Organ Transplants Return to Center Of Ethical Debate

By James F. Childress

Organ transplantation was central in the development of biomedical ethics in the late 1960s and early 1970s. Consider for example Paul Ramsey’s classic “Patient as Person” (1970), much of which was devoted directly or indirectly to questions raised by organ transplantation. However, organ transplantation dropped out of the limelight in the mid-1970s, as a quick glance at the major anthologies in the field will indicate. In the 1980s, however, ethical questions about policies of organ procurement and distribution have again become central, in part because of the development of the immunosuppressant medication cyclosporine.

“Express donation” has been selected by state legislatures and the federal government as the dominant mode of transfer of solid organs such as hearts, livers, and kidneys. Nevertheless, policies are still ambivalent about whether the primary donor should be the living individual or the family after the individual’s death. Decedents’ documents of gift have been relatively insignificant; few donors cards are signed or located when the transfer of organs must be made, and in practice procurement teams have respected familial wishes.

There are reasons to believe that individuals will remain reluctant to sign donor cards for fear of being vulnerable to being declared dead prematurely or having their deaths hastened (see 1985 Gallup poll). In this context, educational policies should be reconceived to overcome attitudes of distrust and should be aimed at individuals as decisionmakers for family members rather than as signers of donor cards. The failure to sign a document of gift may only reflect a decision to leave the donation up to the family. Experiments in required request, as mandated by most states and by the federal government for institutions receiving Medicare and Medicaid funds, need more time before it can be judged whether they are effective.

According to the Federal Task Force on Organ Transplantation, donated organs belong to the national community, not to organ procurement and transplantation teams, and therefore the public should play a major role in determining the criteria for distribution and allocation of donated organs. In implementing this conception, the United Network for Organ Sharing (UNOS) faces several ongoing questions. One question concerns the extent and modes of public participation. A second question is how such factors as medical need, probability of success, and time on the waiting list should be made operational.

A point system has been adopted, but it is important to continue to assess the weights assigned to various factors in view of updated data to make sure that the weights represent medical utility (maximization of welfare among patients suffering from end-stage organ failure) and justice. An important aspect of patient selection is determining when the local community is obligated to share organs with other units in the national system; for example, currently kidneys must be shared if there is a patient with a six-antigen match or a phenotypically identical recipient.

A major unresolved issue is multiple listings. In 1987-'88, the UNOS board of directors shifted several times on this issue, in part because of the tension between liberty and equal access. The main argument for permitting patients to be on more than one waiting list stresses freedom of choice, while the main argument against multiple listings centers on the unfair advantage gained by patients able to enter several lists.

Regarding the availability of organs for nonresident aliens—the most controversial topic faced by the federal task force—UNOS relies mainly on a few standards and on procedures of accountability. Centers transplanting donated cadaveric organs into nonresident aliens must charge the same fees and treat equally all patients on the waiting list. At the local level there should be a mechanism for community participation and review. UNOS reserves the right to audit all activities involving nonresident aliens and will automatically review any center more that 10 per cent of whose transplant recipients are foreign nationals.

Two final areas of concern about equitable access probably cannot be addressed by UNOS and will require attention by other institutions. First, current UNOS policies to ensure patients equitable access to organ transplants apply only to patients already on the waiting lists; the do not address equitable access to the waiting lists themselves. There is evidence that women, minorities, and low-income patients do not receive transplants at the same rate as white men with high incomes. More research is needed to determine why this is so and to shape a response.

A related concern is the so-called green screen for patient admission to waiting lists. The End Stage Renal Disease Program of Medicare ensures virtual universal coverage for (continued on page 2)
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kidney transplantation, as well as for dialysis, but ability to pay remains important in liver transplants (average $130,000) and heart transplants (average $95,000), where coverage by government programs and by insurance companies is spotty. On the one hand, the argument for societal coverage may stress the continuity between the extrarenal transplants and procedures already covered in terms of efficacy and cost. On the other hand, it may stress the uniqueness of organ transplantation.

This latter argument, offered by the task force, focuses on the social practice of organ procurement and its moral connection to distribution. The society attempts to increase the supply of donated organs by asking its members, whether rich or poor, to donate organs. But it is unfair and even exploitative to ask all people to donate organs if access to donated organs is will be determined largely by ability to pay rather than by medical need, probability of success, etc. A consequentialist version of this principled argument focuses on the possible negative impact of unequal access on organ donation. For example, after Oregon decided not to provide Medicaid funds for most organ transplants, it was reported that some low-income people organized a boycott of organ donations. At the very least, trust in the system of distribution, as well as the system of procurement, is a precondition for individual or familial donation of organs. (Professor Chil­dress was vice chairman of the Federal Task Force on Organ Transplantation and is a public member of the UNOS board.)

