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<td>The Morality of Organ Donation in the Modern World</td>
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Roughly 100,000 individuals in the United States are in desperate need of a new organ, and this number is steadily rising (Donatelifeline.net, Understanding Donation). Physicians are able to thoroughly diagnose more diseases today than any other time in history. In a time when the population is becoming increasingly older, this development should not be surprising. Life expectancies are higher than ever, the consequence being that people are living long enough to contract multiple diseases. The answer to this quandary is obvious; the healthy members of society are being looked upon do donate their own organs to save the lives of others. This sounds like a noble undertaking, but many people are unwilling to give consent. Although there are many hesitations surrounding organ donation, when viewed as a freely given gift, the process is beneficial and valuable for both the donor and recipient.

When a person experiences end stage organ failure, many times their only option is to face organ transplant or death. Organ transplants can come from either a cadaver or a living donor. When a possible cadaver donor is found, brain death must first be declared. Brain death is the state in which all neurological functioning has ceased, and circulation and respiration are continued by mechanical intervention. The only difference from cardiopulmonary death is that the body is able to be kept in a quasi-living state by mechanical means. In reality, brain death should be referred to as simply death. If and when the body is removed from the machines, it will no longer be able to function, and cardiopulmonary death will
occur. If the physician believes the brain dead individual is suitable for organ donation, they are required to contact the Organ Procurement Organization.

The Organ Procurement Organization, OPO, has branches in all states and oversees all cadaveric organ transplants. First and foremost upon arriving, the OPO representative must receive consent from the living relatives, even if the deceased has indicated on his driver's license that he or she is an organ donor. Technically, organ donor cards do function legally as advance directives, but out of respect for the family the OPO will ask permission. When consent is received, the representative will perform tests to find a matching recipient. Blood type is the first parameter that must be compatible between donor and recipient. If the donor is type O blood, they may donate to anyone. If the donor is type AB positive, they may only donate to a recipient that also has type AB blood. The second important test to be done is tissue typing. This test determines the Human Leukocyte Antigens (HLA) present on the white blood cells. There are over 100 known HLA antigens; to be a successful kidney donor, one has to have six of the same antigens (Schall and Baker, 2). Any less, and there is serious risk of rejection. The OPO representative must also determine if the deceased is in proper health to donate, and will not transmit diseases such as HIV or hepatitis to the recipient.

The OPO sets strict guidelines for donor testing to ascertain the health and safety of transplantation. The donor must be thoroughly tested for HIV or other blood borne diseases, and many other diseases, medical history, and organ viability.
There are organ specific tests done for each that may be donated, described by the OPO. For a kidney donation, the creatinine levels are checked; for liver donation Alanine Aminotransferase (ALT), Aspartate Aminotransferase (AST), Alkaline Phosphate, and total bilirubin levels are checked; for lung donation a sputum sample is gram stained to rule out any infectious bacteria; and for heart donations a twelve lead EKG is performed, confirming the full functional ability of the heart. This process occurs in both living and deceased donors (OPTN Policies, 2.0).

During the course of the testing, the donor is being maintained by respirator machines to ensure that the organs to be collected remain viable. A consistent blood pressure must be kept throughout this time, to continue perfusion of the organs. When organs are confirmed as usable and a match has been secured, the donor is rushed to the operating room. Time is of the essence, because the deceased is now removed from machines and allowed to undergo cardiopulmonary death. Therefore, the organs are no longer being perfused and are now at an increased risk of necropathy. The organ harvest is done in a sterile operating room, just as any other surgery would be performed, with complete respect for the body. Once the organs have been removed they are placed on ice and rushed to the recipient, who will receive them immediately.

A living donor must go through all of the same testing as the deceased donor to verify proper function of the organs. A living donor obviously does not have to be maintained as does a brain dead donor, making the process much more streamlined.
The surgical removal, while done as quickly as possible, does not have the same sense of urgency, because there is no risk of necropathy until the organ has been completely removed from the body. The only real difference is that commonly living donors have chosen a recipient, usually a family member. When an organ is donated to a family member, the chances of HLA types matching are significantly higher (Schall and Baker, 4). The chance of rejection is lowered significantly when a close relative, such as a sibling, is the donor. It is also very difficult in this country to donate to an unknown recipient. The donor is screened extensively to make sure there are no ulterior motives, such as monetary reward. Most individuals would not think of donating an organ unless their family member needed one, in which case most people would jump at the opportunity (Levinsky, 2000).

According to the National Institutes of Health, the most common type of organ transplant is a renal transplant. This is especially common in living donors, because it is quite possible to survive and even thrive with just one kidney. For the surgical procedure, the donor is put under general anesthesia, and the nephrectomy is usually performed laparoscopically. Laparoscopic kidney removal is achieved by only three or four small incisions in the abdomen and side. Most people feel less pain and recover more quickly when the surgery is done this way. The kidney can be maintained for up to 48 hours, but usually this is not necessary as the donor and recipient tend to know each other and are in the same hospital. The recipient is put under general anesthesia as well, and the kidney is placed in the pelvic area,
commonly the iliac fossa. The arteries and veins are connected from the pelvis to the new kidney, and the ureter of the kidney is attached to the bladder. The surgery usually takes about three hours, and the patient keeps both of their original kidneys, unless they are causing infection (Liou, National Library of Medicine).

