Altruism, Autonomy, and Human Dignity for the Sustainability of Post-Mortal Organ Donation

Aiyub Mohammad Fahad Alwehaibi

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ALTRUISM, AUTONOMY, AND HUMAN DIGNITY FOR THE SUSTAINABILITY OF POST-MORTAL ORGAN DONATION

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Aiyub Mohammad Fahad Alwehaibi

May 2017
ALTRUISM, AUTONOMY, AND HUMAN DIGNITY FOR THE SUSTAINABILITY
OF POST-MORTAL ORGAN DONATION

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ABSTRACT

ALTRUISM, AUTONOMY, AND HUMAN DIGNITY FOR THE SUSTAINABILITY OF POST-MORTAL ORGAN DONATION

By
Aiyub Mohammad Fahad Alwehaibi

May 2017

Dissertation supervised by Professor Henk ten Have, MD, PhD

In most countries, the shortage for transplant organ sources has become common due to the significant increase in number of awaiting organ recipients, which, in turn, urges countries develop systemic programs in order to increase the number of organ donors and resolve their problems. Generally, either living or deceased organs are accepted in transplant practice, yet, each source holds its own benefits and adverse effects. Living organ donation encounters controversial and problematic issues at individual, social, and humanity levels. Cadaveric organ donation faces the obstacles of the criteria of death, which vary from cultural to medical perspectives, and the effective means to attract the public. Currently, presumed consent policies operating in Spain, Belgium, and Singapore have proved their effectiveness in increasing the number of donor organs. However, the increasing number of donor organs should not be a sole,
sufficient indicator for the effectiveness of a policy. Instead, the sustainable growth in the
number of organ donors after their death should be the goal of a policy in order to
promote a promising outlook for organ donation sources. And, the factor that enhances
the sustainability is public trust.

The dissertation proposes a new approach for a more long-run outcome in
increasing the number of organ donors. It is a model for a sustainable source of post-
mortal organ donation. The model encourages deceased organ donation by assurance of
the core value of donation act- altruism, and the protection and appreciation for donors as
well as healthcare professionals. Most importantly, the model targets on obtaining and
maintaining public trust by protecting one’s autonomy and human dignity, thereby
creating a sustainable source of donor.
DEDICATION

I dedicate this work to my father, mothers, and siblings.

Mohammed Alwehaibi
Fatimah Almarshad
Norah Alamor
Abdulrahman Alwehaibi
Hosah Alwehaibi
Afra Alwehaibi
Abdulsalam Alwehaibi
Wohibi Alwehaibi
Wafa Alwehaibi
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Faisal Alwehaibi
Nariman Alwehaibi
Rema Alwehaibi
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بسم الله الرحمن الرحيم
In the name of Allah, the Entirely Merciful, the Especially Merciful.

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Chapter One: Introduction

In most countries, the shortage for transplant organ sources has become common due to the significant increase in number of awaiting organ recipients while the amount of organ sources exhibits a reversed tendency to the need. The unmet need for the transplanted organs impels many countries to develop systemic programs, aiming at increasing the number of organ donors and resolving the pertinent problems.

