The organ transplant process has stood as a life saving practice for over fifty years. However, since the beginning there has been controversy surrounding the process coming from transplant doctors, recipients, and registered donors and their families. Controversial issues include the medically accepted definition of death, the practice of familial consent, and the development of new ways to increase the number of registered donors around the country. All of these issues center around the fact that there are not enough available organs to satisfy the number of people waiting on the transplant list. Addressing and adjusting certain elements of the transplant process will help to settle these issues, and increase the number of organs available for transplant.

Organ transplants became a medical breakthrough in 1954 with the first kidney transplant (Donate Life). From then on, they have shaped the world and saved thousands of lives. Transplants would not be possible without organ donations and the shortage of available organs has led to the increasing pressure on legislation to re-define the standards to which organs may be harvested from deceased donors. According to the Donate Life America Foundation, “approximately 18 people die each day from the lack of available organs for transplant” (Donate Life). This is a huge and unnecessary number of deaths that could be reduced if certain elements of the process were adjusted. While I was visiting my cousin Danny in the hospital after his heart transplant, I witnessed how the shortage of organs around the country has a detrimental impact on people’s lives. I watched as a Rabbi carried out the body of a young boy who died in the room right next
to Danny’s while waiting for a transplant. The number of people waiting on the transplant list is not decreasing anytime soon and several existing components of the transplant process are responsible for the large number of deaths of those waiting to receive a transplant.

One immediate way to increase the number of available organs for transplant is to ban the practice of familial consent. Familial consent is the process by which a doctor seeks a family’s decision on whether or not they can harvest a person’s organs after they have passed away. In recent years, this practice has come under fire because it can undermine the wishes of registered donors if a family decides not to donate their decedent’s organs, therefore taking away a valuable organ for someone in need. The most shocking part about this issue is that “the refusal rate among families of potential donors nationwide is around 50 percent” (Cook, 118). This means that only half of the available organ donors will have their wishes fulfilled if doctors continue to seek familial consent because half of the families veto the decedents wishes. When my Pop-Pop died in February of 2002, the doctors asked our family for permission to donate his organs. Without hesitation, we said yes because we knew Pop was a registered organ donor and we knew there might be a chance this would potentially save someone’s life. In fact, doctors later told us that with my Pop’s corneas, eight people were given the gift of sight. I cannot imagine a family refusing to donate their loved ones organs, especially when it has been documented that the decedent was a registered donor. That is an injustice in our society and continues to add to the annual death rate of awaiting transplant recipients. According to the Donate Life America Foundation, a single donor can supply up to eight organs. Based on the number of registered donors in the United States, the number of
potential organs “could be adequate to meet or even surpass the demand [for transplants]” (Cook, 118). However, this can only be achieved if there is nothing standing in the way. Therefore, the removal of familial consent from medical practices is necessary in order to increase the number of available organs for transplant.

The reason familial consent exits today is the fear by hospitals that families will sue if they are not consulted prior to removing their loved one’s organs. This argument made by hospitals is false. In fact, it directly defies the amendment made to the Uniform Anatomical Gift Act (UAGA) of 2006. Originally promulgated in 1968, the recent amendment to this act includes the concept of “first person consent,” in which no other person can alter the individual’s decision to donate his or her organs after death. This means that the practice of familial consent is not required in order to remove organs from a registered donor who has passed away. Furthermore the UAGA includes an immunity clause that protects doctors from being sued if they were “acting in good faith.” The Organ Procurement Organization states that “a hospital, physician, surgeon, or other person who acts in accordance with this [Act] . . . or attempts in good faith to do so is not liable for that act in a civil action or criminal proceeding” (Bucklin, 334). In other words, a doctor may procure organs from the deceased if they are doing so to save lives, without the approval of the decedent’s family, and they will not have to worry about being sued. In reality, any hospital that practices familial consent for the threat of being sued is in direct violation of the statute made by the Uniform Anatomical Gift Act. Therefore familial consent is simply an illegal impediment in the transplant process.

In order to increase the number of available transplants, hospitals should replace the practice of familial consent with the practice of presumed consent. This is the idea that “a
deceased individual is classified as a potential donor in absence of explicit opposition to
donation before death” (Abadie and Gay, 600). Basically, everyone would automatically
be recognized as a donor, unless they specifically refuse to on a legal document. This
idea was first introduced to the United States in 1968 in an article in the New England
Journal of Medicine, but was not given any substantial recognition (Cohen, 2168). Since
then, it has been steadily gaining recognition because of the shortage of organs for
transplant. Adopting a policy of presumed consent would make it so that “no permission
for the donation of organs need be sought from any party” (Cohen, 2168). According to
Professor Carl Cohen of the Medical School at the University of Michigan, “A system of
presumed consent would very probably increase the supply of needed organs vastly, and
overall, human well-being will be substantially improved” (Cohen, 2168). This
conclusion made by Cohen is based on other countries around the world that practice
presumed consent. In fact, a study published in the Journal of Health and Economics in
2005 was conducted to find out just how great of an impact presumed consent had on
donation rates. It was discovered that “donation rates are 25–30% higher on average in
presumed consent countries, such as France and Spain” (Abadie and Gay, 613). This
statistic shows that the adoption of presumed consent in the United States would lead to
an increase in available organs, therefore saving more lives.

Another controversial issue regarding the transplant process is the definition of
death. In today’s society the question at debate is when it is acceptable for doctors to
begin procuring organs of patients that are registered donors. There have been recent
medical cases where doctors have been pushing the limits of the accepted definition of
death in order to save more lives, but have been recognized as killers rather than saviors.
The solution to this problem would be the re-defining of death to meet the changing medical times, which would ultimately result in an increase of the number of organs available for transplant.