The other transplant possible by a living donor is a liver transplant. The liver is regenerative, so segments are able to be removed from the donor without much consequence. The small piece of liver placed in the recipient will then grow into a larger, more fully functioning liver. There are three types of liver transplant available as explained by the website Healthcare.net. The only one available for a living donor is a reduced size liver transplant. In a reduced size liver transplant, at least two pieces of the liver, each supplied by different vessels, are transplanted into the recipient. Provided that it is healthy, patients have survived with only 20% of their liver, due to the regenerative nature of the organ. If a liver becomes available as a cadaveric organ, there are two options, orthotopic and heterotopic transplants. In an orthotopic transplant, the entire liver is removed and replaced with a healthy donor liver. A heterotopic transplant is often used when there is a chance the original organ may recover. The donor liver is placed in the upper right quadrant, and if the native organ recovers or regenerates, the new organ is allowed to atrophy. If the original liver does not recover, it will eventually atrophy (Digestive Disorders, Healthcare.net).
While the recipients have a longer life expectancy and a greater quality of life with their new organs, they cannot simply live normally. Transplant recipients need to take medications for all or most of their lives. The most important medications are immunosuppressants, used to prevent the patient from rejecting the organ. Since the new organ is technically not part of the recipient’s body, the body recognizes it as an invader, a foreign body to be attacked, the same way the body treats a bacteria or virus. The anti-rejection medicines suppress the immune system so that the white blood cells become less effective and do not destroy the new organ. Unfortunately, this also makes the recipient more vulnerable to outside infections (National Library of Medicine).

There are many different immunosuppressant drugs used in transplant patients, the most common being Cyclosporine A, Azathioprine, and Myocphenolate Mofetil. The American Society of Health Systems Pharmacists describes Cyclosporine A. It can be given to patients who have received a kidney, liver, or heart. It works by reducing the ability of accessory cells to produce interleukins, therefore lowering the number of T cells in the body. Cyclosporine has many adverse effects from drug interactions, so it is very important for the patient to be not only careful, but have full disclosure with their doctor. An interesting note about Cyclosporine A is that patients taking it should not eat grapefruit or grapefruit juice. The grapefruit causes a sudden increase in the concentration of Cyclosporine A in the body, most likely due to interactions with the cytochrome
P450 enzyme. Cyclosporine A is the most specific anti-rejection drug and is marketed under the brand name Sandimmune. This drug is was the first immunosuppressive drug discovered, and is credited with taking organ transplantation from an experimental treatment to an accepted surgical procedure (American Society of Health Systems Pharmacists, National Library of Medicine).

Azathioprine needs to be accompanied by other medications, but it does not have as many side effects. It is a prodrug, converted in the body to its active form, mercaptopurine. It has a generalized effect on bone marrow, lowering the amount of blood cells produced. Therefore, patients who need to take blood thinners should not take Azathioprine (Gbemedu, 2009). It is also used to control severe cases of rheumatoid arthritis. Mycophenolate can be used in patients who have has liver, kidney or heart transplants. It should not be taken by pregnant women, and can also decrease the effectiveness of oral contraception. Mycophenolate suppresses the production of all white blood cells (National Library of Medicine). It is important that all patients taking immunosuppressant drugs be very cautious of infection, staying away from anyone who may be contagious and keeping up with good hygiene. Transplant recipients may also be required to take steroids, antiviral medications, statins, and other drugs to maintain their health.

While the medical facts and procedures seem straightforward, there is no doubt that there are many questions about organ donation. There are many individuals who believe that organ donation is simply unacceptable. While it is
often impossible to change one’s inherent belief system, it is beneficial to address some common misconceptions and arguments against organ donation.

The United Network for Organ Sharing (UNOS) published a reference guide for clergy that outlines various religious views regarding organ donation. There is only one official religion, Shinto, that rejects the notion of organ donation. The Shinto religion believes that the dead body is impure and dangerous, and therefore do not allow cadaveric donations. All other religions either support or do not have official positions on organ donations. Religions without an official position teach that organ donation is an individual decision, and that the individual will be supported in full. Many religions agree with the Catholic Church’s position; that organ donation is a heroic, genuine act of love. Even Jehovah’s Witnesses, who are against blood transfusions, do not oppose organ donation as long as all blood has been removed from the organ before it is placed in the recipient (UNOS, 2000).

While the official standpoint of the Buddhist religion is that organ donation is an individual choice, there is a movement within Buddhism, especially in Korea, that encourages organ donation. Buddhists believe there is nothing intrinsically divine about the body, so it can be used for organ donation without fear of retribution after death. To save another life by donating an organ is considered Buddhist benevolence. A basic principle of Confucianism is duty to parents, which implies that a person should keep his or her body in the way it was received from the parents (Kim et al., 2004). There is also a sense in the Confucian community
that without organs, an individual may be humiliated in the afterlife. This is not the official position of the religion on organ donation, but could contribute to the lack of Asian and Asian-American donors. Also, in traditional Asian beliefs, a person should die at home, rather than bring bad omens upon his family. This belief could also be a contributing factor (Kim et al., 2004).

