



The Physician and Living Donation

Task Force on Clinical Ethics: Report

Adopted by the Board of Directors, March 25, 2011

Introduction

With transplant medicine having, in a certain fashion, become a victim of its own success, the living donation now appears to be another solution to the widespread problem of organ shortage. In Québec, living donations remain relatively few in number. As elsewhere, however, such donations are becoming more common and taking new forms where the links between donors and recipients are manifesting themselves differently.

In November 2007, the Collège des médecins du Québec (CMQ) task force on medical ethics was entrusted with a mandate from the order's Board of Directors to reflect on living donation. The present document is the end-product of the work done by the members of the task force between September 2009 and September 2010. Dr. Marie-Chantal Fortin, a nephrologist with CHUM's Transplant Department and bioethicist whose doctorate focused on altruistic donations, was invited to participate in the exercise. Dr. Fortin served as a tremendous asset in contributing her extensive experience and expertise in this area to the reflections of this advisory group.

The subject of living donations raises a number of questions from a moral standpoint. The task force has decided to address one of these in particular, virtually by necessity given the mission of the CMQ. What happens to medical ethics with living donations? To what extent can a physician agree to collaborate in an intervention at risk of compromising the well-being of a healthy person? Even if it is a matter of enabling another person to survive, these questions should be asked and are rarely addressed as such. For the time being in Québec, the answer to the query is left to the discretion of medical teams working in the field.

In the literature on living donations, there is a consensus affirming that they pose a problem for physicians from a professional ethics perspective. In accordance with the *Primum non nocere* (*First, do no harm*) principle attributed to Hippocrates, the physician must never put an individual at risk, unless it is in that person's interest. Until recently, little has been done about this problem, but, more and more publications today are devoted to this specific issue.

Of course, this document makes reference to authors who have focused on this particular aspect of living donations. It also borrows from the reflections of other groups and those already conducted by the task force itself, including on appropriate care and the decision making process. Inspired by these sources, the document proposes a relatively new way of looking at things such that medical ethics and living donations are no longer incompatible. It will, nevertheless, begin with a brief history of living donations, which is essential to gaining a better understanding of the complex questions they raise, as well as to pursuing the reflection on potential answers from the standpoint of the professional ethics of physicians.

1. Living Donations

History and Evolution

While often forgotten, the practice of living donations has existed for a very long time. In fact, the first successful transplants originated from living donations among identical twins. Indeed, it is quite understandable that twins were the most compatible subjects from an immunological perspective, in addition to being linked on an affective level.

Since the 1960s, however, living donations have been largely displaced by so-called “cadaveric” donations — organ donations subsequent to the death of the donor. In that regard, the newly acquired notion of brain death helped curb a certain feeling of uneasiness and allowed us to, in fact, consider the donor to be dead at the time of their organ’s removal in aid of another person. In our culture at least, cadaveric donations appeared to pose fewer problems than living donations, particularly from a moral point of view. That is how transplant medicine was able to advance... to the point of becoming a victim of its own success. Effectively, with the indications for transplant continuing to grow while the number of potential donors does not, the waiting list of recipients is getting longer and longer.

This widespread organ shortage is resulting in a rapid increase in living donations, especially in view of the fact that they present fewer and fewer risks from a medical standpoint and that surgical techniques continue to evolve. Kidneys, for example, can be removed by laparoscopy¹. Even if the donor and the recipient are not related, living donations seems to offer better results than cadaveric donations².

Living donations continue to develop, and they are doing so in various new forms. The number of such donations is on the rise among people who are related affectively, among spouses, or among friends for instance. In order to proceed, even if the event donors and recipients are incompatible, exchange organ transplants are now being organized. Moreover, while the phenomenon remains marginal, we are seeing an increasing number of so-called “altruistic” donations, which are essentially non-directed and anonymous, with the donors and recipients having no other link than the donation itself. Finally, there is what we call transplant tourism and organ trafficking, which are unfortunately on the rise as well.

¹ In a recent JAMA article, basing themselves on an extensive American study, Segev et al. concluded that kidney donation does not lead to death at a younger age, which seems to be the consensus among observers. However, observers generally agree that the risks of morbidity, particularly in the long-term and among patients at risk, are more difficult to evaluate. Although not exhaustive with respect to this subject, the table in Appendix 2 presents an approximation of the medical risks related to the donation of a kidney.

² This is the conclusion of many observers, whether they are the authors of fairly recent monographs or relatively recent articles comparing success rates.

Types of Living Donations

There are currently several types of living donations³. Generally, “related donors” are donors who are related either genetically, affectively, or both. However, some people occasionally wish to donate a kidney to a loved one but are unable to do so because of some major blood or tissue incompatibility. In that case, another incompatible donor/recipient pair must be found with whom there could be compatibility via exchange of recipients. These are known as “living donor paired exchanges”. There are presently four types of possible exchanges — exchanges among living donor/recipient pairs, exchanges among several living donor/recipient pairs, exchanges involving a cadaveric donation, and chain exchanges (including an altruistic donor, an incompatible donor/recipient pair, and a person on a waiting list for cadaveric donation)⁴. The more donor/recipient pairs participating at these exchanges and entered on a register, the better the chances of successful transplants.

