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Life or Death

The Issue of Payment in Cadaveric Organ Donation

IN 1989, 1878 people died while awaiting organ transplantation. Public awareness programs, professional education, and legislation have not increased organ donation; the motive for consent in organ donation remains altruism. I shall argue that because of an ever larger number of patients listed as candidates for lifesaving organs, the policy of a death benefit payment to motivate families of potential organ donors should be studied. A death benefit of $1000 paid through organ procurement organizations would not necessarily be coercive. Laws now prohibiting organ brokerage and assuring fair organ allocation would continue unchanged. A death benefit payment may most favorably affect the socially disenfranchised through increased organ transplantation in minority populations. Because so many salvageable lives are now lost, only because organs cannot be obtained, pilot programs to determine the impact of death benefit payment to the enabling (consenting) next-of-kin should be initiated. If organ recovery increases sufficiently, a nationwide program could save thousands of lives.

See also pp 1223, 1295, 1299, and 1305.

Background

During 1989, the United Network for Organ Sharing (UNOS) listed 18 946 new patients as candidates for vascularized organ transplants (W. K. Vaughn, PhD, United Network for Organ Sharing, written communication, July 1990). By February 1990, at least 1094 of these newly listed patients died waiting for a transplant. This 5.8% mortality figure included those patients waiting for a kidney or pancreas (1.7% died waiting) or a lifesaving heart, liver, or heart-lung combination (14% died waiting). With the current success of transplant procedures, the shortage of donor organs was primarily responsible for needless death.[1,2]

The 1094 deaths of newly listed patients, however startling, actually understate the number of patients who died while waiting for a transplantable organ, because many patients waiting for an organ were listed prior to 1989. Since October 1987 when UNOS began a national waiting list of patients, data compiled quarterly disclose an increasing number of patients on the waiting list, a steady but small increase in transplant operations, and an alarming number of patients who die waiting (Table).[3] Actually, 1878 people died during 1989 while each was on the active national list to receive a cadaveric vascularized organ. These patients could have been saved by organ transplantation. For the last 3 years, the number of organ donors has not increased, staying at approximately 4000 donors annually in the United States.[3,4] The issue in transplantation today is, therefore, that lives are being lost because cadaveric organ recovery is not currently meeting the need.

Many important guidelines about organ donation were promulgated during a period when organ recovery meant freeing one or two patients from dialysis therapy, not necessarily saving anyone's life.[5,6] For many years transplant professionals have known that lifesaving organs are often not obtained because procurement personnel are turned down by family members of the potential donor.[7,8] Altruism (the major motivational guideline), professional and public education, and legislative efforts[5,9-12] have not worked universally to increase organ donation commensurate with the need. Experienced organ procurement coordinators have dealt with families who might consent to organ donation from the brain dead family member, but refuse because there is no financial incentive for the decision to permit organ recovery. The concept of a death benefit paid to the donor family so that organ recovery might be more positively viewed should now emerge as a matter to examine and debate. Several active organ procurement organizations should test the concept of death benefit payment in

Potential Organ Transplant Recipient Listing: Patients Receiving Transplants and Patients Who Died Waiting for Transplants

Time Period		No. of Patients			
Year	Quarter	Total on List	New on List	Transplant Received	Died Waiting
1987	Oct-Dec	13168	4695	2053	291
1988	Jan-Mar	14332	4411	2172	376
1988	Apr-Jun	14766	4153	2512	393
1988	Jul-Sep	15395	4484	2654	433
1988	Oct-Dec	16035	4368	2644	414
1989	Jan-Mar	16966	4764	2609	516
1989	Apr-Jun	17705	4665	2705	456
1989	Jul-Sep	18511	4728	2732	396
1989	Oct-Dec	19173	4789	2830	510
1990	Jan-Mar	20177	5169	2875	565

From the Jacksonville (Fla) Transplant Center.
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the field. If a greater number of organs are procured, a nationwide program should be adopted so that a compassionately administered, centrally controlled death benefit payment plan to families of cadaveric organ donors is operating throughout the United States.

The main argument supporting a study of death benefit payment for organ recovery is the prospect of saving lives through organ transplantation. Topics that remain important to the question include altruism, coercion, organ brokerage, access to lifesaving organs only for those who can pay, and legal issues.

Altruism and Coercion

During the 1960s and 1970s, nearly all cadaveric organs recovered for transplantation were kidneys. Because of effective dialysis treatments, few patients died if a kidney was not procured. Altruism (the regard for or the devotion to the interests of others) was deemed the appropriate motive for obtaining cadaveric kidneys. Now, approximately 70% of all solid-organ donors give vascularized organs other than kidneys[13]; the hearts, lungs, and livers are lifesaving. The medical community has retained altruism as the only motive for cadaveric organ recovery, perhaps for the incorrect assumptions that altruism emerges with counseling and education, that altruistic behavior should prevail in this matter, and that persons unwilling to exhibit altruistic behavior should not be coerced into any other behavior as this coercion would impinge on free personal decision making.[5,10,14-16]

When I was a newly appointed attending transplant surgeon, I was called concerning a case of fatal head trauma in a young man. The usual efforts at "altruistic counseling" about organ recovery began with the next-of-kin, an older brother. The brother stopped us abruptly—I was sure our request would be denied. "I hated that s.o.b.! Go ahead and cut him . . . take his organs! Where do I sign?" I was stunned, mostly because my own moral concepts had been attacked. But I was also wrong to believe that counseling could make this individual aware of the needs of others. He was not only filled with hatred, but also unwilling (and maybe unable) to discover any facet of altruism. Counseling and teaching—especially at the bedside of a brain dead potential donor—may be fruitless with next-of-kin who have ideas entirely alien to our own.