There is a small minority of Islamic scholars who maintain that organ donation is against Muhammad’s teaching. The prophet, in his final sermon, stated that “god made the life, property, and honor of Muslims sacred until the day of judgment.” This group of scholars interprets this statement to mean that god intended the human person to remain as he created them, and the body should not be altered in any way. There are others who believe that if a subject is doubtful or not addressed specifically, Muslims should avoid it completely. However, the vast majority of Muslim scholars support organ donation and transplantation. They believe that Islamic laws are made by god for the benefit of human life and society, and organ donation is right because it benefits human life (Aasi, 2003). The general view of the religion as a whole is that a dying man who provides his organs to another will be rewarded, as he has helped another person. The prophetic tradition of Islam is that all believers are like a whole, so the organ of one person may be transplanted to another person, as they are like one body (Aasi, 2003).

Not all opposing viewpoints are religious, however. The most common false belief about organ donation is that physicians or emergency medical technicians will
not work as hard to save someone who is an organ donor. In fact, in most cases, these medical professionals do not know if a person is an organ donor or not. A physician will not inquire about organ donation until after the time of death. The majority of physicians have taken the Hippocratic Oath, a promise to do no harm and to save the lives of anyone he or she is able to. Even if the patient is a potential organ donor, the doctor will spare no measure to try to save him or her. In most, if not all, cases, the medical team providing treatment is not associated with the transplant team. The OPO is not notified until all life saving efforts have been exhausted (OPTN Policies, 2.0).

Another issue surrounding organ donation is the misunderstanding of brain death. Brain death is a definitive medical, legal, and moral pronouncement of death. The problem arises when the family is allowed to see the brain dead patient. Since the patient is supported by respirators, the heart is still beating and the patient is breathing, although not on their own. The patient may look very alive. However, as soon as the machinery is removed, the patient is unable to continue breathing on his or her own, and becomes completely dead. There are stories of pregnant women still being able to birth a living child while they are brain dead. These stories stir up much controversy, because it would seem that the woman must still be alive as well. This phenomenon is definitely amazing, but does not hold any argument against brain death (Dubois, 2009). Many parts of the human body can function for some time outside of the body; that is what makes organ donation possible. Many times,
brain death is confused with comatose or permanent vegetative states. When a patient is in a comatose or permanent vegetative state, they may be breathing on their own, and they have some brain function. Comatose patients have sleep-wake cycles and breathe spontaneously (Dubois, 2009). There is no recovery from brain death. At times, the family may be asked to decide to remove their loved one from the machinery, effectively ending the life of the patient. This can be a very difficult decision for the family, but is not the case in a brain death situation, wherein the patient is already dead and removing machinery would cause no change in their condition. Therefore, this should not be a concern in the organ donation decision.

An objection commonly voiced by extreme pro-life activists is that declaring a person dead based on lack of brain function takes away the definition of a living embryo. They believe that if a human being can be pronounced dead in this way, then it would follow that an embryo is not living until it forms a brain. This logic is flawed; it is missing a key concept of human biology. In utero, an embryo does not depend on the brain to live. As one develops after birth, the brain is an absolute necessity, and when it dies, one's life is over (Dubois, 2009). There are also those in the Catholic community that believe this view of brain death forces the human body to be completely separate from the soul; which goes against Catholic teaching. This group argues that since the soul is the life force of the body, if the body is showing signs of life such as a beating heart, the soul must be present. The argument against this viewpoint is that a brain dead individual is functionally decapitated
(Dubois, 2009). For the soul to still be present, the head and the body would have to both be considered living things, a viewpoint that goes against not only common sense, but the Catholic notion of the unity required to be human.

Pope John Paul II, in 2000, expressed support of the brain death diagnosis. He stated that a healthcare worker, in sound moral conscience, can use these criteria to pronounce death. He also rearticulated his support of organ donation in general, calling it a genuine act of love. However, he reminded the medical community that the human body, no matter in what state, must always be treated respectfully. John Paul II also wrote that, “Moral certainty is considered the necessary and sufficient basis for an ethically correct course of action” when pronouncing death in a brain dead patient (Evangelium Vitae, 1995). There is another obstacle to organ donation, the precautionary principle, which states that one should always err on the side of caution when regarding risks of harm to a person. The quote by John Paul II directly states that this principle does not apply to brain death situations.

The double effect principle, essentially the Catholic moral construct, can be used to sort out the issue of organ donation from a moral standpoint. The parameters of an ethical act are; firstly, that the act itself is good or at least morally neutral, secondly that the good effect is intended and any bad effects are unavoidable and unintentional, and thirdly, that the good effect outweighs any bad effect (McIntyre, 2004). The act of physically transplanting an organ is morally
neutral. The effect intended is to save or significantly better the life of the recipient, and no harm is intended to the donor. In most cases, there is never a bad effect. However, a situation in which organ donation would be considered ethically wrong based upon this formula is if the donor were to die as a side effect of the procedure, and the physician knew this and performed the surgery anyway. In the case of brain death, the donor is already deceased, so that situation would never occur.

As shown above, the Catholic faith has a very public standpoint on the morality of organ donation. The Catholic belief that organ donation is the ultimate gift stems from inherently Catholic values such as love, charity, and kindness. There is both biblical and historical support for this position, and it has been further expanded upon by every pope since organ donation became a medical possibility.