It is important to properly distinguish these different types of donations because they raise slightly different moral issues. These issues have, in turn, given rise to a number of attempts to establish frameworks to more or less formally govern the practices that surround them.

Existing Framework Governing Living Donations, Particularly in Québec

The current situation with respect to the governance of living donation practices in Québec is not easy to understand. A certain type of framework is in the process of being established for exchange donations, while, in April 2009, Canadian Blood Services inaugurated a Living Donor Paired Exchange Registry, in which Québec intends to participate. For all other practices, however, the governing framework remains minimal, at least to our knowledge. Québec-Transplant has had a registry for all living donations made in the province for a long time, but the organization’s official mandate has been limited to cadaveric donations to date.

This situation is not unique to Québec and is easily explainable. Contrary to cadaveric donations, which quickly required systematic organization in order to centralize organs and allocate them correctly, living donations have been quite able to develop without such coordination. Until anonymous non-directed and paired exchange donations made their appearance quite recently, donations were organized at centres on a strictly local basis.

³ The following definitions are borrowed from the document entitled *Le don et la transplantation d'organes par échanges: considérations éthiques sur une nouvelle option*, prepared by the Commission de l'éthique de la science et de la technologie (CEST) in 2006. They appear to be the subject of a large consensus.

⁴ See Appendix 1 for illustrations of these four exchange types.

These exchanges are most often deemed as private exchanges, in the same way as everyday clinical interventions⁵.

Given this historical perspective, we understand the importance still placed on the professional ethics of physicians as the governing framework for these exchanges. However, we can also see the paradox we are confronted with. Upon first glance, at least, the very logic of living donations runs counter to the professional ethics of physicians in clinical situations, which generally prohibit them from putting a patient at risk in the interests of a third party.

Finally, the implementation of a more formal framework for the new types of living donations does not diminish the need for profound reflection on the practice. On the contrary, it highlights the critical importance to refocus on its most elementary forms. Even though there is just one donor and one recipient, living donations already pose major problems from a medical ethics standpoint.

2. Living Donations and Medical Ethics

One could effectively think that agreeing to one patient taking risks in the interests of another runs counter to the very logic of clinical medicine and the professional ethics of physicians. *A fortiori* if the patient in question is not ill but healthy. This is why most observers have arrived at the same troubling conclusion — living donations seem to contradict medical ethics, at least the professional ethics of physicians in clinical situations⁶.

A Unique Situation and Untenable Position for Physicians?

The professional ethics of physicians are very clear, as much in Québec as anywhere else. The rules of conduct call doctors first and foremost to defend the interests of their patients with respect to their health rather than their own interests or those of a third party. Section 60 of the Code of Ethics of Québec Physicians even stipulates the following:

A physician must refuse to collaborate or participate in any medical act not in the patient's interest as it pertains to his health.

⁵ We will see that this distinction between private or public exchanges established by David Price is interesting for the purposes of addressing the question of living donations and medical ethics.

⁶ In a very brief article, Norman B. Levinsky offers a good summary of the problem, which is raised by most people concerned with living donations.

Of course, it could be argued that this ethical stipulation is not absolute and already allows for exceptions. Certain specific contexts do indeed demand a reassessment of this regulation, particularly in the case of physicians taking part in research projects. In a clinical context, it is an individual's well-being that counts, and physicians are obliged to ensure that they act accordingly. On the other hand, the ethics of research rest on a person agreeing to take certain risks to allow for the acquisition of new knowledge for the common good. One way of reconciling these two somewhat contradictory objectives in clinical research is via the consent of patients, who must agree in full knowledge of the cause. Another way is to allow ethics committees, and not physicians, to judge the pertinence of the research⁷.

Will the logic of living donations ever take after that of clinical research? That could be envisaged, and our reflections could be steered in this direction — insist on the consent and protection of donors and assign physicians the responsibility of protecting them. With that perspective in mind, doctors need to judge not only the quality of donor consent, but also the appropriateness of the exchange.

Even more than the research activity, living donations could put physicians in a difficult position by obliging them to bear the heavy burden of an extremely difficult decision. They would be the ones who have to assure that the benefits for the recipient outweigh the risks for the donor. No wonder that the majority of those who have studied this problem have concluded that physicians should proceed only if the risks for donors are minimal, the benefits for recipients very significant, and if there are no other alternatives⁸. Some even come to the conclusion that, in the case of liver transplants at least, this type of exchanges is always too risky and that we should, therefore, continue to favour cadaveric donations⁹.

The Particularity: Not One, But at Least Two Patients, One of Whom is Healthy

Fortunately, this affirmation has prompted some to push the reflection even further¹⁰. Where does the difficulty actually stem from? Does it reside in the need to compare the benefits and risks? Within a clinical context, physicians are constantly reasoning by measuring the foreseeable risks and benefits of their interventions. They then proceed only if the anticipated benefits for the patient outweigh the risks, which is often the case in the clinical setting because the patients are generally ill. When the patient's condition warrants care and treatment, physicians simply choose what they think to be the most appropriate course of action, and they discuss this with the patient and their loved ones. The search for this balance between risks and benefits is at the very heart of clinical

⁷ The practice guide entitled *Le médecin et la recherche clinique*, addresses these subjects in greater detail.

