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Association of American Physicians and Surgeons, Inc.
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Omnia pro aegroto

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To the Honorable Sam Thumma, Professor Nita Farahany, Esq.
National Council of Uniform Law Commissioners

Dear Commissioners,

The topic of organ donation typically focuses on the recipient, garnering public approval for the life-saving practice of organ transplant. The donor is often portrayed as heroic or noble for volunteering the use of his body in this way. However, little attention is given to interpretation of criteria used before transplanting organs, potentially resulting in the breech of ethical boundaries. The consent of the donor or surrogate is also seldom discussed. When objections by the donor's family are raised at the time the organ transplant is desired, the family may be treated as being out of touch with reality. A closer look at the trends in organ donation, both in the US and internationally, is needed to safeguard the lives and dignity of donors in the context of a highly profitable industry.

When the Universal Law Commission created the Uniform Determination of Death Act (UDDA) in 1981 it read as follows:

"An individual who has sustained either 1) irreversible cessation of circulatory and respiratory functions, or 2) irreversible cessation of all function of the entire brain, including the brain stem, is dead." [1]

The recent effort to make changes to the standard has raised concern in the context of organ transplantation, where the criteria are currently known to be applied loosely. There has been persistent objection to the use of the neurological brain death diagnosis as an equivalent to cessation of circulatory and respiratory function because it is used inconsistently. Although the criteria appear to provide safeguards, the barriers can be overcome if convenience and timing are more important to the transplant team.

One of the more disturbing twists on application of the standard definition is the procedure referred to as donation after circulatory death. In this procedure, the patient is allowed to "expire", after which the chest is opened. The vessels to the brain are clamped off, causing brain death. The heart is then resuscitated and subsequently removed and transplanted. It is described in detail in an American College of Cardiology article as an "emerging frontier." [2]

The desire to increase the organ transplant donor pool is expressed in medical literature and paints a disturbing picture of an increasingly callous attitude toward vulnerable life. The transplant business is lucrative, and the temptation to hasten the availability of needed organs is evident. Some publication titles alone convey this such as "Heart Transplantation following donation after circulatory death: Expanding the donor pool."[3]

Another troubling development has been the increase in the number of donor patients who are euthanized prior to donation. Euthanasia, or physician assisted death, represents to some physicians another opportunity to increase the number of transplant donors. In his article, "Doctor wants to Harvest Organs from Patients After Euthanizing Them," Alex Schadenberg describes a letter published in JAMA clarifying that people who die by euthanasia will often refuse to participate in organ donation because they prefer to die at home. Dr. Johan Sonneveld outlined in the letter a procedure that is calculated to permit organ donation after allowing the patient to die at home.[4]

The experience with euthanasia in Canada has revealed that some patients are pressured into making the decision to be euthanized and then donate their organs as a noble act for society. In an article in LifeSite, John Smeaton, chief executive of the UK-based Society for the Protection of Unborn Children, is quoted as saying "there is growing evidence that coercion plays a substantial role for many vulnerable people with regards to so called physician-assisted death. Conflating this decision with organ donation further complicates the issue of coercion." Euthanasia deaths accounted for five percent of all of Ontario's overall organ and tissue donation in 2019. In 2017 it was 2.1 percent.[5]

An important question we need to ask is why the Uniform Law Commission seeks to eliminate the diverse perspectives of ethical issues in the cultures of different states. While standards are important, there may be good reason to allow for differences. Truog laments the threat of having different state laws on determination of death:

> [S]ome states could choose to entirely eliminate the determination of death by neurologic criteria. The impact would be 2-fold: in those states it would no longer be permissible to procure transplantable organs from patients diagnosed with brain death and physicians could be required to provide intensive care unit beds and life support to patients who will never regain consciousness. Such an outcome could have disastrous consequences for our existing systems of organ procurement and transplantation, leading to thousands of otherwise avoidable deaths.[6]

It appears that Truog believes the lives of recipients count but those of the donors do not.

The reliability of the irreversible absence of the function of circulatory and respiratory systems as a criterion for defining death engendered a measure of stability for the task of making a determination of death. The uncertainty introduced by using neurological criteria has served the organ transplant business almost exclusively and has created public mistrust of the medical profession's integrity. AAPS has defended life from conception to natural death and rejected

the temptation for physicians to step in to induce death for any reason. The definition of death that best aligns with AAPS principles is the standard of irreversible cessation of respiratory and circulatory function. The Commission, considering its broad influence on the laws of this nation, should take into consideration the severe consequences of moving boundaries that protect life.

Sincerely,

Sheila Page, DO
President, Association of American Physicians and Surgeons

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