

## *Donor Benefit Is the Key to Justified Living Organ Donation*

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Spurred by a severe shortage of cadaveric organs, there has been a marked growth in living organ donation over the past several years. This has stimulated renewed interest in the ethics of this practice. The major concern has always been the possibility that a physician may seriously harm one person while trying to improve the well-being of another. As Carl Elliott points out, this puts the donor's physician in a difficult predicament: when evaluating a person who volunteers to donate an organ, "a doctor is in the position of deciding not simply whether a subject's choice is reasonable . . . but whether *he* [the doctor] is morally justified in helping the subject accomplish it."<sup>1</sup> This question has become even more difficult since the introduction of living donor operations that are more risky than living kidney donation (e.g., adult-to-adult liver donation) and the suggestion that volunteers at added risk may sometimes be acceptable.<sup>2</sup> So, how can we decide when the risk is too much?

Physicians are taught to respect the ethical principle of nonmaleficence and at least do no harm. At first glance, it might appear that we should abandon all forms of living organ donation because they always inflict at least some harm on the donor and rarely may even cause death. However, it is important to remember that the principle of nonmaleficence is not absolute and

may be justifiably overridden when the expected benefit of a procedure is greater than the harm inflicted.<sup>3,4</sup> Therefore, if living organ donation provides enough benefit, it may be ethically acceptable despite the certainty of harm. For surgical procedures that are designed to cure or palliate an ill patient, the potential benefits are clear and justify the harm of surgery (e.g., amputating a gangrenous limb to save the patient's life). In the case of living organ donation, however, where is the benefit that justifies inflicting harm and exposing potential donors to the risks of uninephrectomy or partial hepatectomy?

### **Where Is the Benefit That Allows One to Inflict Harm during Organ Donation?**

It has long been believed that the answer to this question is found in the expected benefit for the recipient, and this must exceed the risk for the donor. For example, almost 40 years ago, Professor Hamburger said, "The doctor must respect the desire of one person to risk his life for another; he must only be sure that the risk to the donor is very much less than the probability of success for the recipient."<sup>5</sup>

Although the suggestion that donor risk must be outweighed by recipient benefit has intuitive appeal, I believe that calculating this balance is problematic and is not the key that should

guide physicians (and other professionals) trying to decide if a potential donor is acceptable. There are several reasons for my view. First, medical predictions of risk and benefit are fallible. Second, even if these variables could be reliably estimated, a simple arithmetic comparison of donor risk and recipient benefit would not be sufficient. If the risk to a volunteer is very high, donation should generally not be permitted even if the predicted benefit for the recipient is greater. On the other hand, when there are no other donors, it may be reasonable to allow a mother at added risk to donate part of her liver to her beloved only child, even if the likelihood of success is very low, because transplantation offers the only hope of saving him. Supporting this suggestion are the results of surveys indicating that most adults would be willing to accept a great deal of risk to donate organs to their loved ones.<sup>6</sup> A third problem with basing a volunteer's suitability on the relative size of donor risk and recipient benefit is that this criterion suggests that medical factors are the only ones that matter and fails to recognize the importance of personal values, which vary widely.<sup>7</sup> Finally, this standard asks donor physicians to change their loyalty in a major and, I believe, unacceptable way. Norman Levinsky reminds us that "In caring for an individual patient, the doctor must act solely as *that patient's* advocate. . . ."<sup>8</sup> A physician cannot accomplish this goal if, in trying to decide whether to recommend a procedure, she is asked to balance the risks for one patient against the benefits for another. Such an approach would pose a clear conflict of interest, and this realization has led to the widespread recommendation that potential donors and recipients be evaluated by separate teams of professionals.

### Justified Living Organ Donation Requires Benefit for the Donor

How then should transplant centers decide if a potential organ donor is acceptable? Remember that, from the viewpoint of the donor physician, a potential donor is her patient.<sup>9</sup> Therefore, in keeping with Dr. Levinsky's admonition, the evaluating physician must limit her concern solely to the volunteer's welfare; she should not allow him to donate simply because the recipient may benefit. For the physician to recommend her patient as an acceptable organ donor she must believe that there will be *benefits for the potential donor* that are sufficient to offset the risks for the donor.<sup>10</sup> This approach accommodates and considers individual values, avoids conflicts of interest that arise under the donor risk-recipient benefit balancing plan, is concordant with the clear benefit standard used to determine the acceptability of incompetents as donors, and directs physician loyalty to where it belongs—solely with her patient.