⁸ The argument developed by David Price is very clear in this regard.

⁹ This is the opinion supported by Klintman and Lake, for example, for whom living donations pose a problem with respect to liver transplants in particular.

¹⁰ Among them, it is important to cite Aaron Spital, a number of whose articles are listed in the bibliography. He was the primary inspiration for much of the argument developed in this section.

practice and the professional ethics of physicians. For moral agents who must decide and act, the search for the best balance between risks and benefits of planned interventions is recognized as the preferred approach (beneficence, nonmaleficence). Therefore, the problem does not lie there.

Rather, the difficulty arises from the fact that these situations involve not only one, but two patients, one of whom is in relatively good health. Physicians normally measure the risks and benefits of interventions for a single, most often ill, patient. They proceed only if the anticipated benefits for this patient are greater than the risks. In the case of a living donation, however, two patients are concerned. Thus, what are we really talking about when we refer to risks and benefits? Are we talking about the risks for one person and the benefits for another one?

A Situation That Will Never be Simple

It is true that the donor seems to be taking all the risks in such situations, while the recipient only has benefits to gain from the exchange. However, is this really the case?

Donors do effectively take certain risks with a living donation, particularly the risk of experiencing some medical complications. However, there are fewer and fewer medical complications today thanks to technological advances. At the same time, we see that, in the case of related donations, donors often draw significant benefits from the exchange — especially psychological benefits in terms of enhanced self-esteem. So we can think that donors achieve a sense of balance for themselves, readily capable of justifying their willingness to participate in the exchange. In fact, several studies have shown that most of the time, related donors have no difficulty to make their choice and that they don't have any regrets whatever happens.

As for recipients, they clearly have benefits to draw from this type of exchange, getting the chance to enjoy a longer and higher quality of life. It is wrong, however, to think that recipients assume no risk at all. Some studies have shown that they run risks from a psychological standpoint. When donors and recipients are related in particular, already powerful affective links come into play. Any recipient should be aware of the moral implication that a living donation represents. In fact, some recipients prefer to wait for a cadaveric donation to avoid having to assume such a heavy debt that they consider impossible to pay off.

Thus, in the case of a living donation, we are no longer facing a typical two-dimensional clinical picture involving risks and benefits for a single patient. Instead, there are four factors at play — the risks and benefits, and the donor and recipient¹¹. In fact, there are

¹¹ See the illustration in Appendix 2.

risks and benefits for each of the individuals concerned, and they both must decide for themselves what an acceptable balance is.

Moreover, there is yet another dimension to consider — that of the physician, or more generally, of anyone that plays a role in the intervention. Those that intervene are not only mandatory players in these situations, but also moral agents responsible for their actions. In this role, physicians must not only advise the donor and recipient of the benefits and risks, but they must also decide whether or not they agree to take part in interventions that involve such benefits and risks. In the grand scheme of things, the doctor remains completely liable, but decision making responsibilities are shared by all players.

A Truncated View

A picture is often worth a thousand words. Juxtaposing only the risks for the donor and the benefits for the recipient demonstrates a truncated view of these situations. By focusing too much on the risks incurred by donors and the benefits drawn by recipients, we end up with an abstraction of the benefits for the donors and the risks for the recipients, which have its repercussions.

From that perspective, the balancing of benefits and risks quickly translates into conflicts of allegiance for the caregivers involved. To avoid these conflicts, which they consider inherent to such situations, many propose the separation of caregiving teams, assigning one to the donor and another interdependent of the first to the recipient¹². Others suggest naming a “representative” to protect the donor¹³. While these measures may be interesting, are they really applicable? Even if they were applicable, someone somewhere will have to judge the acceptability of the exchange. Who should that be? Who could pretend to know if the benefit for the recipient makes the risk for the donor worth it?

A New Situation and New Perspective

The members of the task force are in agreement with those who propose the adoption of a broader vision. Clinical logic could very well apply to living donations. However, that is conditional upon the recognition that there are at least two patients and an entire intervention team involved in these situations. All these players have to balance risks and benefits that are not always evident. Each has to assume his/her share of the responsibility in the decisions. Indeed, as soon as the perspective broadens to include the benefits, risks and all the players concerned, it becomes clear that there are many types of decisions to be made in these situations. All decisions cannot rest on the physician's shoulders alone. Before concluding that there is a conflict of allegiance for physicians, we must know at least who is responsible for what.

¹² This proposal is well explained in the article by Linda Wright et al.

¹³ In its document about living donations, the Canadian Council for Donation and Transplantation proposes both recommendations — naming a representative and separating the teams.

This new perspective corresponds entirely with what the task force drew from its previous work on appropriate care — whatever the clinical situation, it turns out that the care is more appropriate when the decision making process has been properly carried out¹⁴. The living donation certainly constitutes one of the most complex clinical situations. Nevertheless, the grid developed to get a better understanding of the decision making process in clinical situations could be very applicable, if we distinguish the various players participating in the process and their individual ways of gauging the benefits and risks. The picture is never simple when it comes to living donations but it is worth to be analysed more carefully.

