

COMMENTARY

The “New Charter for Health Care Workers” and the ethics of organ donation and transplantation

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Abstract

Comparison is made between the proposals put forward by the “New Charter for Health Care Workers” in the matter of organ transplants and other models of bioethics. The personalist approach adopted by the New Charter is illustrated and the proposals contained in it are finally placed alongside the reference ethical principles underlying the Italian transplant network: they are found to be fully in agreement.

Key words

- bioethics
- deontology
- organ transplantation

The “New Charter for Health Care Workers” (henceforth referred to as the New Charter) published by the Pontifical Council for Pastoral Assistance to Health Care Workers [1] follows on the first edition of the charter published in 1995 [2].

The New Charter contains a section (paragraphs 109-114) dedicated particularly to the matter of “Organ and tissue donation and transplantation” [1]. This section has been not only updated but also reinforced with completely new considerations absent from the corresponding section (paragraphs 83-91) of the previous edition (“Donation and transplanting of organs”) [2].

The following paragraphs will briefly compare the approach of the New Charter on the question of organ transplants first with a few other models of bioethics and then with the reference ethical principles adopted in Italy in the field of organ transplants.

THE ETHICS OF TRANSPLANTATION IN SOME MODELS OF BIOETHICS

The field of bioethics is influenced by a number of models [3], some of which are rooted in schools of thought whose origins go back through many centuries of human civilisation. Some models, such as individualism, communitarianism, utilitarianism, deontologism and personalism, for instance, are more widely recognised than others: the fundamental principles of each can be applied to the issues surrounding the ethics of transplantations.

According to *individualism*, moral principles cannot be based on either facts or objective values: they are

based instead on the autonomous choices of individuals. Individualism is thus emphatically non-cognitivist: values are unknowable. In this approach the principle of autonomy obviously plays a central role: anything done autonomously is legitimate, provided that it does not impinge on another person's freedom [4].

In the individualistic approach to the ethics of transplants the overriding consideration is the individual's freedom to choose whether or not to donate, or even to sell, or to refuse any form of transfer. The body is considered private property; consent is paramount and any form of presumed consent or consent given by third parties is inadmissible. The preferred arrangement in this perspective is a system based on opting in.

In contrast to individualism, *communitarianism* encourages interpersonal relations. As with individualism, there are no universal values: moral values spring from the community and the good of the community consequently prevails over that of the individual [5].

In a communitarian perspective the ethics of transplants must be based on individual responsibility and participation in the common good. However, the common good should not imply a disproportionate cost for the individual: hence a preference for a system based on opting in.

Utilitarianism is a form of consequentialism: the legitimacy or otherwise of an action is judged in terms of its consequences and the risk/benefit ratio. The relevant criteria are thus efficiency and efficacy, irrespective of the intention [6]. One of the key theorists of this model was Jeremy Bentham, who stated that: “Nature has

placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne. They govern us in all we do, in all we say, in all we think" [7].

The utilitarian therefore espouses the belief that the donation of organs is a positive event since it implies a high probability of saving a life, and deems an opt-out arrangement to be more effective, as it is presumed to ensure the availability of a higher number of organs.

Deontologism, on the other hand, acknowledges the existence of universal rules and duties that must be observed (although moral rules may, regardless of circumstances and outside influences, be adapted, if necessary, to a specific action) [8]. This is the typical Kantian approach, summarised in the categorical imperative: "Act in such a way that you treat humanity (...) as an end and never merely as a means to an end" [9].

In the matter of organ transplants the deontological view attributes particular importance to avoiding the exploitation of donors and promoting the good of recipients, and prefers an opt-in system.

The approach of *personalism* holds that "When engaging in any kind of rational thinking, even of a lay nature, the human being is the reference point, the end and not the means, the transcendent truth for the economy, the law and history itself. In discussing medical or bio-ethical ethics these preconditions of a philosophic order must not be thought of as a mere abstraction because both ethics and medicine are destined for man, who must be considered in the fullness of his worth (...). (It is) the human person who is the point of reference and the measure of what is legitimate and what is not" [10]. Underlying the personalist model are:

- the principle of the defence of the physical life of every human individual: every medical act must have the patient as its end;
- the therapeutic principle (of totality): the overall good of the individual must come before any other good of the collectivity;
- the principle of freedom and responsibility: the participation of every single individual must be fully aware and free from coercion;
- the principle of sociality, solidarity and subsidiarity: the common good is achieved by protecting and promoting the good of the individual.