I. Backgrounds and Problem Statement

In general, either living or deceased organs are accepted for transplant practice, still each source holds its own benefits and adverse effects. Depending only on the sources of living donors, either out of altruism, familial relationship, familial coercion, or even financial incentives, has not met the need for organ transplantation. Living donation of organs encounters many controversial and problematic issues at the levels of individuals, societies, and humanity. From an ethical perspective, living donation has provoked endless debates around the issues of beneficence and non-maleficence in medical practice, human dignity, and justice. In the practice of living organ donation, healthcare team members inevitably cause harm to a person’s health to various levels but not for the health benefit of the person himself; besides, the act of harming is to bring benefit to the third party, assuming the absence of financial factors during the transplant procedure. There is no guarantee that risks will be absent for the donor at any point of the present or future; as a matter of fact, there is awareness of the possible risks without creating benefits for the donor. In order to create beneficence to the recipient, healthcare professionals have to violate the principle of non-maleficence in their practice. Such practice is considered unacceptable in medical practice.
On the other hand, the organ sources from the deceased are believed not to be effectively used even though they provide a potential solution to the widening disparity between organ supplies and organ needs. After a valid consent has been obtained for donation, transplantation of a deceased donor organ raises no doubt about the violation of non-maleficence. The result of this practice solely benefits the recipient’s welfare and the act of removing organs from the deceased does not cause harm to any individual as long as the removal is based upon a valid consent. Additionally, many other serious issues are on the account of using living organ donation, such as organ black market and injustice. Although the existence of organ black market has been in debates for quite long time, these debates often focus on the human body, human welfare, as well as social consequences. The debates have not directed the public to be aware that the root cause is the use of living donor organs and that living organ donation should be discouraged. In the matter of justice, the benefits for individuals are often weighed against the benefits for the society, individualism or utilitarianism, or social fairness entitles the equal benefits for all individuals or the maximal overall utility distributed among social members.

Frequently, these two common sources of donor organs have been often separately discussed according to the viewpoints of the authors. Putting these two sources in a comparative picture would initiate a more thorough comprehension of the cause-and-effect relationship between the practice of organ donation to individuals and societies, as well as create mutual understanding and provide educational information to all involved parties. Ultimately, the community would obtain a sustainable number of donor organs and close the gap between the needs and supplies of organ donation.

In many nations, the policies for organ donation have started to shift to the source of the cadaveric organs for the foreseen potential in increasing the number. Current policies encourage
or force people to become donors upon their deaths (e.g. presumed consent, mandated choice
policy) or family to donate organs of their loved one upon their loved one’s death (e.g. required
request policy). Yet, the biggest obstacles fall in the criteria of death, which vary from
cultural/religious to medical perspectives, and the means to attract the public to this path. In
order to gain public trust, a transparent and consistent definition of death which is culturally
acceptable is necessary. Elicit talk about death would be an effective way to bring together the
medical professionals, policy makers, and the public and create the harmony between medical
and cultural aspects. Also, building the most effective incentives requires the policy makers to
view incentives in more perspectives rather than only financial or altruistic incentive. Incentives
may be in various forms which are determined by particular social cultures. They should be
created under a generic frame, then could be adjusted to fit the cultural diversity of the society
rather than only targeting the general public.

Altruism has remained the major principle in the act of organ donation, either from living
or deceased donors. It has been proved as the essence of the act of donation, but why do many
debates suggest it be less considered in or excluded from calling out for organ donation? They
contend that it is sometimes obscured when the donors and recipients are related for the
possibility of being unduly influenced by the intensity of social pressures or responsibility rather
than being out of altruism. Also, using altruism as the means of policies for organ donation has
not improved the existing issues in organ donation, evident by the low number of non-related
living organ donors or the rising numbers along with social and ethical issues, such as implicit
trading as the result of the policy for the altruistic act or violation of human rights. This solution
may solve the issues temporarily; however, resolving the problem by making the act astray from
the essence would not enable any society to achieve the goal of bettering and sustaining the
organ donation sources. The approach should be an acknowledgement of altruism as the required act from all the involved parties rather than only donors or donors’ families.

Another well-known means by which organ donation is operated are financial incentives. This policy when applied for living organ donation has showed more serious ethical issues than when used for cadaveric organ donation. Nevertheless, the idea of financial incentives has not been in favor in most parts of the world for fear of creating a black market for organs. Moreover, financial incentives are unlikely to co-exist with altruism in a policy for organ donation because financial compensation could become a way to erode altruism or turn altruism into coerced will, or compel people with financial hardship to donate their organs for the compensation amount rather than for the wellbeing of the others. Financial incentives eventually will create an organ trade markets with demands, needs, price tags, exploits, and profits. On the other hand, whether financial incentives would have the same effects on deceased organ donation or not and whether the gratitude for the deceased organ donors should be in the financial form have not much been discussed.

