LETTERS to the Editor

Comments on Organ Donation

In the article "Defending the Donor's Decision" (*Health Progress* 89, no. 2 (March-April 2008): 61-67), D.W. Donovan opines that to enhance organ donation rates, the process of registering first-person organ donors must be improved. I differ with Donovan regarding the assumption of validity of first-person consent as it is currently obtained. His defense of first-person consent fails because of his omission to first demand a transparent and open debate among all stakeholders to establish moral, legal and scientific agreement on existing controversies, including the following points:

1) The assumption of a wide, general consensus on the concepts of neurologic or cardiorespiratory death is incorrect. Considerable disagreements on these issues do exist. (See R.D. Truog, "Brain Death: Too Flawed to Endure, Too Ingrained to Abandon," *The Journal of Law, Medicine & Ethics* 35, no. 4 (2007): 273-281.) Disclosure of that information is important to those who want to make personal, autonomous decisions on organ donation. Brain (heart-beating) or cardiac (non-heart-beating) organ donation criteria of death do not fulfill the criterion of moral and medical certainty that ethicists, medical scientists and legal and religious scholars have emphasized.

2) The argument that achieving the good of organ donation comes at little or no cost to the donor is unsubstantiated. The basis for this argument is the belief that the patient is indeed dead. Substantial arguments have been put forward to assert that the practice of organ procurement violates the dead-donor rule. Non-heart-beating organ donation disregards more than 60 percent of the quality measures recommended for end-of-life care in the terminally ill. (See M.Y. Rady, J.L. Verheijde, and J.L. McGregor, "Organ Donation after Circulatory Death: The Forgotten Donor," *Critical Care* 10 (2006): 166-169, available at http://ccforum.com/content/10/5/166.) Families suffer long-lasting traumatic memories, depression and posttraumatic stress disorders that complicate their bereavement and grief reactions. Health care professionals have expressed moral distress toward end-of-life practices involved in organ donation and some even consider it an act of euthanasia or physician-assisted death. (See M.S. Mandell et al., "National Evaluation of Healthcare Provider Attitudes toward Organ Donation after Cardiac Death," *Critical Care Medicine* 34, no. 12 (2006): 2,952-2,958.)

3) Because death cannot be assumed during procurement interventions, the use of the medical model of consent to donation is appropriate. The procurement of organs is indeed a surgical procedure, potentially resulting in the death of the donor, and thereby constituting a situation that should require a great deal of information before consent can be accepted. The clinical diagnosis of "brain dead" for the purpose of organ removal has followed a slippery pathway. The main purpose of the argument of "saving lives" has developed perhaps to provide moral justification for a resolution to the organ shortage crisis through subtle introduction of euthanasia and physician-assisted death.

4) The Uniform Anatomical Gift Act (UAGA) of 2006 allows procurement organizations to operate on the premise of presumed intent, effectively constituting an opt-out system for organ donation. This piece of legislation makes moot the issue of first-person consent. (See J.L. Verheijde, M.Y. Rady, and J.L. McGregor, "The United States Revised Uniform Anatomical Gift Act (2006): New Challenges to Balancing Patient Rights and Physician Responsibilities," *Philosophy, Ethics, and Humanities in Medicine* 2 (2007): 19, www.peh-med.com/content/2/1/19.)

5) The communitarian argument in favor of organ donation appears disingenuous in light of the fact that large groups in society have no, or limited access to, health care, including organ transplantation.

I disagree that the system of first-person consent could make a significant contribution toward improving organ donation rates in an ethically appropriate manner in light of the current circumstances of less than optimal disclosure of information, absence of consensus on the definition of death, lack of process transparency, and continuing issues of fairness in organ allocation.

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Comments on Leadership Formation

I want to say how much I appreciate the article by Zeni Fox, "Continuing the Mission: How Do Health Care Leaders Keep Catholic Identity Alive in Today's World?" that appeared in the March-April 2008 issue of *Health Progress*. I intend to share it with my pastoral care staff. I especially like the comparison between Acts and the early church. The challenges she outlined with the realities that we face in long-term care today are so real and very helpful to see in print. I heard Zeni speak several years ago here in Louisville, Ky., and am happy to know she is still offering us hope as teacher, writer and being 'church' for and with all of us!

Another article, from that same issue of *Health Progress*, that I outlined and shared at our recent Mission Committee meeting, was Dennis Winschel's

"Formation Path in the Workplace: How Does it Work?" We at Nazareth Home are initiating person-centered care with our residents and also with our associates. At our last town hall meeting we had "learning circles" and each circle addressed the question: "What would you most like to change here at Nazareth Home?" It was so enlightening! And much of it, in my way of looking at the comments as director of mission and pastoral care, has to do with "the formation path." In living our mission here, we believe in the development of the whole person, and our associates gave us much to think about regarding ways to improve our quality of resident care by improving our formation of co-workers.

Thank you for sharing these valuable articles.

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