The suggestion that *donor benefit* is the key to determining donor suitability does not mean that recipient benefit is irrelevant. The probability of a successful transplant is an important consideration, but not as a simple balancer of donor risk; rather because it provides essential information that affects the probability that the potential donor will benefit. For example, if there is no chance for a successful outcome, no one could benefit from forging ahead with transplantation.

### How May People Benefit from Donating an Organ?

Other than the occasional discovery during the donor evaluation of a treatable serious medical disorder, no physical benefit accrues to living organ

donors. However, many donors experience psychological and emotional benefits, including an improved quality of life and lasting increases in self-esteem as a result of the knowledge that they have helped to save a life. Even when donors do not reap these rewards, they may gain another that may be even more important—that is, seeing a loved one resurrected and then having that cherished person available for sharing the joys of life.<sup>11</sup>

These psychological and emotional benefits can be very large. This is illustrated by the reflections of a set of parental donors, each of whom had donated a kidney to their daughter several years before: “There is no doubt in our minds that we, as kidney donors, have gained much more than we lost.”<sup>12</sup> I suspect that the more important the intended recipient is to the potential donor, and the more likely there is to be a successful outcome, the more likely it is that the potential donor will benefit, and the larger the expected benefit will be. The fact that the vast majority of donors are glad they donated and would do it again if they could supports the view that many living donors derive much inner benefit from donating an organ.<sup>13</sup>

May we use psychological benefits to balance medical risk? I believe the answer is yes, because psychological benefits can be at least as important as physical ones. This was emphasized by George Schreiner over 30 years ago:

If giving a kidney is for [the donor’s] spiritual or psychiatric good, and this is recognized as part of the total person, it seems to me that the particular mutilation [i.e., organ donation] becomes quite permissible under the extension of the principle of physical totality to the totality of a spiritual person.<sup>14</sup>

### How Can We Determine If the Amount of Donor Benefit Is Sufficient to Offset the Risk?

When a volunteer is competent to make decisions, fully informed, healthy, eager to donate, and deeply concerned about and connected to the recipient’s welfare, and where there is a high probability of success and no other good alternatives, most transplant professionals would agree that the likelihood of donor benefit is much higher than the very small risk involved. At the other end of the spectrum are situations where the risk for the volunteer is so high that no anticipated benefits would be sufficient to offset it (e.g., a parent offers to donate her heart to save her child). In cases that fall between these extremes, however, when the potential donor is less than ideal but where there are no glaring contraindications to donation, how can we determine if the probability of donor benefit is sufficient to offset the added risk?

Because psychological and emotional benefits are subjective, they cannot be quantified precisely. Furthermore, because these are the only benefits that a donor can experience, and because they are not physical, physicians have no special ability to estimate either the probability that a donor will benefit from donating or the size of any donor benefit that may occur. Therefore, perhaps more important than asking *how* can we estimate how much benefit a donor will experience and is it enough to offset the risk is to ask *who* is best suited to this task?

I believe the answer is usually the potential donor herself, assuming that she is competent and thinking clearly and that she has been presented with and has understood the medical risks and benefits of organ donation. The probability that a donor will experi-

ence psychological benefit (or psychological harm) depends heavily on individual values and life plans, the details of which are available only to the volunteer. Therefore, usually it is the potential donor who can best assess how likely she is to benefit and whether anticipated nonmedical benefits are worth the medical risks, because only she knows and understands what is most important to her. Physicians are the only ones that can delineate the physical risks of donation, but the experts regarding the expected psychological impact of donation on the donors, which is where the possibility of benefit lies, are generally the donors themselves.

