AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 7
(I-24)

Introduced by: David Welsh, MD, and Thomas G. Peters, MD

Subject: American Kidney Donation Legislation

Referred to: OMSS Reference Committee
(xxxx, MD, Chair)

Whereas, over 90,000 Americans with End-Stage Kidney Disease (ESKD) are awaiting a kidney transplant[1]; and

Whereas, over 8,000 Americans waiting for a kidney die or become too sick to transplant each year for lack of an available kidney[1]; and

Whereas, living kidney donation in America, including anonymous (volunteer) donation to wait-listed ESKD patients has not grown for two decades[1]; and

Whereas, our AMA Code of Ethics state that it is "appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence"[2]; and

Whereas, United States House of Representatives bill H.R. 4343 states that "experts are arriving at a consensus that trials are necessary to find new methods of promoting additional organ donation which will save lives and reduce organ trafficking"[3]; and

Whereas, several innovative pieces of federal legislation, including H.R. 9275 which creates a pilot study (trial) offering a delayed tax credit to living donors giving a kidney to Americans on the waiting list, as well as other bills are or may soon come before the United States Congress[4,5]; therefore be it

RESOLVED, that our American Medical Association actively support H.R. 4343, H.R. 9275, the Kidney Transplant Collaborative's Living Organ Volunteer Engagement (LOVE) Act provisions, and other legislative and regulatory efforts consistent with AMA policies to increase both living and deceased organ donation to Americans suffering from End-Stage Kidney Disease (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 9/23/2024

REFERENCES

1. Organ Procurement and Transplantation Network, national data, 20 August, 2024: https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/#

2. AMA Code of Ethics 6.1.3: Studying Financial Incentives for Cadaveric Organ Donation: https://policysearch.ama-

assn.org/policyfinder/detail/%226.1.3%20Studying%20Financial%20Incentives%20for%20Cadaveric%20Organ%20Donation%22?uri=%2FAMADoc%2FEthics.xml-E-6.1.3.xml

3. H.R. 4343. Organ Donation Clarification Act of 2023. 118th United States Congress. https://www.congress.gov/bill/118th-congress/house-bill/4343/text

4. H.R. 9275. End Kidney Deaths Act of 2024. 118th United States Congress. https://www.congress.gov/bill/118th-congress/house-bill/9275/text?s=1&r=1&q=%7B%22search%22%3A%22HR+9275%22%7D

5. Kidney Transplant Collaborative. (2024). Enact the Living Organ Volunteer Engagement (LOVE) Act. https://kidneytransplantcollaborative.com/policy-priorities/

RELEVANT AMA POLICY

6.1.1 Transplantation of Organs from Living Donors

Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:

(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donor's well-being.

(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.

(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.

(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.

(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.

(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:

(i) the minor agrees to the donation;

(ii) the minor's legal guardians consent to the donation;

(iii) the intended recipient is someone to whom the minor has an emotional connection.

(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.

(i) Inform the prospective donor:

(i) about the donation procedure and possible risks and complications for the donor;

(ii) about the possible risks and complications for the transplant recipient;

(iii) about the nature of the commitment the donor is making and the implications for other parties;

(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and

(v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.

(j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.

(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.

(l) Permit living donors to designate a recipient, whether related to the donor or not.

(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.

(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:

(i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);

(ii) domino paired donation;

(iii) nonsimultaneous extended altruistic donation ("chain donation").

(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.

(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).

(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.

(r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.

AMA Principles of Medical Ethics: I,V,VII,VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

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6.1.3 Studying Financial Incentives for Cadaveric Organ Donation

Physicians' ethical obligations to contribute to the health of the public and to support access to medical care extend to participating in efforts to increase the supply of organs for transplantation. However, offering financial incentives for donation raises ethical concerns about potential coercion, the voluntariness of decisions to donate, and possible adverse consequences, including reducing the rate of altruistic organ donation and unduly encouraging perception of the human body as a source of profit.

These concerns merit further study to determine whether, overall, the benefits of financial incentives for organ donation outweigh their potential harms. It would be appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence.

Physicians who develop or participate in pilot studies of financial incentives to increase donation of cadaveric organs should ensure that the study:

(a) Is strictly limited to circumstances of voluntary cadaveric donation with an explicit prohibition of the selling of organs.

(b) Is scientifically well designed and clearly defines measurable outcomes and time frames in a written protocol.

(c) Has been developed in consultation with the population among whom it is to be carried out.

(d) Has been reviewed and approved by an appropriate oversight body, such as an institutional review board, and is carried out in keeping with guidelines for ethical research.

(e) Offers incentives of only modest value and at the lowest level that can reasonably be expected to increase organ donation.

AMA Principles of Medical Ethics: I,III,V,VII,VIII,IX

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