Books

Recent Acquisitions

(New additions to the collection of the National Reference Center for Bioethics Literature.)


Corless, Inge B. and Pittman-Lindeman, Mary, eds. AIDS: PRINCIPLES, PRACTICES, AND POLITICS. New York: Hemisphere, 1988. 252 p. Nineteen essays covering AIDS experimentation, types of treatment, and federal regulation, and public policy relating to it. The disease's effects on various populations such as women, children, drug users, etc., and its social impacts are primarily discussed.

Downie, R.S. and Calman, K.C. HEALTHY RESPECT: ETHICS IN HEALTH CARE. Boston: Faber and Faber, 1987. 266 p. Ethical problems such as personhood, responsibility, experimental research, and euthanasia are explored along with philosophical foundations of morals.

Hiskes, Anne L. and Hiskes, Richard P. SCIENCE, TECHNOLOGY, AND POLICY DECISIONS. Boulder, CO: Westview Press, 1986. 198 p. Society's influence on policymaking since the early 1900s is considered. Issues in nuclear power, hazardous waste disposal, recombinant DNA experiments, and biomedical technology are used as examples.


Northrop, Cynthia E. and Kelly, Mary E. LEGAL ISSUES IN NURSING. St. Louis: C.V. Mosby, 1987. 598 p. Two nurse lawyers describe the legal and ethical aspects of different nursing situations ranging from hospitals, factories and public schools to private businesses and unions.

U.S. Congress. Office of Technology Assessment. INFERTILITY: MEDICAL AND SOCIAL CHOICES. Washington, DC: U.S. G.P.O., 1988. 402 p. Ethical, economic, and legal issues of various reproductive technologies such as in vitro fertilization, surrogate motherhood, and gamete intrafallopian transfer are discussed in response to requests from Senate and House committees.


Marlene Johnson
Arms Control Not Under Fire In ’88 Election

By Bryan Hehir

This essay is written in the midst of a presidential campaign with a passion for peripheral issues. The failure of the candidates to join the debate on the substantive foreign and domestic concerns facing the United States in the 1990s is widely lamented, but not easily remedied. In the face of this pessimistic assessment of the early stages of the campaign, it is helpful to note how one issue is not being debated. Arms control is not under attack by either candidate on political, technical or moral grounds. This fact stands in striking contrast to the presidential campaign that opened the 1980s.

In 1980, the superpower arms control process had stalled; President Carter had taken the SALT II Treaty off the table in the face of Congressional opposition and the Soviet invasion of Afghanistan. Mr. Carter’s decision was undoubtedly influenced by the fact that his challenger, Mr. Reagan, was vigorously attacking the treaty as fatally flawed and indicting the approach to arms control that produced SALT I (1972) and SALT II. In brief, arms control was debated in the 1980 campaign to the detriment of the issue.

True to his campaign promises, President Reagan decisively subordinated arms control to the goal of substantially expanding defense spending in his first term. The one exception to this pattern was accidental: The Reagan Administration tabled a “zero option” in the intermediate-range nuclear force negotiations, apparently convinced that the Soviet Union would never agree to it. In time, this proposal became the basis for the INF treaty signed at the Washington summit of December, 1987.

The second Reagan term and the emergence of Mikhail Gorbachev as the Soviet leader have yielded significant changes in the pace and status of nuclear arms control. The summits of 1985 (Vienna), 1986 (Reykjavik) and 1987 (Washington) produced movement on two arms control fronts.

First, the INF treaty eliminated medium and short-range nuclear launchers in the European theater, leaving only battlefield nuclear weapons in Germany. Second, the continuing U.S.-Soviet negotiations on strategic nuclear weapons have shaped a consensus in principle on the value of “deep cuts” in the strategic arsenals. The formula being used—each side would maintain 1,600 launchers and 6,000 nuclear warheads—would not be a “50 per cent cut” as it is often described, but it would constitute substantial reductions. Equally significant for the U.S. political process is the fact that the “deep-cuts” proposal is endorsed broadly across the political spectrum. This agreement has reduced the salience of the arms control issue in the campaign, even though significant differences exist between the candidates on SDI and the future configuration of U.S. strategic forces. Both candidates support the INF treaty and the idea of deep cuts.

