Transplant allocation

Transplant AllocationMichelle ByrneUniversity of PhoenixHealth Law and EthicsHCS 545Mary CummingsJuly 10, 2013Transplant AllocationOrgan allocation is done in a systematic fashion when an organ becomes available. In 1984 the Organ Procurement and Transplantation Network (OPTN) was established.

The United Network for Organ Sharing (UNOS) ??? coordinates organ donation and allocation throughout the U. S., but the system procurement and distribution actually involves multiple entities, including local procurement organizations and transplant centers??? (University of Missouri, 2011, para. 1).

Organs are removed at the hospital and sent to a transplant center where a recipient is waiting. There are many ethical issues that have arisen since the first transplant took place, which has made the need for different acts very important. The first successful living-related organ transplant occurred in 1954 and was a kidney donated between identical twins. The first successful cadaver organ transplant, also a kidney, was done in 1962.

Because of advances in technology there are more people waiting for organ transplants, this in part, helped to establish the Uniform Anatomical Gift Act in 1968 and the National Organ Transplant Act (NOTA) in 1984. NOTA ??? authorizes financial support for Organ Procurement Agencies (OPO??™s) and prohibits buying or selling of organs in the United States??? (New York Organ Donor Network, para. 6). Organ type/waiting timeMany patients who are candidates for organ donation, excluding those who have living donors, must

wait for an organ to become available because of the shortage of donor organs.

Because each patient??™s situation is different, his or her waiting time may vary. There are many considerations to be taken into account, depending on the organ. Some of these considerations ??? include but are not limited to: age, blood type, medical urgency, waiting time, geographic distance between donor and recipient, size of the organ donor to the recipient, and the type of organ needed??? (Transplant Living, 2010, para. 2).

When an individual needs a heart transplant his or her physician assigns him or her a status code, which indicates the medical urgency. Hearts are available locally first and then in specific sequence by zone. Patients in need of a lung transplant are grouped, whether they need one or two lungs.

If two lungs are available and the first recipient only needs one lung, the second lung goes to someone who only needs one also. Thoracic organs are available locally first then in a specific sequence by zone. ??? If you are waiting for heart/lung transplant, you will be registered on the individual UNOS patient waiting lists for both the heart and the lung??? (Transplant Living. 2010, para. 1).

Once the patient is eligible for a heart, he or she will receive the lung transplant from the same donor. If an individual is a candidate for a liver transplant he or she is given a status code by his or her physician, which indicates his or her mortality or medical urgency. ??? The current kidney allocation policy considers characteristics of both the donor and the

transplant candidate in allocating kidneys equally, efficiently and effectively??? (Transplant Living, 2010, para.

1). Organ transplantation??? An organ transplant is a surgical operation where a failing or damaged organ in the human body is removed and replaced with a new one??? (Center for Bioethics, p. 5). When a person becomes ill because of organ failure his or her doctor will evaluate him or her to see if he or she is medically eligible for a transplant. If the patient is medically eligible they are sent to a transplant center for further evaluation. The candidate is placed on a waiting list, which is maintained by the United Network for Organ Sharing (UNOS). When a person dies and his or her organs become available an organ procurement organization (OPO) takes the organs into custody.

??? The OPO then matches the donor organs with the appropriate transplant patients by gathering information about the donor organs and entering it into a computer program??? (Center for Bioethics, p. 7). This program takes all the information from the patients waiting for an organ and produces a ranked list of who should receive the organ first. The first person on the list is offered the organ first. Sometimes the first person on the list may not receive the organ because they are not available for immediate transplantation or they are not healthy enough for the surgery. Once the candidate is selected the OPO delivers the organ to the transplant center and the transplant surgery is done. Although this sounds like a lengthy process it must occur quickly because organs are only transplantable for a short period once they have been removedAutonomy and transplant allocationOne aspect of autonomy concerning transplant allocation is the patient??™s right to

refuse an organ if he or she feels a future organ may be a better offer. This situation usually occurs with kidneys.

Because this has happened, the United Network of Organ Sharing (UNOS) has come up with a system in which those patients willing to accept an organ from a marginal donor will get the first option for it. The reason this became a concern because organs were being wasted because too much time went into finding someone to accept the organ. The effect of transplant allocation and peoples choices are dictated by two different forces. ??? First, depending on their intrinsic characteristics, some patients may be more likely to accept organs of marginal quality than others??? (Su & Zenios, 2004, p. 281).

??? Second, the rule used to prioritize patients on the transplant waiting list can encourage patients to be either more or less stringent in their choices??? (Su & Zenios, 2004, p. 281). Although the option to wait for a better organ may work for kidney transplants, there may not be the same autonomy for other organs.