"Give and it will be given to you. A good measure, pressed down, shaken together, running over, will be put into your lap; for the measure you give will be the measure you get back." (Luke, 6:38) This is the message we find in the Gospel, encouraging Catholics to give to their neighbors. The Gospel of John tells us “love until the end.” God tells Cain that yes; he is indeed his brother's keeper. And Jesus states that “whatever you do to the least of my people, that you do unto Me” (Matthew, 25:40). There is a resounding theme in these messages, that love is the greatest of all things, and it will be rewarded in heaven. What greater act of love than to save a life by giving up part of oneself?
Organ donation societies call transplantation the “gift of life.” As presumptuous as it sometimes sounds, truly it is not a conceptual stretch. To donate an organ is to give a gift of that organ. To think of the organ as a gift, as one should, means to think of it as somehow still “connected” to the donor. This leads to the thought that the donor has given a gift of his very person. Jesus gave the world the greatest gift of love, sacrifice of himself. To give the gift of an organ is, in a smaller way, sacrificing of a part of oneself. By donating an organ, the individual is acting in Jesus’ image. Pope John Paul II stated that the self-offering of Jesus is “the essential point of reference and inspiration of the love underlying the willingness to donate an organ.” Self giving is an essential component in Catholic teaching, and organ donation clearly fits into this. However, choosing not to donate organs is not a sin. As long as the person is acting with a well informed conscience, the choice is left up to the free will of the individual.

There are those who think that the whole body is needed for resurrection. As Paul teaches the Corinthians, the body at death and disposal, and the body at resurrection have a tremendous difference. The physical body is not the same as the spiritual body. Even though Jesus appeared to his disciples in His earthly body, He was in a miraculous state in which He could be seen by humans, which would not be the case in heaven. Paul explicitly states, “earthly body will not enter into the heavenly inheritance” (1 Corinthians 15:50).
Before transplantation was a medical option, any mutilation or changing of the human body was generally not permissible by Catholic teaching. The only exception was medically necessary amputation of a limb in order to save the patient. This fit with Aquinas’s principle of totality, which states that body parts may be removed only for the greater good of the rest of the body. Removing an organ from an otherwise healthy individual is not for the greater good of the body; thus, the moral decision about living donations was a difficult one. It was finally decided that transplantation is morally good because it is an act of charity. Furthermore, it is a benefit for the donor, not a physical good but a virtuous good. What follows is an excerpt from moralist Fr. Gerard Kelly:

Organ transplantation is licit provided it confers a proportionate benefit on the recipient without exposing the donor to great risk of life or depriving him of an important function...the principle argument is the law of charity which is based on the natural and supernatural unity of mankind and according to which the neighbor is ‘another self.’ Thus arises the principle that ‘we may do for the neighbor what we in similar circumstances may do for ourselves (Kelly, 1956).

Of course, this notion of charitable giving directly forbids the selling and commercialism of organs. To sell organs would be to treat the body as a commodity, to see it as simply a collection of parts. This is not treating the body, living or dead, with dignity, and is strictly forbidden by Pope John Paul II when he stated, “any procedure which tends to commercialize human organs or to consider them objects of exchange or trade must be considered morally unacceptable, because to use the
body as an object is to violate the dignity of the human person” (John Paul II, 2000). This is also realized in American society, and is not only a Catholic viewpoint. The Organ Transplant Act of 1984 forbids the selling of organs as well. The fact that there is a law regarding sale of organs proves that society has not lost respect for the body as a whole, a thought held by many opponents of donation. To treat the body as an object goes against human nature (Meilander, 1999).

Throughout the course of history, society has had to regulate things which could or could not be bought and sold. The exchanges of human beings in slavery, the sale of public office, and payment in return for criminal justice have all been outlawed. Human nature clearly has some sort of notion about things that cannot be bought. To allow commercial exchange of organs would mean to go against a fundamental human response. There is no way to think of a person as separate from his or her body, even after death, and a person is made up of relationships, and as society and Catholic teaching have proved, not a commodity (Meilander, 1999). Selling an organ removes the charity aspect of the organ transplantation, thus making it morally unacceptable in the eyes of the Catholic Church.

There are those that strongly believe in the commercialism of organ donation (Gan, 2002). It is a fact that there are thousands more potential recipients than there are organ donors, and offering monetary compensation may well produce more donors. Also, according to these proponents, it is a person’s right to do with the body what they wish. If someone wants to sell their organ, they should be allowed to.
Selling organs can provide immense help to impoverished families who have nothing else to create income; not only would they be helping others but they would be helping themselves. In many third-world countries, organ sale is already a common black market activity, resulting in harm to the donor via poor surgical practices, and possibly harm to the recipient if the organ has not been properly tested. Legalizing organ sale and providing market regulations would hopefully cause black market sales to cease. The government permits people to risk their lives for money every day—look at firefighters, police officers, and other dangerous professions (Gan, 2002). Donating an organ may even be a lesser risk than these jobs necessary to society. Also, everyone in the organ transplant equation benefits from the transplant, seemingly except the donor. Paying for the organs would eliminate the inequality.