At this time, presumed consent policies operating in countries such as Spain, Belgium, and Singapore have proved their effectiveness in increasing the number of people becoming organ donors after they die and eliminating the issue of organ black markets. Nonetheless, the increasing number of organ donors should not be a sole, sufficient indicator for the effectiveness of a policy. Instead, the sustainable growth in the number of organ donors upon their death should be the goal of a policy in order to promote a prosperous outlook for organ donation sources. So, what could be the element that enhances the sustainability of postmortal organ sources? Public trust seems to be the major factor for this issue.
II. Ethical Considerations

This dissertation proposes a model to encourage deceased organ donation by assurance of the core value of a donation act (i.e. altruism) and the protection and appreciation for donors as well as healthcare professionals. The model ultimately targets on obtaining public trust and creating a sustainable source of donor organs. The model consists of three essential components: altruism from involved parties (including the society), autonomy, and human dignity in developing policies for cadaveric organ donations at both global and local levels. In this model, more varieties of options for organ donation will be introduced to the potential donors or their families, such as they can choose to receive or refuse the different forms of gratitude for their altruistic act. Besides, the donor or the family can choose their preferred gratitude. Some options could be funeral expense, health insurance, discount or exempt from the hospital bill, making donation to a charity group of choice, cash, etc. The appreciation for the decision should be at the moment they decide to donate the organs while the gratitude will be granted after the procurement. Understanding sociably fit incentives would facilitate the policy makers in building the list of suggested gratitude forms. Implementation of this model should bring an increasing and sustainable source of organ donation in the future. The model is then theoretically applied and evaluated for its outcomes in order to prove its ethical justifications yet flexibility to cultural backgrounds and healthcare systems.

The ethical justification of this model is explained by discussing the following issues: the development of organ donation and normative ethical background (chapter 2), the evolution of organ transplantation (chapter 3), living versus deceased organ donation in social and ethical aspects (chapter 4), pros and cons of the current policies and proposals on organ donation (chapter 5), a model for a sustainable source of post-mortal organ donation (chapter 6),
applications of the proposed model for organ donation in Saudi Arabia and Iran (chapter 7), and summary and suggestions (chapter 8).

Chapter two discusses the status of organ donation and reviews the normative ethical background of autonomy, human dignity, and altruism. Social, political, and medical backgrounds have influence on the evolution of organ donation. Some people discredit autonomy in medical practice, arguing that this concept shades other moral values and creates conflicts, because the involved parties often do not share the moral values. Whereas, many scholars emphasize the importance of the right to autonomy in medical settings. Respect for autonomy means respect for personal values and beliefs, making no interference with them as long as the individual owns the sufficient understanding corresponding to the decision that should be made. Every person also is responsible for making an autonomous decision; responsibility becomes accountability in this context because freedom comes hand in hand with responsibility. A person is responsible to learn and use knowledge and evaluate the corresponding consequences to make a free and responsible choice.

The notion of human dignity as an existential value and the uniqueness of human beings serves as fundamental for the arguments throughout this work, because it fulfills arguments in both secular and theological perspectives. Human dignity is an inherent value and independent of the external values. Every person has dignity equal to another’s; human dignity is the identity of a person and must be respected and protected.

Altruism is acknowledged as a both universal and particular common morality. It is a universal because everyone accepts it in all cultures; it is a particular morality when its values require a special knowledge, or even experts or scholars to explain in the cases when the moral norms abide to religious norms. Therefore, altruism is a common morality, which is accepted
and should be committed among every member of a society. This perception assists a creation of a community-benefit policy that prevents public trust erosion.9

Chapter three discusses the status of organ donation and its ethical issues worldwide. Most parts of the world are facing the disparity between demand and supply for organ donation. The shortage of organ donors has been caused by a great deal of ethical problems in various perspectives, such as sources of organs and organ donation policies. The ethical issues accumulatively result in losing public trust, hence, impeding the growth of number of organ donors.