Autonomy may be taken out of the patients hands in two different situations. The first situation is if the person is not available for immediate transplant surgery. In this case the organ would be offered to the next available candidate. The second situation would be if the person is not healthy enough for transplant surgery. Again, in this situation, the organ would be offered to the next available recipient.

Another issue that comes up with autonomy is, if a family member is willing to donate an organ, does the person receiving the organ have full autonomy to say yes or no, or do his or her emotions override his or her decision.

Autonomy also comes into play when a person??™s religious or other beliefs related to death make them feel that the body must be completely intact for burial. Nonmaleficence and beneficence With the obligation to do no harm to others ??? would at first seem to prohibit doctors from operating on perfectly healthy people to remove one of their kidneys, for undoubtedly any operation produces some harm (the cutting itself, the small but inescapable risk of infection, the small risk of complications of surgery including the tiny risk of dying)??? (Gillian, 2011, p. 3). The beneficence side of this argument is that the donated kidney is being a greater benefit to the recipient that outweighs the risk to the donor.

If more people were to become donors than beneficence would apply here because the organ is bringing about a greater good for those who need these organs. There is much controversy over the harvesting of organs from brain dead patients being kept alive on life support. To supporters nonmaleficence applies here because we are doing no harm to the donor because they are already dead. Not everyone holds this same belief and these people feel that taking a beating heart out of the person is causing harm. For these two reasons, some families will donate organs and others will not.

The beneficence side of this argument is that the harvested organs are being used for the greater good of those who need them. If family members do not perceive the benefits of harvesting their loved ones organs, you usually will not get consent. JusticeThe justice and fairness of the allocation system is called into question when economic and value judgments affect who is admitted to waiting lists, and of those admitted who gets the available organs. The pressure to get available organs is getting worse because the

demand for organs outweighs the supply. ??? If transplant centers were to relax their standards to include more people- such as those who lack insurance, have severe intellectual disabilities, older persons, prisoners, illegal aliens, and foreigners who cannot get transplants in their countries- then the list of those waiting could easily triple or quadruple??? (Caplan, 2011, para 7).

??? Justice requires some rule or policy that insures that the supply of donated organs is used wisely and consistently with what donors and their families would wish, such as giving priority to saving children??™s lives, or to American citizens??? (Caplan, 2011, para 7). ConclusionThere is much debate and ethical dilemmas that continue to go on today about transplant allocation. Some of these debates are whether an alcoholic should receive a liver transplant, should we be able to use the organs of a person put to death in prison and should we give older organs to the elderly. ??? The primary ethical dilemmas surrounding organ transplantation arise from the shortage of available organs??? (Centers for Bioethics, 2011, p. 13). ??? Each year, thousands of patients who are on the United Network for Organ Sharing (UNOS) transplant waiting list die, as the number of allografts that become available do not meet the demand??? (Bramstedt, 2006, p.

170). Some patients wait months and years for an organ and because of this they run the risk of further deterioration, which can make them unsuitable for a transplant when an organ becomes available. ReferencesAbouna, G. (2003). Ethical issues in organ transplantation. Medical Principles and Practice, 12, 54-69. Bramstedt, K. (2006).

Is it ethical to prioritize patients for organ allocation according to their values about organ donation. Progress in Transplantation, 16(2), 170-174. Caplan, A. (n.

d.). Organ transplantation. Retrieved from http://www. thehastingscenter. org/publications/briefingbook/detail. aspxid= 2198Center for Bioethics. (n.

d.). Ethics of organ transplantation. Retrieved from http://www. ahc. umn. edu/img/assets/26104/organ_transplantation. pdfFour fundamental ethical principles (a very simple introduction).

(n. d.).

Retrieved from http://www. web. mnstate. edu/gracyk/courses/phil%20115/four_basic_principles. htmlGubernatis, G. &. (2000).

A superior approach to organ allocation and donation. Transplantation, 70(4), 699-702. Morrison, E. (2011).

Ethics in health administration: A practical approach for decision makers. Sudbury, MA: Jones and Bartlett Publishers. New York Organ Donor Network. (n. d.). Transplantation.

Retrieved from http://www. donatelifeny. org/all-about-transplantation/organ-transplant-historySU, X. &. (2004).

Patient choice in kidney allocation: The role of the queueing discipline. Manufacturing & Service Operations Management, 6(4), 280-304. Transplant Living. (n.

d.). Organ, tyoe, and waiting time.

Retrieved from http://www. transplantliving. org/before-the-transplant/about-organ-allocation/waiting-for-an-organUniversity of Missouri. (n. d.).

Organ transplantation. Retrieved from HTTP://www. ethics. missouri. edu/organ-transplantation. aspx