Disregarding the religious standpoint for a moment, let us delve into the more secular arguments against these viewpoints. There has been a psychological theory since the 1970’s of “crowding out;” that extrinsic motives will always be chosen over intrinsic if given the chance over time. Essentially, it states that the introduction of monetary reward will weaken moral obligations (Rothman, 2006). To explain further this theory, a description of a social experiment follows. In a certain daycare, parents often arrived late to pick up their children, and were not penalized. The daycare, at the instruction of the study leaders, imposed a fine when parents were late. Surprisingly, the rate and number of parents arriving late
increased at this time, and did not decrease when the fine was removed. The psychologists believe that this is due to the crowding out principle; “When help is offered for no compensation in a moment of need, accept it with restraint. When a service is offered for a price, buy as much as you find convenient” (Rothman, 2006). The parents rushed to pick up their child when they knew the caretakers were taking time out of their own days to voluntarily watch their child, but when the fine was imposed, and the caretakers were getting paid for this time, the parents didn’t care as much (Rothman, 2006). This can easily be related to the situation of organ donation. Rather than altruistically giving the gift of an organ, family members may, and probably will, choose to purchase an organ rather than run the risk of surgical complications for the potential familial donor.

There will also be serious social consequences if the sale of organs is legalized. Experts calculate that the average price for a kidney will be $125,000, tax free (Rothman, 2006). This will certainly change societal relationships. It can be assumed, however, that only the lower middle class and poverty stricken individuals will be interested in selling an organ for profit, and rightly so. Since a human being only needs one kidney to live, can a parent demand their eighteen year old child sell a kidney to repay college expenses? Similarly, will selling of kidneys become so mainstream that society needs to create a new system? Bill collectors, lawyers, welfare officials will all have to begin asking about kidney sales in their daily proceedings. The implications for legalizing the sale of organs are
clearly unknown, and thus may bring unintended consequences into society that it is not prepared for.

The argument among proponents of opening an organ market often state that it will work because potential donors will be medically screened and only safe and matching organs will be delivered to the recipient (Becker, 2006). They forget that they are speaking of individuals willing to mutilate their bodies in return for monetary gain. It follows that some of these individuals will not have a problem lying or withholding information from the physician in order to be eligible to be a paid donor. Of course, this is generally speaking; it is not doubted that there are those who would donate organs willingly, with the money being only a perk. Regardless, the donors who withhold information and give an unhealthy kidney ruin the market, because it dissuades others from purchasing. There is also the welfare of the donor that needs to be considered. Assume that a donor is selling his or her kidney to pay off debt, and that the debt is sufficiently paid off with the money from the kidney sale. The current debt is paid off, but what happens if the donor has complications from surgery, or if another family member has a medical emergency? The donor family has essentially, in this situation, not gained anything from the process.

A physician is meant to do no harm, according to the Hippocratic Oath. He or she realizes that in taking organs from a donor, they are in essence doing harm to that person. The physician also realizes that the altruism and charity of the donor
outweigh the harm being done (Starzl, 1992). When one sells an organ, the physician faces a conundrum. Does monetary gain for the donor outweigh the harm being done? Putting physicians in a place to have to make that decision will most likely cause a decrease in the amount of physicians. It can be concluded that selling of organs takes away the beautiful and charitable act of giving the gift of life, and makes the act of organ transplant not a good, but a morally questionable act.

The United States’ determination to continue to keep the commercialism of organs illegal, while honorable and just, does not solve the problem of the current organ crisis. Therefore, many possible solutions are still being created and judged. In order to understand and critique these possibilities, the entire United States policy must be considered. The legal history of organ donation in the United States is extensive. There are many regulations put in place to deal with the complicated medical and legal issues that arise due to organ transplant. The first legislation to address organ donation was the National Organ Transplant Act, NOTA, of 1984. NOTA established organ donation policies and created Organ Procurement Organizations to oversee the transplant process. The most important achievement of the act was to create a task force on organ transplantation that would study policy issues and suggest changes when needed. In 1986, the NOTA task force noted in its first publication the large disparity between the number of those who need organs and the number of donated organs available.
In 1987, the Uniform Anatomical Gift Act, UAGA, was passed. This act, first and foremost, explicitly prohibited the sale of organs. UAGA also guaranteed that the deceased’s wishes would be acted upon in the event that the family had differing opinions. It also streamlined the process of documentation, and organized the entire donation process. An important distinction stated in the act is the responsibility of physicians to ask either patients or the family of patients if organ donation is an option after death. This should not undermine the importance of the family to talk about organ donation and to know what the patient wants, but it is the responsibility of the doctor to present donation as an option in the event of death. The Patient Self Determination Act of 1991 gave even more power to advance directives mandated by the patient; these directives will be followed, essentially no matter what.

There are 59 OPO’s in the United States. They provide all of the deceased donor organs to their specific geographical area. All patients waiting for an organ are placed on a waitlist, and a computer algorithm provides the distribution order. First on this list are patients within the OPO’s geographic area, then regionally, then nationally. The algorithm also considers medical status, blood type, HLA type, and time spent on the waiting list. Special preference is given to those under the age of 18. The transplant surgeon has the authority to deem any organ unacceptable based on his or her judgment, and can decline an organ on behalf of the recipient (OPTN Policies).
The current policy of organ donation in the United States is the opting-in method. The donor or the donor's family must express consent before organs are donated. The consent may be from an organ donor card or a designation on the driver's license, not solely by words. Some European countries follow the presumed consent model of organ donation. Unless a person explicitly opposes donation before death, all deceased individuals are considered organ donors. In most presumed consent models, family members do have the final say. Countries such as Austria practice pure presumed consent, meaning that they do not contact the family at all before harvesting organs (Healy, 2010). The only way an individual can opt out is by officially registering at a courthouse, and these individuals, should they ever need an organ, are placed on the bottom of the waitlist.

