a very close friend or relative needing a kidney transplant, if they would hope to gain as much as 15 extra years of life. In such a situation, I would feel obligated to be tested as a possible donor, although I would do that with fear and trembling. I would then breathe a sigh of relief (instead of feelings of regret) at being told I was not a good match. However, if that situation occurred today, I would be denied that sigh of relief.

Given the “daisy chain” option as another medical advance, and given excellent health, I would be a good match for someone else, someone who was a total stranger to me. I could tell myself I really do not have any strong moral obligation to sacrifice a kidney and assume the risks of surgery for someone who was a complete stranger to me. However, it is much harder to have that view if the person in need of that transplant is a close relative or very good friend. This is where the emotional and ethical complexity begins.

Given the daisy chain option, the person who will ultimately benefit is that close relative or very good friend. That stranger is just a link in the chain. I am no longer a “poor match.” Consequently, I would have to somehow assuage the feelings of guilt that would be welling up within me, given my reluctance to really commit to donating that kidney, but knowing also my reluctance might cost that relative or close friend 15 extra years of life. What I would need to do is to find a way to rationalize my reluctance. One option would be to ask myself: “Do I really believe that relative or close friend would do the same for me? After all, we have had our political and religious differences. He might not be willing to do that for me. I have never seen him as some sort of moral hero. So why should I do that for him?” Another option would be to consider how he ended up with kidney failure to begin with. I would recall the many times I had admonished him regarding his poor eating habits, that he was putting himself at risk for diabetes and heart disease and kidney failure. “Why should I have to take responsibility for his irresponsibility? I tried my best to convince him to change his eating habits.”

“What will others think of me, especially if they are aware of the daisy chain option? Well, they need to ask that same question of themselves. They could be the start of that daisy chain.” Anyway, my understanding is that transplant surgeons would never accept someone as a transplant donor if they expressed any reluctance at all. They would just describe me as being “not a suitable candidate (for psychological reasons).” Of course, I would have to express my reluctance to that surgeon while telling myself I was not really reluctant.² I had my ethically persuasive reasons for being reluctant. I am not engaging in self-deception. I wish I had never read Kierkegaard. He is making this very difficult.

“It is exceedingly comic that a speaker with sincere voice and gestures, deeply stirred and deeply stirring, can movingly depict the truth, and can face all the powers of evil and of hell boldly, with cool self-assurance in his bearing, a dauntlessness in his air, and an appropriateness of movement worthy of

admiration—it is exceedingly comic that almost simultaneously, practically still ‘in his dressing gown,’ he can timidly and cravenly cut and run away from the slightest inconvenience.”³ Maybe Kierkegaard was just in a bad mood when he wrote those words.

Notes

1. In 2018, there were 786,000 patients in the United States living with kidney failure. Roughly, 554,000 were receiving dialysis; the remainder were surviving with a kidney transplant. In 2020, there were approximately 90,000 individuals on the national transplant list awaiting a kidney transplant. In 2020, there were 5,725 living donor kidney transplants; in 2019, there were 7,397 living donor transplants. Roughly, 23,000 kidney transplants occurred that year, the remainder being cadaveric transplants. Roughly, 30% of kidney patients on the transplant will either die on the list or be removed from the list to die shortly thereafter. The average wait for a kidney transplant is 2.5–3.0 years. Roughly, 37-million Americans are living with chronic kidney disease. National Institute of Diabetes and Digestive and Kidney Diseases. *Kidney Disease Statistics for the United States*; 2021; available at <https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease> (last accessed 21 December 2021).
2. Donors must pass a psychological screening. Each transplant center does this differently. At the University of Michigan, every donor must speak with a social worker at the hospital. Non-directed (altruistic) donors have a second, more intensive, screening with a specialized psychologist. This just reinforces the point that they are trying VERY hard to weed out people who might regret their decision.
3. Kierkegaard S. *The Sickness Unto Death: A Christian Psychological Exposition for Upbuilding and Awakening*. Vol. 19. Hong HV, Hong EH, trans. and eds. Princeton, NJ: Princeton University Press; 1980 [1843], at 91.