Prioritizing registered donors in organ allocation: an ethical appraisal of the Israeli organ transplant law

Jacob Lavee[a,b,c] *and Dan W. Brock*[d]

Purpose of review
A new organ transplant law in Israel, which gives priority in organ allocation to candidates who in various ways support organ donation, has resulted in a significant increase in organ donation in 2011. We provide an ethical analysis of the new law.

Recent findings
We note that by continuing to require opt-in consent, the Israeli law has an ethical advantage over opt-out laws, which may result in some use of organs from donors who have not consented. We discuss the fair response to 'free-riding' candidates who, usually for religious reasons, are opposed to donation, but nevertheless seek a transplant, who will not receive any priority over candidates who have been registered donors for at least 3 years before listing. We spell out several reasons why it is potentially unfair to prioritize patients whose first-degree relatives are registered donors, whereas it is fair to prioritize candidates who have been living directed or nondirected donors. Finally, we note the difficulty of ensuring public awareness of the priority system, which is necessary for its fairness.

Summary
Athough needing some modifications, the new Israeli law is based on sound ethical approach that seems to begin already to bear fruits.

Keywords
opt-in vs. opt-out consent, organ allocation, transplantation law, wait list priority

INTRODUCTION

The organ donation rate in Israel has traditionally been among the lowest in Western countries, ranging between seven and eight deceased donors per million population [1]. Only 228 patients of the 1069 candidates listed for kidney, heart, lung or liver transplantation in Israel in 2010 were allocated an organ for transplantation from deceased or living donors that year [2]. The causes for this low donation rate have been multifactorial. One of the major reasons for the low consent rate for organ donation, which is most repeatedly cited in public opinion surveys as arousing significant antagonism toward organ donation, is the so-called 'free-riding' behavior of those who reject brain death and, thus, organ donation yet do not abstain from being active candidates for organ transplantation themselves [3].

THE ISRAELI ORGAN TRANSPLANT LAW

In an attempt to overcome this impediment and to increase incentives for organ donation after death, the Israeli Parliament has adopted in 2008 a unique comprehensive Organ Transplant Law [4], which grants prioritization in organ allocation to candidates who have been registered as organ donors for at least 3 years prior to being listed as candidates. In addition the law grants a higher priority to candidates for organ transplantation who have given their consent for actual organ donation of their deceased next-of-kin or have been nondesignated

[a]Heart Transplantation Unit, Department of Cardiac Surgery, Leviev Heart Center, Sheba Medical Center, Ramat Gan, [b]The Sackler Faculty of Medicine, Tel Aviv University, [c]Israel National Transplant Center, the Ministry of Health, Tel Aviv, Israel and [d]Division of Medical Ethics, Department of Global Health and Social Medicine, Frances Glessner Lee Professor of Medical Ethics, Harvard Medical School, Boston, Massachusetts, USA

Correspondence to Jacob Lavee, MD, Director, Heart Transplantation Unit, Department of Cardiac Surgery, Leviev Heart Center, Sheba Medical Center, Ramat Gan 52621, Israel. Tel: +972 52 6666271; fax: +972 3 5302410; e-mail: jaylavee@netvision.net.il

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KEY POINTS

- The new Israeli Organ Transplant Law sets a unique legal precedent by granting priority in organ allocation for transplantation to candidates who have registered as organ donors at least 3 years before being listed or have been live organ donors.
- The law also grants controversial priority to candidates whose first-degree relatives have been long time registered organ donors or deceased donors.
- The Israeli law has already started to impact organ donation rate, which has significantly increased in 2011.

living kidney or liver-lobe donors. A recent amendment to the law has broadened the prioritization to be granted to any living donor. Finally, the law grants the lowest grade of priority to candidates who have not signed the donor card themselves, but have first-degree relatives who have done so [3].

The central goal of the new Israeli law is to increase the organs available for transplantation. That goal is ethically uncontroversial. In the case of organs necessary for life, such as hearts, lungs and livers, the benefit sought is saving a patient's life that would otherwise be lost from his or her organ failure. In the more common case of kidney failure, in which renal dialysis is an alternative treatment, the benefit sought is a substantial improvement in the patient's quality of life, but often an increase in life extension as well. Both of these benefits of transplantation are important and uncontroversial. Preliminary evidence that the new Israeli law has already begun to achieve the goal of increasing organ supply could be found in the organ donation results in 2011, which have recently been presented [5]. In 2011 there has been a significant increase in the number of deceased organ donors directly related to an increase in the consent rate (from 49% in 2010 to 55% in 2011) and an increase in organ donation rate (from 7.8 donors per million population in 2010 to 11.4 in 2011, $P < 0.0001$).

