

Transplantation: a question of ethics

[Sociology](#), [Ethics](#)



In the advent of the 21st century, approximately six-thousand patients on the pending list for organ transplants and replacements passed away hoping to receive the treatment (Kogan, 1991). For the privileged organ receivers, second chances are a reality. Their transplant is a chance for them to live their life better than before. Advancements in the medical field have made it possible for a multitude of Americans to obtain these life-resuscitating donations, otherwise known as gifts.

The medical world did not encourage the idea of organ extraction for transplantation without consulting the next member of the family. For instance, in Scotland, it is understood that a basic prerequisite for seeking consent from the family members will be subsumed in their legislation (Caplan and Coelho, 1998). Clinical ethics weighs up the probity of decisions on the subject of medical care made by or with patients and their family member.

Predicaments of clinical ethics include making a decision on whether or not to get rid of life-supporting therapy or treatment, making medical decisions for a patient- or family-consented organ donation, or a down for the count person, and taking care of wishes for euthanasia from patients themselves or their closest relatives (Caplan and Coelho, 1998). For instance, majority of medical centers rely at present on substitute or consent given by a qualified member of the family.

This consent can pass on a predicament to the relatives, who must settle on whether to respect the patient's official donor card. This process can grow if the family member, who is assessing the situation, does not have a solid judgment, and a full grasp of the patient's desires, or doubts derived from

their personal morals. As a result, a previously fit individual's will, which is recognized either in verbal or written agreement, can be outweighed by the decision of the family members (Ross, 1998).

One way of tightening the difference between the supply and demand of transplant organs is by making optimal use of the so-called donor registries (Blumstein and Sloan, 1989). Verifying from the register should be a requirement before organ extraction and, as an additional precaution, family members should be consulted on whether they are aware of any opposition that had failed to register. Enlisting non-donors might reduce opinions of impropriety on the part of the registration course of action, and may strengthen the ethical and moral grip of the registry.

The principal drawback to making record of non-donors is that doing so may be construed to mean that those who have not been consulted about their leading to organ donation or who call for more information have not had the chance to turn down (Caplan and Coelho, 1998). The Human Tissue Bill particularly cares for presumed consent for organ and tissue donation in which the donor's preferences were formally expressed.

Medical doctors believe that this modification is appropriate to change the importance in the new legislation away from the restrictions of tissue or organ donation and would without a doubt, make a donation hassle-free, for the welfare of the patients (Blumstein and Sloan, 1989). The condition for absence of objection would establish the needed stability in the process to protect likely organ benefactors (Kogan, 1991). When a family considers how many other lives could be saved with the consent they can give for an organ

donation, they thought of the greater goodness that this simple blessing could bring (Wilson, 1993).

Some parts of the United States have donor registries where interested parties can record their request to be a benefactor. At the time of the possible donor's death, the donation centers can authenticate their bidding to be an organ contributor. Other states have put into practice First-Person Consent in which a driver's license designation or an authenticated donor card is the mere validation required for donation to take effect. Still other states hinge on the promising donor's nuclear relatives to grant consent (Ross, 1998).

Today, groups armed with moral agendas are seeking to gain public support for their programs. The main controversies have resided in those areas in which private morality and public policy overlap. To make the decisions centralized, World Medical Association was founded as an organization of several of the world's national medical associations. Instituted in 1947, this medical society has embraced an international code of medical ethics and many other ethical pronouncements.

The center of operations is in Ferney-Voltaire, France (Blumstein and Sloan, 1989). Ethical decision-making techniques are made available by the World Medical Association to help the medical professionals deal with social and ethical implications or problems like those cited above. We can make value judgments rationally, even when we have intertwined feelings about an issue if we are consciously aware of the values we hold. We can avoid making judgments at an emotional level without carefully considering our alternatives.

The ethical decision-making techniques should help people to clearly identify their values and to make decisions about ethical and social issues consistent with those values in the medical context (Blumstein and Sloan, 1989). All the same people are not forced to depart their lives just to donate. Living humans can donate liver, kidney or lung, in addition to tissues such as bone marrow and blood. Medical knowledge and the procedures for organ transplantation have recently become sophisticated in less than half a century.

Today, a good number of individuals have the chance of lengthening their lives or simply a second chance on a healthier life (Wilson, 1993). As a donor, they may well salvage or better the quality of life for as many as 160, 000 Americans who die each year waiting for organ transplants (Caplan and Coelho, 1998). Though, this has to be completed between close relatives to guarantee the most fitting genetic match and consented, peaceful acceptance.

While mourning for the patient or donor, the family can in any case find solace in realizing that their beloved relative's organs and tissue continue to exist in others and resuscitate the lives of those in need (Kogan, 1991). In the special case of heart transplantation, even if the design problems are solved so that implants in humans are feasible, ethical problems will remain. The cost of manufacturing and implanting an artificial heart now exceeds \$100, 000, far more than most potential recipients can afford (Blumstein and Sloan, 1989).

Can and will taxpayers and insurance premium payers accept the burden of providing such a heart for all who need them? If not, who will choose which

individuals will receive them, and how will these choices be made? Should such ethical problems have been resolved before allocating \$10 million in government funds per year for several years to heart replacement research (Blumstein and Sloan, 1989)? Though some bioethical decisions involve individuals, many involve larger groups, including families, communities, and even whole countries.

In addition to emotional comfort, two other criteria can be used to assess the validity of a decision, that is, universality and balanced good. The criterion of universality asks whether the result would be acceptable if everyone in a similar situation made the same decision. The criterion of balanced good asks whether the decision results in the greatest good for the most people (Wilson, 1993). Application of these ethical decision-making techniques should be beneficial to the medical professional in coping with the increasing number of ethical issues facing health professionals, and all citizens, in today's complex world.