In January of 2011, the Colorado state Senate introduced a proposal that would make Colorado the first state to adopt the presumed consent model. The legislation reads,

The bill changes the organ donation program so that a person is presumed to have consented to organ and tissue donation at the time the person applies for or renews a driver's license or identification card unless the person initials a statement that states that the person does not want to be considered as a possible organ and tissue donor (Colorado State Bill, SB 11-402).

The bill has no provisions for those who pass away before being able to possibly opt out. This policy, experts have stated, will most likely reduce the number of living donors available, because people know they will be subjected to organ harvesting at
the end of their life anyway. Research has shown that presumed consent systems do not increase the number of organ donations more than opting-in systems do. However, studies have shown that most Americans do want their organs donated after death, but by some flaw, the organs are never taken. This could be due to many reasons, all of which would be eliminated by switching to a presumed consent model. Bioethicist Arthur Caplan states that “there is nothing coerced or disrespectful in asking those who do not want to be donors upon their death to say so” (New York Times, Room for Debate). He does admit that changing the law will not be enough, and further education of the public is still needed. It is also possible, according to bioethicist MaryAnn Bailey, that the people who are unsure about organ donation to begin with will opt-out, as well as those who would be in favor of opting-in, due to fear of such an aggressive policy (New York Times, Room for Debate).

This system, while surely able to increase the number of donors, is still flawed in the gift-giving sense. Presumed consent does not leave any room for a charitable choice of the donor. It, like the selling of organs, takes away the altruistic nature of organ donation that makes the act so heroic. Presumed consent systems view the organs as something that society has a right to, not as part of the whole person. In this view, the whole is simply the sum of the parts, and nothing more. There are other ways of increasing informed consent than resorting to this method of organ procurement.
At the 2011 Technology Entertainment and Design conference, Dr. Anthony Atala unveiled what could be a long awaited answer to the organ question. It will take years to perfect and be usable, but he essentially created an “organ printer.” This machine, resembling a 3D printer, is able to create an organ using the recipients own cells in about seven hours, eliminating the wait and any chance of rejection. It uses a small tissue sample as the base, and works layer by layer to create a new organ. This is still very new technology, and still theoretical, but it is bound to have vast impact on the organ donation system in this country. It seems that this new technology would be acceptable with Catholic ethical teaching. In fact, the Vatican Science Theology and Ontological Quest Foundation in 2010 paired with NeoStem to advance research in the potential of adult stem cells in regenerative medicine (Catholic News Agency, 2010). The Vatican’s official statement includes their endorsement of “cutting edge adult stem cell science which does not hurt human life, we come one step closer to a breakthrough that can relieve needless human suffering” (Trafny, 2010). In this case, the organ is being made from the person’s own cells, in an effort to save their life. As long as the cells are not embryonic stem cells, it would follow that the organ printer is tolerable under Catholic ethical standards.

One new program for donors has been seen in the United States, and is completely within the charitable mindset of donation. “Donor chains” as they are known, or “kidney swaps” allow those living donors who are not a match for their
loved one to perform a paired exchange with a similar pair. This process definitely has potential for mitigating the need for organs. In 2009, a donation chain led to ten kidney transplants. It is estimated that these paired donations can allow for 1,500 more living donor transplants per year. As always, there are ethical questions that arise, even though the act itself is within the Catholic charitable duty. A chain such as the one described above will leave a potential donor having not donated. It is hoped that this donor will start another chain, since their loved one received an organ, but this is not always the case. Statistically, the longer the wait time, the more likely that the potential donor will change their decision. Another question raised is of organ quality. If one person donates a 60 year old kidney, should their loved one be able to receive a 20 year old kidney? Questions such as this put physicians in quite the ethical dilemma (Shapiro, Glazier, 2009). While many discussions and ethical debates still need to occur, from the forefront it seems that a donor chain is an ethical way to increase the number of donated organs. Catholic teaching would suggest, as for the age of the organs that they should not be discriminated against unless they are not going to work in a specific patient. Donor chains are still rare, and have a long way to go before they become every day events (Crowe, 2007).

Since the 1990’s there has been an increase of both living and deceased donors, but unfortunately also an increase in the number of those requiring new organs. In a Gallup poll, 85% of Americans stated that they would donate their
organs after death, but in reality only 48% of potential donors end up becoming donors. This can probably be attributed to the family of the deceased and their decision making process, which can be heavily affected by the OPO or physician. A strategy to increase organ donation would be to have the OPO and physician spend more time with the family, answering any questions they may have and explaining more fully the donation process. In some states, such as New York, registering to donate and carry a donor card is a difficult process (Rothman, 2006). Making the process easy for potential donors would certainly increase the amount of people who carry a donor card. The public policy should not change, but the public viewpoint needs to. More information and education regarding organ donation should be made available to the general public so that they may be able to make an informed decision when it becomes necessary.

An easy place to turn to make sense of all of this information is faith. Salesian spirituality instructs believers to live out their faith in daily life, but does not expect miracles from everyone. To have faith and to be one with God, according to St. Francis DeSales, is to do everything in life for love of God. DeSales realizes that people in life are called to different vocations, and not everyone will live the religious life. He instructs to live out relationships in love, and do nothing through force. A Salesian person possesses humility, and is unpretentious and approachable. Humility leads to gentleness, which DeSales defines as “controlled, directed, and loving strength” (Introduction to the Devout Life). Living this way is a process, and
does not happen automatically or instantaneously. It is important that living the
devout life is always strived for.