This new perspective allows for a better understanding of the position of each individual involved in living donations — donors, recipients, and those who accompany them. It also enables us to make a better distinction between the moral issues physicians are confronted with, as well as those faced by donors, recipients, and all the other social players involved in organ donation and transplant medicine. The new perspective allows us to specify their respective responsibilities, and in so doing, to identify the moral issues to which they must respond. It also enables us to understand the importance of interdisciplinary collaboration with respect to living donations. Given the extreme significance of psychological and social factors for both donors and recipients, the teams must possess the resources capable of properly evaluating these aspects. These may be overlooked by strictly medical expertise.

At the same time, the new perspective makes it possible to avoid certain pitfalls, such as placing undue importance on donor consent, which is purely theoretical if the risks the donor should take are ultimately assessed by others. Another stumbling block is wanting to scrutinize and judge the deep-seated motivations of donors, especially those of unrelated donors, who often cause us to wonder whether or not there is some underlying factor like a psychological disorder or financial motive that, rather than altruism, would explain their wish to donate. As such, it enables us to be less apprehensive in coming to grips with new forms of living donations.

This approach could be more fruitful than the various measures proposed to achieve similar objectives. As mentioned, there have been numerous recommendations that there be two separate teams in all cases of living donations — one for the donor and the other for the recipient. Within the context of the broader new perspective, the teams must, first and foremost, have a clearer idea of their responsibilities, to be able to support all the players in the best way possible with the resources available. Finally, the task force believes that we could look at many other examples among all the problems associated with living donations and, by applying the same analytic framework, find realistic solutions.

¹⁴ See the task force report entitled *Pour des soins appropriés au début, tout au long et en fin de vie*, available in French only, or the paper entitled *Physicians, Appropriate Care and the Debate on Euthanasia*, A reflection which has been drawn from the task force report and accepted by the board of directors.

It is important to clarify one important point, however. The fact that we have a broader perspective does not mean that everything becomes acceptable for physicians. It is very possible that the majority of doctors concerned only agree to proceed if the risks for donors are minimal, the benefits for the recipient are clear, and there are no alternatives — which would be quite understandable. In actual fact, this perspective is not entirely new. It obliges physicians and the other intervening parties to make decisions that respect their professional ethics. However, it obliges them to do so while taking the complete clinical picture into account, as well as all of the players involved.

In summary, the living donation undeniably poses a particular problem with respect to the professional ethics of physicians in clinical situations. No matter how minimal the risk may be for donors, they are nevertheless living persons who are generally in good health and are putting themselves in danger on behalf of someone else. At first glance, the donor takes the risks with a living donation and the recipient is receiving all the benefits. After closer examination, however, we can see that the physician is not alone in having to cope with such a dilemma. Living donations are particular in that they involve several different players and each player is unique. Thus, for every clinical situation, there are different balances to be found and coordinated. Each of these situations demands a certain openness of mind and healthy dose of reflection on the part of all players involved.

3. A Social Ethic for Living Donations

While the living donation actively involves all players in the clinical situation, the personal ethics of the donors and recipients and the professional ethics of the interveners will not be sufficient to meet all the challenges. The living donation is a complex phenomenon that raises numerous questions from both a scientific and a moral standpoint. These questions concern all the social players, and we would be ill-advised to avoid them just because they are difficult. To what length as a society are we prepared to go to counter organ shortage and ultimately defy death? Those who ask this fundamental question are doing the right thing: it should always be in the back of our minds, even when we are determined to promote organ donation in general and living donation in particular¹⁵.

However, all of this complexity must not discourage discussion... on the contrary. The fact that we have determined how medical ethics in clinical situations can apply to living donations in spite of the initial difficulty is certainly reassuring and serves to motivate us to push our reflection even further.

¹⁵ This question was returned to the agenda by sociologist Renée Fox and anthropologist Judith Swazey.

The Complexity and Uncertainty of Organ Donation

By necessity, organ donation and transplant medicine are complex phenomena. In fact, the fascinating nature of these phenomena can sometimes hinder our recognition of just how complex they are. It is easy to overlook the vast diversity of exchanges and practices they encompass, as well as the multiplicity of players involved. However, these factors were not neglected by authors who analyzed the phenomena in an even broader than simply clinical perspective¹⁶.

From a sociological point of view, it is easy to see that organ donation and transplant medicine developed and continues to evolve based on several different logics. The logic of physicians and other interveners is not necessarily that of patients, nor of organizations responsible for the allocation of organs. Indeed, donation systems are composed of different players with specific ethics. The challenge for society is to assure a certain coherence while respecting these necessarily different logics¹⁷.

From that perspective, it is also clear that transplant medicine remains an endeavour that offers benefits but also encompasses risks and major areas of uncertainty — thus the importance of prudence. There are, in fact, practical means of remaining prudent without closing the door to progress. Success in this regard demands the proper documentation of problems.

All practices related to organ donation are not necessarily new. Overall, the fact remains that transplant medicine is not a standard clinical practice where we can easily measure the benefits and risks. It is a practice that calls for the collective gathering of data to be able to follow its evolution and readjust our actions¹⁸. This is not to say that a research project, which must be carefully controlled, is always needed. However, it is absolutely essential that data concerning these interventions be gathered in order to be able to analyze and extract validated information. From therein stemmed the widespread idea of creating a central registry even when the interventions remain local, and *a fortiori*, for exchange donations. Numerous observers support this idea¹⁹, which the members of the group consider to be effectively essential.

