CONCLUSIONS WMA SCIENTIFIC SESSION PHYSICIANS IN THE ORGAN DONATION AND TRANSPLANTATION PROCESS: ETHICAL CHALLENGES

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DONATION AS PART OF END-OF-LIFE CARE

1. Governments and professionals have been called to develop deceased donation to its maximum therapeutic potential. But deceased donation rates are extremely variable across countries, even when comparing those with a similar socio-economic background. One of the reasons behind these variations is the different care given to patients at the end-of-life, which impacts upon the potential donor pool and the extent to which possible organ donors transition to actual organ donors. Healthcare professionals may not systematically consider organ donation and facilitate it because they feel conflicted. While the social value of organ donation is a powerful reason to consider it, their most important motivation should be the respect for the overall best interests of the patient (the donor). As part of end-of-life care, the wishes of the patient about donation should be routinely established. If the person wished to donate, then it is in that person's (overall) best interests to donate, and therefore that in itself is a reason for doing everything possible (that is ethically and legally justified) to enable donation to occur.

2. Donation after the Circulatory Determination of Death (DCDD) has been developed by a limited number of countries throughout the world, despite patients are dying daily under circumstances that would enable DCDD. A Statement developed by an International Collaborative to expand the practice of DCDD has addressed three fundamental elements of the DCDD pathway: i) the process of determining a prognosis that justifies the withdrawal of life-sustaining therapies (WLST), a decision that should be prior and independent of any consideration of organ donation and in which transplant professional must not participate; ii) the determination of death should be based on the permanent cessation of circulation to the brain; iii) the acceptability of ex situ and in situ preservation measures as long as restoration of brain perfusion is precluded to not invalidate the determination of death.

3. When addressing the question of whether professionals should offer donation as part of end-of-life care, it is critical to make an analysis of the facts and of the outcomes of relevance for the agents involved – the patient, their family, the transplant recipient, the ICU doctors and nurses and the society at large. From the perspective of the principles of autonomy, beneficence, non-maleficence (burden) and justice, organ donation should be offered as part of end-of-life care by health professionals, as long as the burden can be properly addressed by: i) ensuring that donation does not risk a good death (avoiding suffering and respecting the wishes of the dying patient); ii) understanding organ donation always as Kantian, not utilitarian, where patients (donors) are ends in themselves; iii) making evident the delayed benefits of organ donation; iv) learning to understand the needs of patients outside of our hospital or unit.

4. Advancing towards the paradigm of organ donation at the end-of-life in Latin America entails the consideration of DCDD. Argentina, Brazil and Chile can be considered in a position of moving towards piloting DCDD programs given that the three countries have a regulatory framework that accommodates the practice of WLST, the acceptability and extended practice of WLST when sustaining measures are no longer deemed beneficial to patients, and the existence of a transplant legislations that do not explicitly regulate DCDD, but do not prohibit it. To implement pilot

programs, there is a need to evaluate the legal and ethical framework, develop specific procedures that address the critical phases of the pathway, promote education and professional training and communicate the program to the population.

ORGAN TRAFFICKING AND TRANSPLANT TOURISM

1. Organ trafficking and human trafficking for the purpose of organ removal are crimes that violate fundamental human rights and pose serious risks to individual and public health. The current reality reveals a risk for an increase in the frequency of these practices driven by the high demand of organs, the unequal distribution of wealth in the world, the technical progress of transplantation and migration. The most vulnerable, women, minors and migrants, may be a higher risk of becoming victims. Governments, international organizations, NGOs and Medical Associations must join efforts in a multifaceted approach to fight this menace.

2. Healthcare professionals may face different situations in their clinical practice that place them in a position to prevent and combat transplant-related crimes: i) during the management of patients who may be considering to travel abroad for transplantation; ii) during the evaluation of donor-recipient pairs, particularly when one or both of them are non-residents due to their special vulnerability; and iii) when caring for transplant recipients who return home after a transplant abroad to receive follow-up care. The Council of Europe, along with other international organizations, have issued professional guidance for professionals to support them in those instances. The implementation of these recommendations could help healthcare professionals and policy makers committed to curtail these practices and to preserve and safeguard ethical donation and transplantation programs. In addition, the Council of Europe, through its international network of National Focal Points (NFP), annually collects information about patients who traveled for transplantation to another country. The international exchange of information about these patients is helping to better understand and analyze the phenomenon of travel for transplantation, to assess its dimension, and to identify possible hot spots of transplant tourism that deserve careful investigation by the concerned countries. In addition, it is contributing to gain better knowledge of the profile of donors and recipients, the quality in the transfer of recipient care and its impact on post-transplant outcomes, and to develop tools and protocols to improve practices and foster international cooperation.

3. Healthcare professionals may face the dilemma of respecting the confidentiality and privacy of their patients and the obligation of reporting transplant-related crimes. Systems for professionals to collect and report data related to suspected or confirmed cases of transplant-related crimes should be carefully designed to address their concerns with regards to breaching patient privacy. The extent of reporting duties and their normative weight will be dependent on the context in which reporting occurs and on the systems that are in place to ensure that information will be used effectively and that vulnerable individuals will be protected from harm.

4. DNA-PRO-ORGAN, for the time being focused upon kidney transplantation, is an operative program conceived by the University of Granada (Spain) and supported by the OMC-CGCOM and ONT, that promotes the creation of database of biological samples that keep help traceability from donor to recipient and viceversa. Expected to be first piloted in countries where organ trafficking is an important reality, it can become a useful tool to investigate suspected cases of organs trafficking, a type of crime where the lack of documentation or the use of forged documents make investigation highly challenging.