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The organ donation process: An ethical commitment

El proceso de donación de órganos: un compromiso ético

Dear Editor:

We have read with interest the letter to the editor entitled ''Moral complexity in the organ donation process: a prudential act''[1] and felt it necessary to make a few comments on some aspects of its argumentation. Organ transplantation is a life-saving therapy, and patients on the waiting list have no alternative therapy. As intensivists, we are responsible for reducing the number of patients on the waiting list by facilitating the donation process in our units. In fact, Donation-Oriented Intensive Care (DOIC) is a common practice in our units[2] and in most developed countries. Fortunately, the debate is well-resolved, and in full compliance with the principles of bioethics, the following aspects could be argued.[3]

Regarding the principle of beneficence: end-of-life decisions should be made primarily based on values rather than facts. For the patient, it represents an opportunity to express values such as solidarity and altruism and may be the best therapeutic option until their poor prognosis is properly assessed. For the family, it provides solace in the face of loss, and for patients on the waiting list, it offers a genuine chance of survival.

Regarding the principle of non-maleficence: DOIC requires ensuring the absence of suffering and the patient's comfort, as outlined in existing protocols. Therefore, if deemed appropriate, DOIC should consider the possibility of having the patient accompanied by their family at the intensive care unit (ICU) setting. The option to revoke consent for DOIC is mandatory.

Regarding the principle of autonomy: All human beings aspire to live with dignity, as recognized by science, society, and law. A dignified life deserves a dignified death as an inseparable concept. Respecting dignity necessarily involves considering the option to donate each person's organs, either directly or through representation, thus respecting the patients' wishes and values. Providing this option is indeed a moral obligation for the health care personnel involved in patient care. Failing to offer it based on compassionate arguments would represent an undesirable paternalistic attitude.

Regarding the principle of justice: the use of ICU resources for DOIC is a matter of cost-opportunity. The moral obligation of health care providers is to allocate resources to a real—not a hypothetical—situation. Choosing a patient for DOIC vs the hypothesis that those resources could be allocated to a patient who might present represents the denial of an opportunity to stay alive in favor of a potential situation that does not exist yet.[4]

We agree with the authors that the donation process requires a deep understanding and analysis of each patient's situation. Therefore, SEMICYUC considers DOICs necessary to be included in the ICU care practice and, consequently, includes this reality in both its documents and recommendations.[5]

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Organ donation process: more than just guidelines and protocols

Proceso de donación de órganos: algo más que guías y protocolos

Dear Editor,

We have read with satisfaction and interest the 2 responses[1,2] to our letter "Moral complexity in the organ donation process: a prudential act."[3] As we stated in our letter, the ongoing debate in the intensive care medicine setting[4,5] presents an opportunity to delve deeper into the moral aspects inherent to organ donation, fostering reflection that not only improves these programs but also helps all parties involved act justly in every decision.

Every organ donation is morally complex. Without being exhaustive, each case entails the wellbeing of the patient on the transplant waiting list; the donor's previously expressed will together with his or hers desires, beliefs and values; the interpretation that the surrogates will make of those wishes; the positive impact that donation might have on a family in mourning or the basic fact of converting a patient into a donor. To underestimate or oversimplify these factors would be, in our opinion, a mistake.

In general terms, considering a moral debate as settled is an error. In medical ethics, as Childress and Beauchamp acknowledge in the latest edition of their renowned work,[6] although referring to the principles of autonomy, beneficence, non-maleficence, and justice is necessary, it is not sufficient to determine the moral goodness of a medical act. The moral character of the professional and the real, concrete circumstances are equally important elements. Real experience in the ICU setting shows that simply listing these principles does not absolve the professionals of their responsibilities towards their patients, as they cannot cease to be a moral agent.

For this reason, we continue to find the 3 recommendations in our article relevant. Let's repeat them. First, the intensivist is not merely an executor of a system, a procedure, or someone else's will, but a moral actor: as such, they make decisions freely. And every free decision in critical circumstances is both difficult and costly.

One might deny the existence of a moral and emotional cost in the organ donation process. It might be said that this cost is irrelevant, or even decreed that emotional wear renders the intensivist unfit to ''work in a specialty where such challenges are common.'' However, this does not eliminate the real experience of the medical team: the truth is that each decision tests their moral agency, and these decisions come at a cost. Unlike our kind respondents, we not only believe this wear is real; we believe it is good, as it shows that the professional is taking the moral dilemmas of the donation process seriously.

A second recommendation also seems pertinent. As a person, each patient is unique, and respecting their dignity involves recognizing them as an end in themselves. These are not empty words: the unconscious or involuntary danger of subordinating the person to the program is real and does not disappear simply by denying its possibility. The best way to avoid moral instrumentalism is not to deny its possibility but rather to make sure that the professional can recognize and acknowledge the existence of a r̈ed lineẅhen managing organ donation.

This is why prudence, in its deepest sense, seems to us the fundamental virtue here. In the end, neither the law, nor the clinical practice guidelines, nor procedures can provide the professional with sufficient moral certainty to do justice to the donor, the patient, the families, and the program. For this reason, we believe that the professional faced with an organ donation process must possess certain virtues,[7] beginning with a solid understanding of the good, recognition of the various goods at stake, and the ability to righteously deliberate on what is good and appropriate in each specific case.

Finally, let's move to the third recommendation, which we find particularly relevant. In ethics, there are never closed debates, and the more important and valuable the issue at stake is, the more important it is to avoid closing the discussion. Honest and open dialogue is the best guarantee for genuine improvement in donation processes. From this perspective, professionals and public authorities should be the most interested in not declaring the debate closed but rather recognizing and exploring the complexity and richness present in each case. Morally speaking, an organ donation process is, for the professional, something more than fixed, predetermined guidelines and protocols.

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