On the other hand, the centralization of data should not lead to the imposition of a general logic that curbs the various logics already at work. As was the case for clinical aspects, the objective here is, rather, to know how to reconcile these different logics. As such, the

¹⁶ In the case of organ donation, we often refer to sociologists who have studied the broad notion of “donation”. However, some of them have examined the social practices surrounding organ donation, including Nora Machado in Sweden and Fox and Swazey in the U.S. In fact, these two authors had a long history of participating on care giving teams before setting their highly critical sights on organ donation.

¹⁷ We are referring here to the analyses of Nora Machado.

¹⁸ This passage refers once again to the work of Fox and Swazey.

¹⁹ See, for example, the articles by Feng and Friedman Ross et al.

challenge is to find a certain general logic without imposing a whole regulatory system and without tightly controlling all living donations. When the exchanges remain private between related people, for example, it is probably sufficient to standardize practices so that they respect this overall logic. If the exchanges involve several people and various centres, there is a need for a slightly more organized system, if only to assure the equity of exchanges.

The Difficult Question of Commercialization

On top of that and from a social perspective, transplant medicine is a costly enterprise that can clearly challenge the principle of justice especially since living donations put the emphasis on the delicate question of free donation.

Although it did not focus on this particular problem, the task force noted that transplantation tourism is effectively on the rise and organ trafficking is indeed a reality even though it is prohibited in virtually every part of the world. Hence, the numerous efforts to curb the practice nationally and globally, primarily on the legal level. The task force does believe that transplantation tourism and organ trafficking are unacceptable drifts. However, it sees the proposal of a general logic for organ donation that is likely to rally the different social players, including doctors, as another way of combating these phenomena. This is, nevertheless, a formidable challenge because it calls for knowing how to promote organ donation in general and living donations in particular, while imposing certain limits on what is and is not acceptable in a given society. Of course, these limits are not always easy to establish²⁰.

A Societal Ethic

Rather than expressing an opinion on the precise form of control that would be most appropriate for living donations, which would overstep its mandate in any case, the task force prefers to insist on the ethics to be promoted for living donations among the population and physicians. Like various other observers, the members are of the opinion that the general logic to propose for living donations should draw its inspiration from cadaveric donation systems, which, for the most part, are based on social solidarity. Whether its governing framework is more or less formalized, all organ donation is fundamentally a social exchange. In fact, the most complex forms of living donations seem easier to control than simpler forms because they more clearly resemble cadaveric donations with which we are more familiar. As we have seen, though, every donation calls for the generosity of the people directly involved and the collaboration of numerous other social players.

²⁰ The paper produced by the task force in 2007 on the conduct expected of Québec physicians with respect to patients involved in organ transplants abroad testifies to this difficulty. This sub-question alone necessitated a long discussion. Entitled *La conduite des médecins face à des patients ayant subi ou devant subir une transplantation d'organe à l'étranger*, this paper is available on the CMQ web site.

Again, neither the choice of social solidarity, nor the gathering of information or standardization of practices calls for excessive centralization and control of all procedures. In that sense, it would be possible to say yes as a society to a central registry of living donations, but no to committees of experts such as those that exist in certain places to authorize all living donation cases²¹. It would be possible to say yes to standardized procedures, without going into all the details like knowing whether two independent teams are absolutely required. We could say yes to a central assignment system for certain forms of living donations that works in collaboration with local authorities, as is already the case for cadaveric donations. Most importantly, we could say no to commercialization and encourage solidarity, even when the exchanges remain to a certain degree private.

An approach based on solidarity and self-regulation seems more promising to the task force than an overly restrictive approach. For physicians, at least, the living donation goes beyond standard clinical practices. Thus, they must remain prudent. They must thoroughly collect and analyze the data to be able to progressively adjust their practices to the logic and the objectives that society will wish to adopt in this regard.

Conclusion

For the task force, living donation, even in its most elementary form between related persons, gives rise to a new challenge from a medical ethics standpoint. Upon termination of the reflection process, the members of the group believe that there are several interesting ways of meeting this challenge. As soon as we see each player in the clinical situation as a moral agent responsible for their choices, medical logic in clinical situations can very well apply to living donations and to the new forms under which this practice is currently developing. Living donation can indeed be acceptable from a medical ethics viewpoint. However, it demands certain moral points of reference and a healthy dose of reflection on the part of physicians, patients and other social players.

In conclusion, the task force hereby recommends that the Collège des médecins du Québec:

- Distribute this report to physicians in order to encourage their own reflection on medical ethics and living donations.
- Contribute to the development of a social ethic capable of supporting living donations with their benefits and their limits.
- Support the official creation of a registry of all living donations carried out in Québec.
- Support the establishment of a more formal framework for paired exchange living donations.
- Within the scope of the order's mandate, support efforts aimed at curbing the commercialization and trafficking of organs.

²¹ We are making a reference here primarily to the prevailing situation in France.