The following paragraphs show how the ethics of organ transplants set forth in the New Charter are typical of the personalist approach.

WHICH BIOETHICS MODEL FOR THE ETHICS OF TRANSPLANT DONATIONS IS EXPOUNDED IN THE NEW CHARTER?

The approach to the ethics of organ and tissue donation and transplantation described in the New Charter [1] is of a typically personalist nature.

The principle of the defence of physical life and the therapeutic principle are expressed in the duty to protect the life of the living donor and of the recipient, the establishment of strict criteria to certify death, respect

for the deceased's body and for the identity of the donor and of the recipient, as well as in application of the criterion of proportionality when reaching decisions.

The principle of freedom and responsibility translates into the duty to provide adequate information, obtain free and witting consent, avoid all forms of coercion, and provide instruction to ensure respect for responsible choices.

The principle of solidarity, as it applies in the setting of organ transplants, is asserted in paragraph 109, which first reaffirms the declarations contained in the earlier version of the Charter (in paragraph 83): "The progress and spread of transplantation medicine today allows treatment and recovery of many patients with serious ailments who until recently could expect only death or at best painful, restricted life" [1, 2]. This is followed by an assertion of the principle of solidarity that is even more explicit than in the previous version: "The donation and transplantation of organs are significant expressions of *service to life* and of the *solidarity* (in italics in the original) that binds human beings together and they are a "peculiar form of witness to charity". For these reasons they have a moral value that legitimizes their use in medical practice" [1]. The earlier version of the Charter had merely stated: "This service to life", which the donation and transplant of organs represents, shows its moral value and legitimizes medical practice" [2]. Solidarity does not mean that those who are not prepared to donate are to blame for the scarcity of available organs. It is part of an asymmetric reciprocity: the gift of an organ is matched by the gift of gratitude. Solidarity is not separate from the principle of justice, whether distributive justice ("*suum unicuique tribuere*") or commutative justice ("*neminem laedere*"). It also refers to the duty to organise services, to take measures to counter forms of degeneration (e.g. trade), to adopt effective policies to increase the availability of organs, and to spread the practice of donating.

THE NEW CHARTER AND THE ETHICS OF THE ITALIAN TRANSPLANT NETWORK

The Italian transplant network "endorses a model that gives priority to the patient being treated by the physician. In other words it adopts the therapeutic criterion, taking into account the probability of success and rejecting any criterion involving social usefulness, which could easily become discriminatory.

A person-centred approach to ethics does not, however, neglect the social dimension: after all, an organ available for transplantation is a common good. Thus the therapeutic principle must be supplemented with additional considerations:

- justice: each patient must have equal access;
- duration of wait: time spent on the waiting list should count towards priority;
- clinical usefulness: preferment in the assignment of organs for recipients best placed to ensure the longest use of them;
- net benefit: introduction of a balance between urgency and outcome" [11].

The proposals contained in the New Charter on the question of donation and transplants are thus fully in

agreement with the ethical principles underlying the Italian transplant network, which holds that the following are essential requirements [12]:

- the implementation of mechanisms to coordinate transplant services in accordance with commonly shared regulations drawn up in a transparent manner;
- the management of waiting lists that ensure equity, justice, traceability and transparency;
- efficient and fair mechanisms for the distribution of available organs;
- compliance by personnel with professional obligations (including refresher courses) set out in the ethical codes and regulations applying to their relevant

groups;

- the right of citizens to exhaustive and truthful information regarding the planned operation, its possible consequences, risks and possible alternative measures;
- the duty of professional staff to make every effort to minimise risks;
- the best possible care for donors and recipients;
- the promotion of the practice of donating, the prime objective of which should be the good of the individual recipient and of the individual donor.

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