Before 1954, cadaveric and animal organs were the sources and the focus was mainly the survival of the organ recipients rather than ethical debates or legal issues. Ground rules for organ donation were set by religious teaching from churches.10 Not until the case of the Herrick twin brothers in 1954 started the era of ethical debates in organ donation practice. The very first debates yet still current are the violation of the maxim “Do no harm”11 and the consent for pediatric organ donors.12 The first success of human heart transplants by using the donated heart from a victim in a car accident rendered a serious contention about whether the patient was considered dead with her beating heart during the procurement, leading to the new criteria for death- the brain death.13 The increasing disparity between the organ needs and supplies impels numerous policies for organ donation and procurement. The policies aim at increasing the number of organ donors, sometimes at the cost of moral standards, ethical principles,14 and violation of religious and community norms, resulting in the erosion of public trust.15

Using the sources of living donors creates the most ethical debates in comparison to the other sources. It makes healthcare professionals unavoidably violate the primary tenet “do no harm,” enables or facilitates the operation of organ black markets, and dishonors human
Using living organ donation is unjustified because it establishes a precedent for the saving of life by putting the other lives at risk, even if it is an altruistic donation. More problematically, allowing selling of living organs could commences an ethical debate between principlism versus communitarianism. In deceased organ donation practice, the criteria of death and autonomy stay in the center of arguments. Definition and acceptance of death have a great impact for a person on becoming an organ donor; however, medical and social views often conflict with personal and familial values in these two matters, which create public hesitance or denial in organ donation.

In addition to the two common sources of organs, many other sources have been considered in the transplantation practice. Stem cell transplantation faces ethical questions about the source of stem cells and the meaning of life for stem cells. Savior siblings would be created for the purpose of transplantation only. Sources are organs from animals and are often disapproved in religious practice for its chimeric products corrupting the sanctity of the human body. The suggested source from patients in persistent vegetative state is also widely disapproved for the lack of informed consent and human dignity issues.

Chapter three also discusses the evolution of organ transplantation in time order. The discussion highlights the achievements as well as obstacles in the field. Discussion about organ transplantation is no longer about only the feasibility of the medical methods. Numerous issues of different perspectives need to be reviewed, debated, and addressed before the transplantation could actually happen. At first, a review of the history of organ transplantation illuminates the complexity of the evolution of organ transplantation along with the ethical issues the field has faced; henceforth, interested parties contrive effective approaches to potential organ donors in order to achieve the goal of sustainability of donor organ supplies.
Before the Renaissance period, the idea of transplantation continued to exist in the supernatural, legends, and fantasy, depicted in numerous paintings. During the Renaissance, the idea of transplantation continued experimentally but aimed at more complicated levels—transplanting an organ from one animal to another.23

Not until the early twentieth century, numerous breakthroughs in organ transplantation have been made. In 1933, Yurii Voronoy, a Ukrainian surgeon, performed the first kidney transplant from a cadaver to a patient; in 1947, the first successful kidney transplant between a deceased donor and a living recipient happened in the United States. In 1954, the first transplantation between two living patients—the Herrick twin brothers, was successfully performed by the surgeon Joseph Murray, initiating many other transplants among identical twins in the United States and other countries.24

During the early twenty-first century, the practice of transplantation for kidneys, hearts, livers, lungs, and corneas has become popular medical treatment options in most parts of the world. Even more attempts have also been made for other human body parts which were not believed to be feasible in the past, such as hand transplant, and face transplant.25 The most recent idea of full-body transplant, proposed by Dr. Ren Xiaoping, an orthopedic surgeon in Harbin, China raises concerns among medical experts and ethicists around the world.

III. Deceased Organ Donation—The future for organ transplantation

Chapter four compares the living organ donation and the deceased organ donation in social and ethical perspectives. Living organ donation greatly contributes to the emergence of black markets, disgrace of the fundamentals of medical practice, dishonor of human dignity, and creation of unjust allocation. On the other hand, post mortal organs have become more favorable as potential sources and being less problematic. The biggest issue is the criteria for death. It is
common that there has been a lack of effort in communication about understanding the quality of life and acceptance of death between healthcare professionals and ones under their care. Yet problematic, this matter can be resolved by effective communication and education in healthcare and public settings.