Bibliography

- Abecassis, M. et al. — "Consensus statement on the live organ donor". — *JAMA*. — Vol. 284, n° 22 (Dec. 13, 2000). — P. 2919-2926
- Baskin, J.H. — "Giving until it hurts?: altruistic donation of solid organs". — *Journal of the American Academy of Psychiatry and the Law*. — Vol. 37, n° 3 (2009). — P. 377-379
- Brown, J.B. et al. — "The experience of living kidney donors". — *Health and Social Work*. — Vol. 33, n° 2 (May 2008). — P. 93-100
- Broyer, M. — "Aspects éthiques de la transplantation avec donneur vivant apparenté ou non apparenté". — *Archives de pédiatrie*. — Vol. 9, suppl. 1 (avril 2002). — P. 38s-42s
- Canadian Council for Donation and Transplantation. — *Enhancing living donation: a canadian forum: report and recommendations*. — February 9-12, 2006, Vancouver, C-B. — Edmonton, AB : the Council, Oct. 2006. — 113 p. — ISBN 0-9738718-8-1. — [En ligne]. — http://www.ccdt.ca/english/publications/final-pdfs/Enhancing_Living_Donation_Final.pdf
- Canadian Medical Association. — *Organ and tissue donation and transplantation*. — Ottawa: the Association, update 2000. — 5 p. — [En ligne]. — <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD00-07.pdf>
- Casagrande, A. — "Peut-on parler d'un libre arbitre du donneur vivant?" — *Néphrologie et Thérapeutique*. — Vol. 4, n° 1 (févr. 2008). — P. 55-57
- Cochat, P.; Badet, L. — "Le donneur vivant en transplantation rénale pédiatrique". — *Néphrologie et Thérapeutique*. — Vol. 4, n° 1 (févr. 2008). — P. 77-80
- Collège des médecins du Québec. — *Le médecin et la recherche clinique : guide d'exercice*. — Montréal : le Collège, juil. 2007. — 38 p. — ISBN 978-2-920548-55-8. — [En ligne]. — http://www.cmq.org/fr/MedecinsMembres/Profil/Commun/AProposOrdre/Publications/~media/4AB42010D87E42DB90C0C33AB84DB6B5.ashx?sc_lang=fr-CA&61121
- Id. — *Physicians, appropriate care and the debate on euthanasia: a reflection*. — Montréal: the College, Oct. 2009. — 7 p. — [En ligne]. — http://www.cmq.org/en/MedecinsMembres/Profil/Commun/AProposOrdre/Publications/~media/208E2B537FB144FAAE33DEB458D3AA90.ashx?sc_lang=en&61128
- Id. — Pour des soins appropriés au début, tout au long et en fin de vie : rapport du groupe de travail en éthique clinique. — Montréal : le Collège, oct. 2008. — 50 p. — [En ligne]. — http://www.cmq.org/fr/medecinsmembres/profil/commun/aproposordre/publications/~media/0870A1B4D7EB45E685339190AB340015.ashx?sc_lang=fr-CA&61121
- Commission de l'éthique de la science et de la technologie. — *Le don et la transplantation d'organes : dilemmes éthiques en contexte de pénurie : avis*. — Québec, QC : Gouvernement du Québec, 2004. — 107 p. — ISBN 2-550-43415-3. — [En ligne] — http://www.ethique.gouv.qc.ca/index.php?option=com_docman&task=doc_download&gid=8&Itemid=102
- Id. — *Le don et la transplantation d'organes par échanges : considérations éthiques sur une nouvelle option*. — Supplément 2006 à l'avis Le don et la transplantation d'organes : dilemmes éthiques en contexte de pénurie. — Québec : la Commission, 2006. — 35 p. — ISBN web 2-550-48382-0. — [En ligne]. — http://www.ethique.gouv.qc.ca/index.php?option=com_docman&task=doc_download&gid=49&Itemid=68