If a strategic agreement can be reached in 1989, the next step in arms control will shift to conventional forces. Indeed, if there is a possible obstacle ahead in the U.S. debate about arms control, it is the idea that a deep cut in strategic forces should be postponed until a prior agreement can be reached between NATO and the Warsaw Pact on conventional arms control. Since there is little likelihood of early progress on controlling conventional arms, such a position would mortgage the future on a strategic agreement, which is in reach and should be completed on its own merits.

The question of timing and priority of agreements is important, but essentially tactical. From a broader perspective, it is useful to assess the probable direction of the arms control agenda of the 1990s. Three characteristics are worth noting. First, the focus of arms control will be more clearly political. While there is no escape from strategic doctrine and technical arguments about verification, the future debate will be more political in two senses. On the one hand, the political relationship of the superpowers is under review in both East and West. While no one expects a quick or easy transformation of the U.S.-Soviet competition, there are rhetorical calls to “end the Cold War” accompanied by substantial proposals to recast superpower conduct in ways that could open new roads for arms control. On the other hand, the emergence of conventional arms control from the obscurity of the last 15 years will bring the politics of the Atlantic alliance to the forefront of the arms control agenda.

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The second characteristic will be the complexity of addressing conventional arms control. Both the negotiations on this topic and the analytical literature about it lag far behind the comparable categories for nuclear arms control. The development of an intellectual and political consensus in the West on how to define Western security interests and correlate them with an arms control position is the precondition for successful negotiations. Much remains to be done on this front.

Third, one characteristic of the nuclear debate of the 1980s in the United States has been a significant increase in the attention paid to the ethical issues. There is no sign of abatement of this discussion, but its scope and sophistication stand in striking contrast to the ethical assessment of conventional arms control issues. The normative literature on the relationship between conventional and nuclear questions is less developed than its empirical counterpart.

Roundup

- The Kennedy Institute’s 15th annual Intensive Bioethics Course will be held from Sunday evening, June 18, 1989, through Saturday noon, June 24. The course, which is directed principally toward physicians, nurses, and policy-makers in the health-care field, concentrates on ethical theory and the application of ethical principles to problems in health care and biomedical research. Course participants will have full access to the National Reference Center for Bioethics Literature, which contains the most complete collection of bioethical materials in the world. Full cost with housing and meals ranges from $1,639 to $1,909 depending on choice of accommodations. The inclusive fee for nonresident participants, which includes tuition and six lunches, is $1,261. Physicians attending all sessions of the course will receive 26 hours of continuing medical education category 1 credit. Nurses receive 2.6 continuing education units. Application should be sent to Dr. LeRoy Walters, Kennedy Institute of Ethics, Georgetown University, Washington, D.C., 20057. Please include a curriculum vitae or resume.
- Daniel Callahan, director of the Hastings Center, will speak on May 12 at the Kennedy Institute’s annual Members’ Symposium.
- Dr. Edmund D. Pellegrino, director of the Kennedy Institute, spent September at the Rockefeller Foundation’s Bellagio Study and Conference Center as a resident scholar. He began work on two books, one a biography of Thomas Percival, and the other a moral philosophy of medicine. Dr. Pellegrino was also made an Honorary Fellow of the American College of Legal Medicine.
- The National Science Foundation is inviting proposals for research and related activities examining ethical or value aspects of current research in science and engineering. Preliminary proposals are due Nov. 1 and May 1. Formal proposals are due Feb. 1 and Aug. 1. For additional information call Dr. Rachelle Hollander at the foundation, (202) 357-9894.

Bioethics Position

The Kennedy Institute of Ethics at Georgetown University announces a tenure-track faculty position at the assistant or associate professor level. The position will involve teaching responsibilities in ethics and bioethics in a joint graduate program of the institute and the philosophy department at Georgetown. Candidates must be able to teach in a Ph.D. graduate program in philosophy. Women and minority group candidates are especially encouraged to apply. Please send CV and letters of reference to: Prof. Tom L. Beauchamp, Chair, Search Committee, Kennedy Institute of Ethics, Georgetown University, Washington, D.C. 20057. Georgetown University is an equal opportunity, affirmative action employer.