OPT-IN VS. OPT-OUT LAWS

Not every means of increasing organ supply, of course, would be ethical; for example, taking people's organs without their consent. A virtue of the new Israeli system is that it leaves existing requirements for patients' consent in place and operates by increasing the incentives for giving consent for donation. This is not a small point because the other major path pursued to increase organ supply that a number of countries have adopted is to shift from so-called opt-in consent, the traditional practice of requiring explicit consent for the donation, to so-called opt-out or presumed consent, in which the presumption is that the organs after death are available for transplantation unless the person has explicitly stated that he or she does not want them to be [6]. There is ethical controversy about whether opt-out consent is ethically acceptable consent or even consent at all [7–9]. In particular, the presumption that organs after death can be taken for transplantation, in the absence of the person having stated that they cannot be, will often result in organs being taken after death from persons who would not have wanted, or have consented to this being done. That is because many persons will not have seriously considered whether they would want their organs donated, or did not want them to be but failed to make that wish known and effective as the opt-out system requires, and so their organs will be available for transplantation without evidence that they would have consented to that, or with evidence that they would not. Moreover, in those countries which have adopted the presumed consent, consent of the deceased's relatives is always discussed and obtained prior to organs procurement in order to avoid an unpleasant conflict with the medical team [10▪▪,11]. It has been noted that country-specific, nonconsent factors could explain differences in donation rates and, as the process of donation in presumed consent countries does not differ dramatically from the process in nonpresumed consent countries, it seems unlikely that presumed consent alone increases donation rates [11]. It is, therefore, an important ethical advantage of the new Israeli system that it continues to depend on opt-in consent.

FAIR RESPONSE TO 'FREE RIDING'

Because the Israeli law gives new incentives to donate, or state that one will donate, by a unique and new point system that changes candidates' relative priority for receiving an organ for transplantation, a new ethical issue becomes important: is that point system fair? In general terms, the new law gives priority to persons who in one of several ways contribute to the success of the transplantation system by increasing the potential supply of organs. One way of understanding the ethical principle involved is as reciprocal altruism [12] – for acting in ways that benefit others in need of organs – one will receive priority in getting an organ that one should need. Another way of understanding the ethical principle involved is in terms of fairness, and more specifically a fair practice. The transplantation system is a practice in which persons

undertake actions for the benefit of others in need of organs and in turn receive benefits from others participating in the practice should they become in similar need. Fairness concerns the distribution of the benefits and burdens of the practice, and requires that those who receive the benefits transplantation provides should share in the burdens of the practice. That is why being unwilling to donate, but willing to accept a donated organ for transplant if one is in need, is considered unfair free-riding [13]. We will see that most, but not all, of the features of the new system are fair in this understanding, but others need to be justified by the goal of increasing the supply even if not fair.

As mentioned one of the main motives behind the new prioritization law in Israel was the significant numbers of 'free-riding' citizens who do not recognize brain death as a valid determination of death for religious reasons and, therefore, will not donate, although they are willing to accept donated organs for transplants should they need them. Is it unfair to those 'free riders' to prioritize other candidates who are willing to donate over them? We believe that it is not. True believers in the immorality of organ donation after brain death would not be affected by the new law because if organ donation after brain death is wrong, then it should also be wrong for their own potential organ donors, and hence they should not participate in this immorality by becoming candidates for organ transplantation and accepting an organ. Respecting the religious freedom of those who become candidates requires respecting their refusal to donate, but it does not require giving them the same priority as those who are willing to do so. They are still eligible for transplants if needed, despite the free riding that this entails, simply on the basis of their medical need and medicine's commitment to meeting patients' needs. Moreover, if this new policy achieves the goal of obtaining more organs, everyone will benefit and people who do not sign a donor card, although disadvantaged, will nonetheless be better off than they would have been without the policy.

UNFAIR PRIORITIZATION DUE TO RELATIVES' CONSENT

We can now address whether the specific inequalities in priority between candidates waiting for organs created by the new law are fair. First, the new law gives priority to every transplantation candidate who has had a donor card for at least 3 years before being listed. The 3 years wait is obviously designed to prevent manipulating the system by getting a donor card only after recognizing one's need for a transplant. Having a donor card indicates one's willingness and intention to donate in the future after death, should one then be a potential donor. It is not a binding decision because one can change one's mind and withdraw the card and intention, in which case one would no longer receive priority. More ethically troubling is the fact that in practice in Israel, and in other countries such as the United States as well, the family can veto the cadaveric donation of a deceased person who has a donor card despite these clear wishes of the deceased to donate. This seems a clear violation of the deceased person's autonomy and means that he or she did not have the potential of increasing the organ supply because the family stood ready to block the donation. One way to avoid this difficulty is to make the donor card legally binding, even in the face of the family's opposition, but for various reasons including concern for families dealing with the loss of their loved one, this option has not been pursued [10▪▪]. The Israeli practice so far has shown that families of deceased persons with a donor card have traditionally approved organ donation and almost never vetoed donation as they consider the deceased's signature on the donor card as a signed will [2].