- Davis, F.D.; Crowe, S.J. — "Organ markets and the ends of medicine". — *Journal of Medicine and Philosophy*. — Vol. 34, n° 6 (Dec. 2009). — P. 586-605
- DeMarco, J.P. — "In defense of live kidney donation". — *American Journal of Bioethics*. — Vol. 4, n° 4 (Fall 2004). — P. 33-35
- DuBois, J.M. — "Is living organ donation ethically acceptable?" — *Health Care Ethics USA*. — Vol. 10, n° 2 (2002). — P.E1
- Feng, S. — "Donor intervention and organ preservation: where is the science and what are the obstacles?" — *American Journal of Transplantation*. — Vol. 10, n° 5 (May 2010). — P. 1155-1162
- Fortin, M.-C. — *Les représentations de transplantateurs autour de la question du don altruiste dans deux contextes culturels : entretiens avec des médecins transplantateurs français et québécois*. — Thèse présentée à la Faculté de médecine de l'Université de Montréal en vue de l'obtention du grade de Ph.D. en sciences biomédicales (bioéthique). — Montréal, 2007. — 245 p.
- Fox, R.C. — *Spare parts : organ replacement in American Society*. — New York: Oxford University Press, 1992. — 254 p. — ISBN 0195076508
- Garwood-Gowers, A. — *Living donor organ transplantation: key legal and ethical issues*. — Brookfield, Vt.: Ashgate/Dartmouth, 1999. — 222 p. — ISBN 0754620298
- General Medical Council. — *Transplantation of organs from live donors*. — London: the Council, Nov. 1992. — 2 p.
- Gruessner, R.W.G.; Benedetti, E. — *Living donor organ transplantation*. — New York: McGraw-Hill Medical, 2008. — 791 p. — ISBN 9780071455497
- Hadjianastassiou, V.G. et al. — "2509 living donor nephrectomies, morbidity and mortality, including the UK introduction of laparoscopic donor surgery". — *American Journal of Transplantation*. — Vol. 7, n° 11 (Nov. 2007). — P. 2532-2537
- Hanto, D.W. — "Ethical challenges posed by the solicitation of deceased and living organ donors". — *New England Journal of Medicine*. — Vol. 356, n° 10 (March 8, 2007). — P. 1062-1066
- Hilhorst, M.T.; Kranenburg, L.W. ; Busschbach, J.J. — "Should health care professionals encourage living kidney donation?" — *Medicine, Health Care and Philosophy*. — Vol. 10, n° 1 (March 2007). — P. 81-90
- Ingelfinger, J.R. — "Risks and benefits to the living donor". — *New England Journal of Medicine*. — Vol. 353, n° 5 (Aug. 4, 2005). — P. 447-449
- Institute of Medicine. Committee on Increasing Rates of Organ Donation. — "Ethical considerations in living donation". — *Organ donation: opportunities for action*. — Washington, D.C.: National Academies Press, 2006. — ISBN 030910114X. — P. 263-280
- Kessler, M. — "Aspects juridiques et réglementaires de la transplantation rénale avec donneur vivant". — *Néphrologie et thérapeutique*. — Vol. 4, n° 1 (févr. 2008). — P. 49-51
- Klintmalm, G.B. — "Primum non nocere". — *American Journal of Transplantation*. — Vol. 8, n° 2 (Feb. 2008). — P. 275-276
- Levinsky, N.G. — "Organ donation by unrelated donors". — *New England Journal of Medicine*. — Vol. 343, n° 6 (Aug. 10, 2000). — P. 430-432
- Machado, N. — *Using the bodies of the dead: legal, ethical, and organisational dimensions of organ transplantation*. — Brookfield, VT: Ashgate/Dartmouth, 1998. — 262 p. — ISBN 1855219735

- Manyalich, M. et al. — "EULID project: European living donation and public health". — *Transplantation Proceedings*. — Vol. 41, n° 6 (July-Aug. 2009). — P. 2021-2024
- Price, D. — *Legal and ethical aspects of organ transplantation*. — New York : Cambridge University Press, 2000. — 487 p. — ISBN 0521651646
- Ross, L.F. — "What the medical excuse teaches us about the potential living donor as patient". — *American Journal of Transplantation*. — Vol. 10, n° 4 (April 2010). — P. 731-736
- Ross, L.F.; Siegler, M.; Thistlethwaite, J.R. — "We need a registry of living kidney donors". — *Hastings Center Report*. — Vol. 37, n° 6 (Nov-Dec. 2007). — P. 49
- Schold, J.D.; Kaplan, B. — "The elephant in the room : failings of current clinical endpoints in kidney transplantation". — *American Journal of Transplantation*. — Vol. 10, n° 5 (May 2010). — P. 1163-1166
- Segev, D.L. et al. — "Perioperative mortality and long-term survival following live kidney donation". — *JAMA*. — Vol. 303, n° 10 (March 10, 2010). — P. 959-966
- Spital, A. — "Donor benefit is the key to justified living organ donation". — *Cambridge Quarterly of Healthcare Ethics*. — Vol. 13, n° 1 (Winter 2004). — P. 105-109
- Id. — "Ethical issues in living organ donation : donor autonomy and beyond". — *American Journal of Kidney Diseases*. — Vol. 38, n° 1 (July 2001). — P. 189-195
- Id. — "Ethical issues in living related donors". — *Advances in Bioethics*. — Vol. 7 (2001). — P. 89-123
- Id. — "Living organ donation. Shifting responsibility". — *Archives of Internal Medicine*. — Vol. 151, n° 2 (Feb. 1991). — P. 234-235
- Spital, A.; Taylor, J.S. — "Living organ donation: always ethically complex". — *Clinical Journal of the American Society of Nephrology*. — Vol. 2, n° 2 (March 2007). — P. 203-204
- Steinbrook, R. — "Public solicitation of organ donors". — *New England Journal of Medicine*. — Vol. 353, n° 5 (Aug. 4, 2005). — P. 441-444
- Truog, R.D. — "The ethics of organ donation by living donors". — *New England Journal of Medicine*. — Vol. 353, n° 5 (Aug. 4, 2005). — P. 444-446
- Veatch, R.M. — *Transplantation ethics*. — Washington, D.C.; Georgetown University Press, 2000. — 427 p. — ISBN 0878408118
- World Health Organization. — *Human organ and tissue transplantation: report by the Secretariat*. — Genève: WHO, March 26, 2009. — 14 p.
- World Medical Association. — *WMA statement on human organ donation and transplantation*. — [Ferney-Voltaire, Fr]: the Association, Oct. 2006. — 7 p. — [En ligne]. — [http://www.wma.net/en/30publications/10policies/t7/index.html.pdf?print-media-type&footer-right=\[page\]/\[toPage\]](http://www.wma.net/en/30publications/10policies/t7/index.html.pdf?print-media-type&footer-right=[page]/[toPage])
- Wright, L. et al. — "Ethical guidelines for the evaluation of living organ donors". — *Canadian Journal of Surgery*. — Vol. 47, n° 6 (Dec. 2004). — P. 408-413