Across the United States, the dead donor rule has stood as the requirement when dealing with organ transplants. This rule states that a patient must be dead before a doctor can remove any viable organs for transplants (O’Keefe, 290-291). In 1968, the ad hoc committee at Harvard Medical School suggested that the dead donor rule be expanded to include any person who suffers irreversible brain damage (Veatch, 323-324). The committee believed this would greatly increase the number of available donors for organ transplants. Over the last four decades, this measure has become a widely accepted definition of death, and has led to thousands of organ transplants (Troug and Miller, 674). However, in recent years, doctors have been causing controversy by stretching this definition to include what is known as cardiac death. Cardiac death is when a person suffers “irreversible cessation of respiratory and circulatory function” (Steinbrook, 209), meaning that a person’s organs are unable to function on their own after the removal of life support. The controversy associated with this new definition is the fact that there is no legally defined time limit that a doctor must wait before procuring organs from a patient taken off life support. This issue made headlines in 2007 when a transplant team at a Denver hospital decided to set their own time limit.

In Colorado, in May of 2007, a newborn suffered severe neurological damage during birth. The baby’s condition did not meet the requirement of the brain dead definition, so doctors consulted the family and proposed taking the baby off life support, which would qualify as cardiac death (O’Reily). The family agreed and the baby’s heart
was procured and donated to an infant in need of a transplant. Because there is no clearly defined time period that doctors must wait before procuring organs, the doctors made their own decision to wait seventy-five seconds after the baby was taken off life support to declare the baby dead and begin the procurement of the heart (O’Reily). This created a lot of controversy because critics claimed seventy-five seconds was an insufficient amount of time to wait, possibly believing that there could have been a chance the baby’s organs would have continued to function. However, the reality of the matter was that the baby’s organs would have only sustained life for a few more minutes, which would not keep the baby alive for much longer.

This brings us to the key question: Who will determine when patients’ organs can be procured and who gets to decide whether patients are really dead or not? The American Medical Association (AMA) states that the current definitions of death are “acceptable as long as conflict-of-interest and palliative care protocols are followed” (O’Reily). In reality, the definitions of death are not acceptable because they fail to give a specific time requirement, which results in a lack of faith amongst patients and their families who may believe that doctors are hastily declaring people dead to keep up with the increasing demand for organs. Furthermore, Bioethicists across the country have stated that these questions about time limits and definitions of death, both exemplified in the Denver case, are the “latest [concerns] in the organ transplantation era to stretch the definition of death in ways that undermine Americans trust in physicians and in the organ donation process” (O’Reily). This is saying that people across the country will be skeptical of the transplant process, which may alter their decisions to become organ donors, based on the inconsistency and questionable practices that take place. However,
by firmly and legally establishing a time requirement, the number of organs available for transplants will increase, and there is a good possibility that more people will be willing donors if they know their life will be respected and appreciated if they are near death.

The increasing organ shortage throughout the country has also led scholars to develop new ways to motivate people to become organ donors. One of these propositions has the potential to have a major impact on today’s society. A reciprocity proposal is a plan in which people who register to be organ donors will be rewarded. In our society, whether it is jobs, clothing, or lifestyle, people always want to have an edge over their competition. A reciprocity plan would allow those who register as donors to have an edge over those who are not. It would do so by “significantly increasing an individuals’ chances of receiving an organ should they later need one” (Nadel 312-313). Basically, the simple task of checking the box on the back of your driver’s license can become a lifesaver should you ever be in need of an organ.

In their commentary “Using Reciprocity to motivate Organs,” Mark and Carolina Nadel have outlined a system for the reciprocity proposal that focuses on a system of points and credit for the amount of time a person is a donor. The longer you are a registered donor, the higher your name moves up on a list, so if you ever need a transplant your odds of receiving one will greatly increase (Nadel, 314). Marl and Carolina Nadel also explain that the incentive to become a donor has a great chance of being successful if it is publicized in a specific way. Instead of telling people why becoming a donor is beneficial, the media should advertise the effects of NOT becoming a donor under this new policy. Studies have shown that “individuals are much more likely to act to avoid a bad outcome than to obtain a comparable good result” (Nadel,
For example, the Department of Motor Vehicles could have posters and pamphlets where people apply for their driver’s license that might say “failure to agree to donate could permit those who have committed to donate to move ahead of you on the organ wait list if you later need an organ” (Nadel, 318). By identifying that not being a donor could possibly result in death, people should jump at the chance to register and feel that their lives are safe. This policy and the way it is publicized would dramatically increase the number of donors and thereby decrease the number of deaths per year from those on the waiting list.

Last year, 14,631 organ donors gave the “gift of life” resulting in 28,465 organ transplants across the United States (Donate Life). Though an amazing accomplishment, there are still over 100,000 men and women who need transplants annually. The current system our nation follows for organ transplants is to blame for the thousands of people who die waiting on the transplant list. Hospitals can increase the number of transplantable organs they procure yearly by banning the practice of familial consent coupled with the adoption of presumed consent. Medical associations can further increase the number of available organs by firmly establishing a time requirement to the definition of death. Additional steps in enlarging the number of registered donors are also necessary to decrease the number of death, which can be done with the adoption of the reciprocity proposal. These improvements can undoubtedly increase the number of transplants yearly and become lifesavers.


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http://www.donatelife.net/UnderstandingDonation/Statistics.php