The Israeli law grants priority in organ allocation, albeit of the lowest degree, to candidates who have not signed the donor card themselves but have first-degree relatives who have done so. The rationale behind this principle is that in the past, Israelis who signed a card have systematically consented to donate the organs of first-degree relatives after death, even if the deceased themselves did not sign a card. It should be noted that this clause of priority was added by the Parliament members and was not included in the recommendations of the special advisory committee, which included transplant physicians and coordinators, lawyers, philosophers, ethicists, social scientists and representatives of the main religions, which recommended to give priority based only on the candidates' own registration as donors. The broadened prioritization approach has already been criticized [14,15▪] and is ethically problematic for at least three reasons. First, it is of course true that anyone is welcome to sign their own donor card, thereby, ensuring themselves high priority in organ allocation, irrespective of the number of relatives one may have [16], yet the patient's priority should be based on what one has done, not what someone else such as a relative has done. The relative's donor card should give the relative priority, but not the patient. Second, patients with one or more first-degree relatives will have an advantage over other patients who have no or fewer such relatives. Again, priority is not based on anything the patient has done to support the transplantation system but on

his unrelated social circumstances. Finally, as recently suggested by Quigley *et al.* [15▪], by offering priority points to first-degree relatives of deceased donors the law gives families an incentive to donate a loved one's organs even if the deceased's wishes for donation are unknown or were against donation. In our view this is unfair and violates the patient's autonomy, and can only be justified by holding that the increase in organs it produces, for which we should obtain evidence, is sufficient to override the unfairness. The same ethical problem exists for the provision that gives priority to patients who have a first-degree relative who has been a cadaveric or living donor.

FAIR PRIORITIZATION DUE TO LIVING DONATION

The law initially also gave priority only to nondirected living donors, in conflict with the recommendation of the special advisory committee to give priority to all living donors [2]. The Israeli Parliament has recently agreed to amend this clause and to grant priority to any living donor, directed and nondirected alike. The rationale for Parliament's initial decision to limit priority only to nondirected donors was likely that this was considered a substantially more altruistic act than a directed donation to a relative or friend. This might warrant a higher priority to nondirected over directed donors, but it would remain fair to recognize that even directed donors support the transplantation system and deserve some priority. In fact, the policy of the United Network for Organ Sharing has been for years to give all living donors priority to receive a transplant from a deceased donor, should they ever need one [17]. This point has increasing practical importance as directed living donors become an increasingly large source of organs. Both directed and nondirected donations support the goal of increasing the organ supply.

PROBLEMATIC CONSEQUENCES OF INEQUALITIES IN PUBLIC EDUCATION

Finally, there is one other ethical worry that affects any priority system of this sort, independent of the particular priorities it sets. For it to be fair to give lower priority to patients who have not taken certain actions, whatever those actions, the patients should know beforehand that the lower priority will be the consequence of not taking those actions. As Israel recognized, this requires a very substantial public education program about the new system. Indeed, the Israel National Transplant Center has launched an intensive yearlong multimedia and multilingual public campaign during 2011, which brought the new law to the attention of the public [18]. But any such education program will be only partially successful. This ethical worry is compounded by the fact that it is likely to be more successful with more educated and higher socioeconomic class citizens. So less educated and lower class citizens will be more likely to have a complaint that their lower priority is unfair because they did not know what they had to do to receive the higher priority. This problem is probably much less severe in a small relatively homogeneous (at least in some respects) country like Israel than in a much larger more heterogeneous country like the United States. But it raises an important question about how transportable the new Israeli system would be to very different contexts.

CONCLUSION

Changing national attitudes toward organ donation and increasing organ donation rates is a task that undoubtedly will take several years. The prioritization plan embedded in the new Israeli law is only one of several other elements incorporated in this law, which are all aimed toward the same goal. The early results of the law's implementation appear promising and suggest appropriate responses were implemented to overcome the identified obstacles, however, only time will tell whether expectations of increasing organ donation rate in Israel similar to those achieved in most Western countries will be realized. Meanwhile, in the spirit of the Declaration of Istanbul [19], which the Israeli law has preceded by 1 month, and the recent call for governments' accountability to achieve national self-sufficiency in organ donation and transplantation [20], we suggest that some of the lessons learnt by the new prioritization plan may have more universal application.

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Papers of particular interest, published within the annual period of review, have been highlighted as:

- ▪ of special interest
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Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 000–000).

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