We in the organ transplantation field have falsely assumed that altruism should be accepted by everyone. Our own concepts of regard for the interests of others have been nurtured within the social context of plenty: we are educated, well paid, and generally able to manage circumstances to the benefit of ourselves and others. We have established societal mores about the organ recovery process so that decisions regarding organ donation are entirely altruistic. This posture eliminates the possibility that consent for cadaveric organ recovery could be motivated by something of tangible value even though we know that some population groups harbor different thoughts or feelings about organ donation.[14,17-20] Some individuals may think that we in the organ transplantation field want to take the organs of a dead person (for no payment to that person's family) to make money ourselves from those organs. We who have advocated "free choice" in altruistic organ donation have fully ignored the fact that we are imposing our own values on persons who may not appreciate those values at all. *We may be coercing* some families to accept concepts foreign to them at a time of great personal loss. More tragically, our unwavering belief that altruism must prevail dooms some of our own patients who could be saved.

A death benefit payment for cadaveric solid organs would be neither coercive nor result in loss of altruistic values. Payment would in no way affect the brain dead donor, as no effort to obtain organs is made prior to the time of brain death. Should the family's beliefs be so strongly negative concerning organ removal, a modest sum of $1000 in the form of a death benefit would not be so great a financial temptation to deter strongly held beliefs. On the other hand, should a negative attitude of a potential donor's family be superstition, reaction to "the establishment," or belief that the disadvantaged in society are again being exploited, such a level of remuneration may be enough to help the family toward considering donation favorably.[8,12,17,19,20] A death benefit payment may also foster the belief that society dealt fairly with the family in this matter. Most important, a death benefit payment may increase donation in populations now giving the fewest organs, needing them the most, and being underserved by the present donation system.[8,17,19-22] We should not lose sight of the good of altruism, and we should promote it to an even greater extent. While a death benefit should be offered to all families of potential organ donors, with the understanding that payment would be made after completion of solid-organ recovery, no family would be compelled to accept payment for recovered organs.

Organ Brokerage

There may be concerns that payment for organs would begin or extend a process of organ brokerage or commercialization. On the contrary, reimbursement could be designed so that undesirable practices of payment were essentially eliminated. If there were a standard amount of $1000, paid only through the controlled organ acquisition process as a death benefit to the consenting next-of-kin, those paying large sums (as occurs today in some areas of the world) would be viewed as paying far too much. Were payment to have the desired effect of increasing the number of organs donated, there could ultimately be a surplus of organs such that, at least for kidneys, export to foreign countries might occur. This could reduce the real brokerage for kidneys now condoned in certain transplant centers willing to participate in commercial transactions, actually buying organs from unrelated living donors (Sells,[23] the Council of the Transplantation Society,[24] and *Am Med News*. April 20, 1990:3).

Payment Would Favor the Rich

A death benefit payment to the donor family would in no way favor those who could better afford costly medical care. Any organ obtained, whether or not the donor family accepted the death benefit payment, would go into the organ procurement organization and national organ allocation system in which all recipients are now registered and treated alike. That system is based on matching, time waiting, and medical need. The matching process involves immunologic determinations that are related, at least in part, to race. Renal allograft survival is strongly related to recipient race,[25] and donor-recipient matching within the same race has been associated with better results in some centers[26] since antigen expression differs among different populations. As matters stand now, transplants are least available for certain patients such as

multiparous, transfused, immunologically sensitized black women. Black cadaveric donors, who might match with such recipients, are being lost with the current organ donation process.[8,17,19,21] If a financial incentive to organ donation were productive within this or any minority group, payment to donor families would most likely favor minority populations while not adversely affecting others.

Payment Would Be Illegal

Both state and federal law prohibit buying and selling organs. The National Organ Transplant Act (NOTA) makes it illegal to "acquire, receive, or transfer any human organ for valuable consideration. . . ."[27] Similarly, the Uniform Anatomical Gift Act (UAGA), as revised in 1987 and adopted in some form in 10 states, makes it a felony to "knowingly for valuable consideration purchase or sell" cadaveric organs for transplantation.[28] However, the principal legal, moral, and ethical issue should be preservation of life. The 1987 UAGA permits all persons involved in transplantation (recovery surgeons and their teams, operating room personnel, donor hospital staff involved in donor care, transplant coordinators, transplant surgeons, transplant physicians) to be paid; resource use is also reimbursed. Why, then, would a sum of $1000 per donor (payment for the enabling decision to obtain a lifesaving resource) be considered objectionable only because the money goes to the donor family? The cost per lifesaving and health-restoring organ would be small. Reasonable and legal payment to all who participate in the process of organ donation is now assured except for donor family members, who are the most important participants in the process.