Using this information, one can infer that St. Francis DeSales would highly
courage organ donation. He calls for Catholics to live in love, and to carry the
virtue of love throughout their entire life. One of the greatest acts of love is to
donate organs both in life and after death. As stated above, the Salesian person is
unpretentious and humble, traits that would definitely be needed to consider
donating an organ. One would have to be humble enough to understand that they
do not need certain organs, especially after death. One of the saddest things in
society today is the mistrust of individuals who would like to donate a kidney to a
stranger. To this day, only about 25 people have been allowed to do so, and they are
subjected to severe psychological testing. Evaluators assume that the donor has
ulterior motives, or psychological issues that they are hoping to resolve by donating,
or that they will become depressed afterward. In reality, most people who wish to
donate an organ to a stranger are simple acting out of the charitable love they feel
for others, something DeSales would be proud of, based on his teachings.

St. Francis DeSales would definitely disagree with the presumed consent
model. In this system, members of society are assumed to be donors unless they
sign a paper stating otherwise. Basically, the organs become property of the state
when the person dies. DeSales would view this as using force to fulfill the greater
agenda. Even though the intent is to increase organ donors so that more people can
benefit from transplants, the means do not justify the ends. DeSales would rather that society find other ways, such as love and gentleness, to solve the organ shortage. DeSales has a particularly fitting message when considering all of the panic and stress over the lack of organs; “It is love that gives value to all our works; it is not by the greatness or multiplicity of our works that we please God, but by the love with which we do them.” He does not expect individuals to go above and beyond, however. DeSales believed in the practicality of faith, so that all people, regardless of status, may live as God wishes (Mrg. Vincent, EWTN). This means that he would not expect everyone to become an organ donor, or a world renowned transplant surgeon, or a priest for a transplant center. He would encourage anyone to do what is within their means to help, and laud those who are able to donate their organs, in life or in death. DeSales also recognized that there would be obstacles in life, and each faithful person would suffer adversities and people who would persecute them for their beliefs. He stated, “We have to allow our minds to be pierced by the thorns of difficulties, and allow our hearts to be pierced by the lance of contradiction; to drink of the bitterness and swallow the vinegar, if this is God’s will” (St. Francis DeSales, Selected Letters). This teaches Catholics to be strong in the face of adversity, as long as they are performing the will of God. This may very well be the case when someone makes the decision to donate an organ; they can look to St. Francis DeSales for peace.
As part of the research conducted for this paper, I have added a personal element to the facts and figures, in the form an interview conducted with Ed Ubbens and Evelyn Houston. Ed and Ev are brother and sister, and Ev was diagnosed with Lupus when she was a young adult. A common effect of Lupus is renal failure, and in the year 2000 it became obvious that Ev needed a new kidney. In 2001, Ed donated his kidney to Ev (Personal Communication).

Ed had no reservations in making this decision, which for some may be the hardest decision they could ever make. It also helped that Ed and Ev’s mother had lived with only one kidney for the majority of her life, due to an accident, and experienced no adverse effects. Ed already knew the implications of life with one kidney, something that most potential donors have many questions and concerns about. Ed has not, and does not expect to experience any physical changes as a result of the transplant. He only feels the positive emotional effects of giving “a gift that [he] felt fortunate to give.”

When Ev was asked about the donation process, she revealed that Ed had decided years prior, when her kidney failure was first diagnosed, to donate his kidney if she were to ever need one. If he didn’t immediately offer, Ev would’ve had a hard time asking; “I would not want to put pressure on anyone to do something that they may feel uncomfortable about. Fortunately, I was never put in that situation, because am I blessed with a family who immediately wanted to help out.” Ed never thought twice about donating a kidney to his sister, but Ev was worried
about her younger brother going through surgery for her. Luckily, there were no complications, and Ev awoke from surgery feeling immediately better. All of Ev’s symptoms from her kidney failure were relieved, and she even almost got too much better. As a result of the kidney failure, her blood pressure was very high. After the transplant, her blood pressure decreased so much that she was constantly dizzy. Thankfully, that rectified itself in short time. Even though Ev has to take anti-rejection medications for the rest of her life, she doesn’t mind them because they are now part of her daily routine. Her only regret is that she can no longer enjoy sharing a grapefruit with her family at breakfast.

Receiving a gift comes with a certain responsibility, and Ev understands that, and will never forget it. She says, “My brother unselfishly gave something to me that has extended my life and has given me a new lease on life. It is a blessing that I appreciate so I make sure that I take my medications, eat healthy, and exercise to take care of this gift.” Ed and Ev’s relationship has only strengthened since the transplant, and they are a perfect example of the good that can come from organ donation. Getting emotional and teary-eyed even ten years later, Ev explains it best: “My brother donated to me with such love and unselfishness that I feel that part of my brother is now part of me” (Personal Communication).