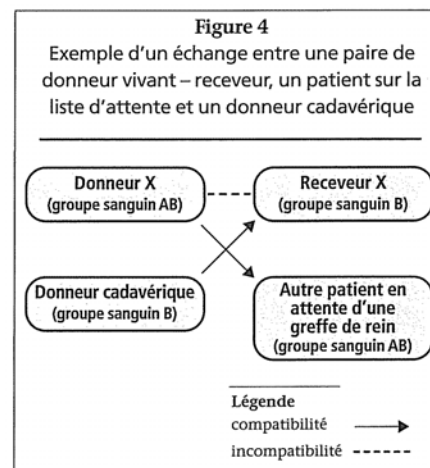
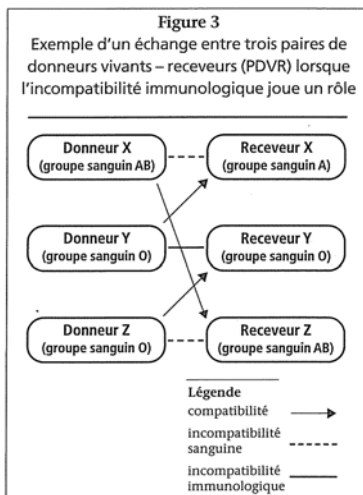
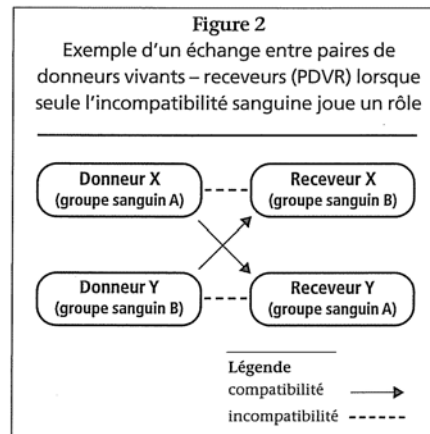
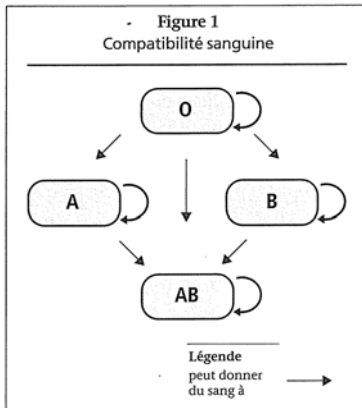
SUPPLÉMENT 2006

À l'avis
Le don et la transplantation d'organes :
dilemmes éthiques en contexte de pénurie

Le don et la transplantation d'organes par échanges :

considérations éthiques sur une nouvelle option

Section 1 – Les différentes formes de don et de la transplantation d'organes par échanges



L'INTERVENANT

	LE DONNEUR	LE RECEVEUR
LES RISQUES	<p>Risques médicaux (pour le rein) :</p> <ul style="list-style-type: none"> - Mortalité : 0,0 % - Morbidité : jusqu'à 10 % - Risques à long terme : <ul style="list-style-type: none"> • IRT : 0,04 % vs. 0,03 % • Incidence accrue d'hypertension et de protéinurie de bas grade chez les anciens donneurs. - Risques à long terme pour les donneurs vivants à risque? <p>Risques psychologiques</p> <ul style="list-style-type: none"> - Problèmes psychologiques chez 5 % des donneurs. - Cas de suicide rapportés chez des anciens donneurs vivants. - Relations difficiles avec le receveur. <p>Risques financiers</p>	<p>Risques psychologiques :</p> <ul style="list-style-type: none"> - Craintes de se sentir endetté face au donneur; - Craintes des conséquences médicales pour le donneur
LES BÉNÉFICES	<p>Bénéfices psychologiques</p> <ul style="list-style-type: none"> • Augmentation de l'estime de soi; • Bénéfice de voir un proche recouvrer la santé 	<p>Bénéfices :</p> <ul style="list-style-type: none"> - médicaux - psychologiques - sociaux <p>une vie prolongée et en meilleure santé.</p>

Les défis moraux soulevés par le don vivant en situation clinique
(Tableau produit par le groupe de travail en éthique clinique)

Members of the Task Force on Clinical Ethics:

D^r Josée Courchesne

D^r Marguerite Dupré

M^{me} Nathalie Ebnoether

D^r Gloria Jeliu

D^r Julie Lalancette

M. Benoit Lauzière

D^r Michèle Marchand

D^r Yves Robert

M^{me} Nicole Rozon

Guest:

D^r Marie-Chantal Fortin, nephrologist with CHUM's Transplant Department and bioethicist