Laws to increase organ supply have been enacted previously with the advice of the transplantation community.[6,27,28] Laws could be amended in such a manner to allow organ procurement organizations to administer and direct a one-time death benefit to the donor family. Such an amendment to both the NOTA and UAGA could pronounce an exemption for such a benefit. This would not permit development of a "market" for organs, or the sale of an organ to an identified recipient since these are currently illegal practices. The amount and source of the benefit would be controlled by law, and bartering for organs would continue to be prohibited. A death benefit would, in my judgment, increase the supply of donor organs that would continue to be distributed under otherwise current laws and allocation policies.

The Payment Process

The death benefit payment to the family would be wholly administered by organ procurement organizations now defined under the NOTA of 1984.[27] Payment would be offered to the individual who legally enables organ donation in any case where solid-organ recovery for transplantation is completed. In general, the enabling individual is defined by law as the spouse, adult son or daughter, parent, brother or sister, or legal guardian (in that order). The organ procurement organization would then be reimbursed exactly as reimbursement for all other costs now occurs. Cost accounting in the organ procurement organization would treat the death benefit payment to the enabling family member no differently than it treats payment to the recovery surgeon, charter aircraft owner, or any other individual involved in the organ procurement and distribution process.

The death benefit, while potentially costing $4 million annually, would not necessarily have a significant impact on the overall cost of organ acquisition. If more organs were obtained through death benefit payment, the increased efficiency and use of nonexpendable resources (fixed costs) would promote an economy of scale diminishing some costs per organ recovered. Few organ procurement organizations are busy enough that they have made the best use of their fixed resources. In addition, it is clearly recognized that successful renal transplantation is far more cost-effective than continued dialysis treatment. Any pilot project to study the fiscal effects of a death benefit payment to families of organ donors should take into account the cost savings resulting from increased renal transplantation vs dialysis therapy.

Other Issues

Other questions remain. Why not extend the same consideration of payment to families of tissue donors? Most tissue donors, while valuable in the care of many patients, do not so identifiably save another human life. This is, in part, due to the processing, storage, and marketing of tissue. Many organizations manage tissue donation and banking that are not centrally controlled, as all organ procurement organizations are. Fiscal reimbursement patterns and regulations are different for organs and tissues. In addition, most cadaveric organ donors give tissue, and payment for organs would most likely have a positive impact on tissue recovery. Payment should not be offered to families of tissue-only donors.

Wouldn't payment lead to "bad organs," as in tainted blood from paid blood donors of the past? No, because cadaveric organ donation has stringent criteria, which would not differ simply because a death benefit is paid. And, cadaveric organ recovery is a one-time event, not a habitual income-producing situation as in the skid-row blood donor.

What about payment for consent, not just recovery of usable organs? In organ recovery, we should not spend money for goodwill or for consent when the decedent is unsuitable to give lifesaving organs. We should be spending dollars to *save lives*. The life is saved by a recovered organ, not a consent to consider organ recovery. Unfair? Perhaps, but the focus must remain on saving lives that are now lost because next-of-kin cannot be fiscally rewarded in a manner that might increase organ recovery.

Conclusions

Payment for organ donation has been judged anathema by some families of organ donors, but the general public may accept such a concept nearly twice as often as would families who have donated a loved one's organs.[14] Probably some degree of sorrow visits families because a loved one was an organ donor, and some negative family reaction to organ donation will happen from time to time no matter what motivates organ donation. I do not believe, however, that a death benefit payment is a "philosophic slippery slope," especially if payment to donor families is studied before its full implementation. Should studies show that some form of death benefit payment expands the organ donor pool, lives will be saved. If pilot studies prove that death benefit payment does not increase organ recovery, massive human tragedy will not result. Reversion to the current system would ensue, or other methods to increase organ donation could be similarly studied. In the case of death benefit payment to the enabling next-of-kin, I believe the risk to society is extremely small and the

potential benefit to those patients who may be saved is considerably greater.

I have argued that we in the organ transplantation field have wrongly adhered to certain moral values of our own, and have coerced others at times of personal tragedy to accept our views. We may have held our philosophic values so dear, in fact, that the very patients whom we place on the waiting list for transplantable organs are dying because we continue to promote only these values. The legal sanctions to organ brokerage must be maintained, and the organ allocation system must be used fairly for all patients in need of a transplant. Payment to families for cadaveric organs might bring into the present system more organs for the underprivileged who are not adequately served now. Our concerns must focus not on some philosophic imperative such as altruism, but on our collective responsibility for maximizing lifesaving organ recovery. Unless proven otherwise by soundly designed pilot programs, I submit that a death benefit payment would save lives that now are lost, lives that should be more important to us all than adherence to concepts and rules that we have promulgated ourselves.

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