This testimonial, and the many others out there like it, truly showcases the heartfelt selflessness that is present in this world. Critics state that altruism won’t work, and people will not freely give of themselves without monetary compensation.
But, in the words of Evelyn Houston, “it demeans and cheapens the reasoning for donation.” There are individuals out there who would gladly sacrifice part of themselves for another. And not just for their relatives; Ed’s wife even offered to donate her kidney if Ed was not a match. Stories like these are what motivate other people to become organ donors.

The large gap between the number of people on the waiting list, and the number of donations has caused quite an uproar among transplant professionals and bioethicists alike. They are calling it a crisis, and desperately trying to solve it. In reality, if a transplant is able to save one more person’s life, then the system is successful. Medical technology has come so far since the days of the first transplant, and society should be grateful for each life saved. Every life is precious in the eyes of God, and we should not put a price on someone. Hopefully, in the future, technology will open new doors and the so called “organ crisis” will be solved with minimal donors needed.

Organ donation in itself does not at first seem to be a controversial topic. However, when delved deeper, there are many social, cultural and religious issues that arise. Through all of the debate and opposition, it remains clear that organ donation is not only a valid option, but a potentially heroic one as well. Pope John Paul II, one of the greatest popes to ever serve, has explained and defended organ donation on multiple occasions, through speeches and letters. He has likened the
act of donation to the sacrificial gift of Jesus Christ. Thus, organ donation, in life or in death, is a gift of one’s true self.

This gift is more than we could ever hope for from buying and selling organs. As Yale Professor Miroslav Volf observes, “When I give you a gift, you receive more than the stuff that has left my hands, partly because you receive not just my gift but also my generosity. Gifts are not simply the "stuff" that travels from one person to the other. Gifts are seeds that God makes grow, sometimes into a bountiful harvest” (Volf, World Magazine 2006). This quote signifies what it is that Catholicism finds so beautiful when organs are given as a freely given gift. It is not simply a transaction from person to person but a charitable act that includes God in it.

By performing organ transplants that arise through organ sale or presumed consent, we have uninvited God from the process. Respect for the human person is lost, and the body has been reduced to a collection of parts. At this point, organ donation becomes not an ethical, life giving action, but a perfect argument for how technology has gone too far. The unfounded fear that the body will be mutilated after death has suddenly became valid. Studies and experts have shown that when organ sale and presumed consent occur, the number of willing donors decreases not increases. These methods should not be incorporated into the United States, for they will bring negative consequences that no one is ready to confront.
Instead, the American people should be further educated about organ donation. There is so much information out there about sex and abortion, but not enough about life saving opportunities such as organ donation. There are a large number of people who think that if they are an organ donor, their doctor will let them die (Organtransplants.org, Myths). Efforts should be made to find the root of this distrust, and then remedy it. Another serious misconception is that the body is mutilated after death by surgeons harvesting organs. In fact, it is exactly the opposite. Bodies are always treated with utmost respect. Also, the entire body need not be present for the resurrection. There is no religious need to bury the body as a whole, because the mortal body does not enter into the heavenly realm in eternal life. There should be priests or other religious personnel available when a loved one passes away to explain this to the family. These explanations and the presence of a religious leader may make the decision to donate much easier for the family.

A study done of families who decided to donate their loved ones organs was performed in the late 1980’s. Although medicine has changed a lot since then, and at the time primarily kidneys were transplanted, human consciousness has stayed consistent. The families all agreed that having the deceased’s organs donated made the death easier to bear. They felt it gave meaning to the passing of their loved one, and allowed them to come to peace with it; “express[ing] the need for transforming the gift of the organs into an attempt to understand and create meaning from the frequently senseless death of a loved one” (Batten and Prottas, 1985). The families
were also of the belief that death is not tragic for the deceased, only for the survivors. Families of organ donors also felt it easier to talk about the death of their loved one. Clearly, organ donation does have a positive effect on the living. Making this study public, and following up with studies using more recent donors, could give families an incentive to agree to organ donation.

There is a movement in the United States currently that goes by the name LifeSharers. It is an organization that believes those who pledge to donate organs upon their death should be given preferential treatment as recipients if they ever need an organ. The group keeps a list of members on the waiting list, and releases them to family members when a LifeSharer dies, so they can perform a directed donation. They believe this will make the transplant process fairer, and also increase the number of donors (Undis, Lifesharers Newsletter). The individuals who participate in this group are not making selfless, charitable gifts. This is a self-serving group that donates organs after death solely to get a reward in life. The proponents of this group believe that altruism alone will not solve the organ shortage, and that people need to get something in order to give something. The Catholic Church clearly states that organ donation is a choice, and it is not a sin to decline to donate organs. Denying organs to those in need because of their personal beliefs, however, probably would be considered a sin.

What happened to bringing out the best in people? To believing that all people are inherently good because they are made in God’s image? Rather than try
to change a system to reward people, policy makers should appeal to the generous spark that is in each and every human being. Changing the system in any of the above proposed ways brings out the worst in people. It makes human beings expect to be rewarded in any situation. It negates any sort of love that one may have for their neighbor. It takes a charitable act and turns it greedy. And that is something society does not need. In 21st century America, in a society that only becomes more and more secular each day, it seems that no one remembers intrinsic human nature. The problem isn’t that people want to keep their organs, it is their fear brought about by misinformation or lack of information. Publicizing organ donation and its processes is the answer. And maybe if appeals were made to kindness, love, and charity of persons, rather than their greed or self worth, people would surprise us.
Works Cited