Although the potential donor may be the person best able to assess her likelihood of benefiting from donation and best able to balance the expected benefit against the risk, this does not mean that the views of the physician are unimportant. On the contrary, it is essential that the physician also examine the balance of risks and benefits. Because organ donation cannot be effected without the physician's help, she is a moral agent here who must consider the donor's welfare and who bears much responsibility for the outcome. Therefore, she may and she should refuse to participate if she believes that donation would do more harm than good, even if the potential donor disagrees. For the physician to give the green light for organ donation, she must believe in her heart that donation makes sense and ultimately she must rely on her own assessment to tell her if it does.<sup>15</sup>

At first glance, my position may seem contradictory. On the one hand, I am recommending potential donors as the best people to assess the relative weights of risks and benefits *for themselves* while, on the other hand, I am arguing that donor physicians must make their own assessments and act

accordingly. The answer to this seeming paradox lies in the recognition that living organ donation involves two moral agents—the potential donor and her physician—and the autonomy of both must be respected. Either one may opt out.<sup>16</sup> But although the physician is not obligated to participate, she is obligated to treat the volunteer with respect. This means that before rejecting a competent individual, she must listen carefully and try to see things from that person's point of view, incorporate that vision into the decisionmaking process, and recognize that in general no one can predict the psychological and emotional impact of organ donation on the donor as well as the donor herself. Thus the volunteer's assessment of the relative size of risks and benefits should be given great weight as the physician makes her own determination.

### Conclusions

It is widely believed that living organ donation may be acceptable only when the expected benefit for the recipient is greater than the risk to the donor. I believe that this is the wrong balance to consider. I have argued that, because the physician's primary responsibility is to protect her patient's welfare, and because living organ donation always involves the possibility of serious harm, the donor's physician should consider this practice justified only when it is anticipated that there will be benefits *for the donor* that exceed the risks to the donor; benefit for the recipient alone will not do. Although the benefits of living organ donation for the donor are primarily psychological and emotional, they may be very large and at least as important as physical ones. Whether a donor will experience these benefits and how important they are depend on that person's values and life plan. Therefore, assuming that she

is competent and thinking clearly, usually it is the potential donor herself who is best able to determine if the expected benefits are worth the risks. On the other hand, physicians must make their own assessments, and they should never be forced to perform a procedure that they think will do more harm than good. Still, physicians are obligated to try to see the situation from the volunteer's point of view. Although they may be uncomfortable about using subjective factors to help determine the acceptability of a procedure that can cause physical harm, it may help to keep Jerome Kassirer's teaching in mind when evaluating potential donors at added risk:

*Primum non nocere* exhorts physicians to avoid life-endangering outcomes whenever possible. Patients, however, may assess the value of an outcome principally by the effect it will have on the quality of their lives. Though difficult to identify and quantify, this value is important to those who must live with it.<sup>17</sup>

## Notes

1. Elliott C. Doing harm: living organ donors, clinical research, and "The Tenth Man." *Journal of Medical Ethics* 1995;21:91-6.
2. Spital A. Ethical issues in living organ donation: donor autonomy and beyond. *American Journal of Kidney Diseases* 2001;38:189-95.
3. Ross L. Solid organ donation between strangers. *Journal of Law, Medicine, and Ethics* 2002;30:440-5.
4. Spital A. Ethical issues in living related donors. In: Shelton W, Balint J, eds. *The Ethics of Organ Transplantation*. Amsterdam: Elsevier; 2001:89-123.
5. Hamburger J. Moral problems of artificial and transplanted organs. *Annals of Internal Medicine* 1964;61:357.
6. Cotler SJ, McNutt R, Patil R, Banaad-Omiotek G, Morrissey M, Abrams R, et al. Adult living donor liver transplantation: preferences about donation outside the medical community. *Liver Transplantation* 2001;7:335-40.
7. Sauder R, Parker LS. Autonomy's limits: living donation and health-related harm. *Cambridge Quarterly of Healthcare Ethics* 2001;10:399-407.
8. Levinsky N. The doctor's master. *New England Journal of Medicine* 1984;311:1573-5. Emphasis added.
9. Delmonico FL, Surman OS. Is this live-organ donor your patient? *Transplantation* 2003;76:1256.
10. See note 3, Ross 2002; see note 4, Spital 2001; see note 7, Sauder, Parker 2001.
11. See note 4, Spital 2001.
12. Pierce EG, Pierce RA. The agony and the ecstasy. *Transplantation Proceedings* 1973;5:1067-8.
13. See note 4, Spital 2001.
14. Schreiner GE. Dialysis and transplantation: ethical problems. In: Wolstenholme GEW, O'Connor M, eds. *Ethics in Medical Progress: With Special Reference to Transplantation*. Boston: Little, Brown; 1966:130-1.
15. See note 2, Spital 2001.
16. See note 2, Spital 2001.
17. Kassirer JP. Adding insult to injury: usurping patients' prerogatives. *New England Journal of Medicine* 1983;308:898-901.