

Who's First in Line? American Organs for Non- American Recipients

by Jane Warmbrodt

Organ transplantation in this country seems to have become a topic guaranteed to evoke strong feelings and, lately, strong ethical concerns.

Since the 1950's, transplantation has evolved with lightning speed. Technological advances in the last three years have doubled, and in some cases even tripled the number of transplant procedures performed. The success of those transplants has led to increasingly longer waiting lists. However, while the transplant side is growing, the donor side is not. This paradox has led to a very real and perplexing shortage of donated organs for transplantation.

Every year, thousands of life-saving organs are buried with their potential donors. Despite public and professional education efforts, despite innovative approaches such as the popular "routine inquiry" laws, the organ donor shortage continues. It is an exasperating fact of life and one that may never be resolved. For that reason, the organs that are donated must be viewed as a precious and very limited resource.

The transplant community has attempted to address this dilemma in a variety of ways, starting with the selection of recipient and with the organ sharing process.

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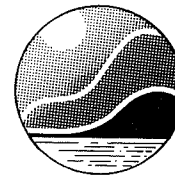
For over a decade, kidneys were placed according to blood and tissue compatibility. The United Network for Organ Sharing, located in Virginia, housed the computer that listed the name, blood and tissue type of every potential kidney recipient in the United States. At the time of organ donation, the computer was accessed,

and its files were searched for the best matched recipient. As a result, kidneys were often exported from the donor city to another city where a better matched recipient resided. Ostensibly, the exporting city had an equal chance of receiving another kidney imported from another center. Since almost all centers used tissue-typing as their criteria for transplantation, this system of importing and exporting organs was somewhat equitable.

However, in 1983 the introduction of a powerful immunosuppressive drug, cyclosporine, changed the whole system. Many transplant centers felt that the use of cyclosporine figured more importantly in the success of a transplant than did matching tissue types. Today many, if not most, centers do not use tissue matching as the most important criterion for recipient selection, and the system of organ sharing has virtually disappeared; for the most part, organs donated in a city stay there and are transplanted there. Thus the wait for a kidney transplant for many dialysis patients has become even longer. While a kidney patient can be maintained on dialysis while waiting for a transplant, the longer the patient remains on dialysis, the greater the chance for further medical complications, which makes it even more difficult to find a donor kidney for which the patient is compatible.

The recipient selection process for liver and heart transplants is based on medical urgency of need and blood-type compatibility. Of the hundreds of patients waiting for a liver or heart, dozens share a common blood type and medical status, and these patients do not have the "luxury" of dialysis as a back-up while they wait. Without a transplant, they will die. Liver and heart patients' lives depend absolutely on the manner in which these scarce donor organs are distributed. Unfortunately, hundreds of these people die every year while waiting for a transplant.

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Midwest Medical Ethics

Editor: Karen Ritchie, M.D., M.A.

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Midwest Medical Ethics is a quarterly publication of the Midwest Bioethics Center.

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Midwest Medical Ethics Winter 1987

This situation can partly be explained by the severe organ donor shortage. What cannot be explained, however, are the disturbing reports that Americans waiting for a kidney, heart, or liver transplant have been by-passed on the lists and that non-immigrant aliens have been transplanted in their place. When these reports first surfaced in 1985, most members of the transplant community dismissed them as preposterous. However, as time went by and the evidence became concrete, no one could continue to deny the problem.

The evidence indicated that non-immigrant aliens, most of whom were very wealthy or who were nobility, were paying transplant centers "cash up front" to be given priority for receiving a transplant. These people were undeniably dying from some type of organ failure; however, their own country prohibited organ donation and/or the technology did not exist to provide the transplant. So they came to America and received transplants. The surgeons who accepted these patients in the spirit of brotherhood can be criticized less than can those who actually solicited such patients for the obvious financial gain. Many medical professionals and members of the public, however, found the practice morally indefensible because Americans were being passed over for these non-immigrant aliens.

These transplantations seem to have slowed down. The federal government has outlawed the "buying and selling" of organs as a response to public outrage. The transplant centers where the transplants were occurring have tightened controls in an attempt to

stop the inflow of non-immigrant aliens. But it has not completely stopped, and that raises some very difficult questions.

There are those who say that any dying patient, despite nationality, should be treated equally and that this country's medical community has a moral and ethical responsibility to do so. It is argued that we cannot draw borders when life and death hang in the balance. While this is a position of great humanitarianism, others feel that it cannot be defended for several reasons.

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The most important components of the transplant process are the organ donors and their families, who have looked beyond their immediate grief and offered life to others. These donors and their families are American citizens, and the entire organ procurement and transplant network in this country is funded by American citizens. Over \$100 million of public money is spent every year to support the system.

It can be argued that, because American citizens are totally responsible for the transplant system, an American citizen should never be

denied a transplant in favor of a non-immigrant alien whose own country has not provided him or her with the same resources. In the best of all possible worlds, we would have enough organs donated to transplant all the patients who needed them, regardless of nationality. However, the reality is that organs are scarce and that is not expected to change. On the other hand, it is difficult to turn our backs on dying people, no matter how we justify it.

Perhaps the most equitable solution would be for America to share its wealth of medical knowledge and transplant technology with other countries. We could send members of our medical community abroad to develop and implement transplantation programs in those countries who are sending people to the U.S. Rather than allowing non-immigrant aliens to deplete America's scarce supply, we could teach their countries how to obtain and transplant organs.

Certainly this would require a financial commitment on the part of the U.S., but the long-term benefits should outweigh the costs. Expending these dollars can be justified. Expending our scarce organs at the cost of the life of a United States citizen cannot be.

This is a difficult issue to resolve and one that bears a great deal of careful consideration by medical professionals, ethicists, and by the source from which all organs come — the public.

Jane Warmbrodt is director of education for the Midwest Organ Bank, Kansas City, Missouri.

Toll-Free Information Service

The National Reference Center for Bioethics Literature has added a new feature to its service. For some time, the Reference Center, in conjunction with the Kennedy Institute of Ethics at Georgetown, has provided free searches of their online database called BIOETHICSLINE. Recently, the National Library of Medicine at the National Institute of Health has provided funding for toll-free telephone access to the Reference

Center. Use of this toll-free number (800-MED-ETHX, 800-633-3849) now makes it possible for individuals to use this service without even the expense of a long distance call.

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