Since the historical kidney transplantation for the twin brothers Herrick in 1954, the ethical issues of beneficence and non-maleficence about living donation remain in ongoing debates. The primary tenet of medical practice is “do no harm,” which makes the act of removing an organ from a healthy individual wrong. Supporters for living organ donation contend that the risk of dying as a living donor is quite low thanks to the modern technology in medicine. Moreover, the remaining kidney can compensate for the missing kidney in a healthy donor.26 Also, as long as the donor does not bear any coercion or manipulation, this practice is ethically justified.27 For any type of living organ donation, healthcare professionals have to violate the principle of non-maleficence to create beneficence to the recipient.28 On the other hand, upon the consent of organ donors, transplantation of deceased donor organ raises no doubt about the violation of non-maleficence.29 The result of the practice solely benefits the recipients’ welfare and the act of removing organs from the deceased does not cause harm to any individual, yet the removal must be consented.30

In order to protect the autonomy in living organ donation, donors must make their informed decision free from any form of coercion. Potential donors must truly understand the risks of being a living donor and the long-term impact it may have on their health, longevity, comfort, and overall quality of life. It is true that every individual has autonomy over his or her body, yet it is unethical if choices are made without being fully informed. A valid consent is obtained only when the patients recognize their legal and ethical rights to control over their own
bodies. Human dignity is an existential value which is the identity of a person and the recognition of what a person is in relation to all other people. Every person has his dignity equal to another, to a community, among communities, and among humankind. Accordingly, recognizing human dignity results in the respect of human freedoms, and protecting human dignity assures the protection of the equal rights for every individual to the benefits of science and technology in improving human welfare. Living organ donation might be justified by its distinction of respect for human freedom since it comes from personal choice. Nevertheless, it does not demonstrate the protection of the equal rights for every human with respect to the individual welfare. Besides, living organ donation enables the existence of organ trades or organ black markets, subsequently widens the disparity between the rich as potential recipients and the poor as potential donors. The inherent values in this case have shifted to extrinsic values. On the other hand, when an individual decides to become an organ donor after death, the decision is made on the basis of the personal/familial values and beliefs. When patients and families take responsibility for their own dying and death, autonomy and human dignity are more likely to be respected and protected.

Generally, discussion about justice often weighs between the benefits for individuals or the benefits for the society. The two creditable theories of justice are postulated by Mill and Rawls. While Mill approaches the justice conception from the utilitarian idea, Rawls’ idea of justice as fairness is clearly on the contrary to utilitarianism. The difference may result from the objects of their theories, that is, Mill is concerned about the overall benefit while Rawls aims to protect those who are least advantaged in society. Living organ donation when applied to Mill’s theory seems to be justifiable for meeting the goal to maximize overall utility, but when applied to Rawls’ theory, it is unjustified for the potential occurrence of abusing the least
advantaged who give away their organs owing to financial need. On the other hand, deceased organ donation when applied to both theories is justifiied. The recipients will have better health while no other’s health is debilitated in the transplantation procedure. Also, the chance of organ trading is much less likely, meaning to lowered or even eliminate the chance of abusing the least advantaged. A new issue that has emerged in the era of media is exploitation. Exploits of donors become more complex and could be in both explicit and implicit forms. Exploits occur not only to poor people but also to people’s altruism by using touched and sometimes professional edited personal stories. Such exploits have caused injustice in organ allocation.

Another serious issue was created and facilitated by utilizing living organ donation: the operation of organ black markets. A great deal of writers strongly disapprove of the existence of such markets for they devalue the human bodies. Organs provided by the black market usually come from poor people in poor health conditions, the unsafe transplant procedure often occurs in a developing country where sufficient authority and policy in organ donation activity is lacking, as well as post-operative care, the role of healthcare professionals as caring for people is likely to be corrupted. Some debaters are in favor of organ trades to some extent because of the ultimate goal of meeting the demand for organs. However, the emergence of profit-seeking bodies that specialize in organ acquisition would be an inevitable result from the nature of trading.

Either related or non-related living organ donation raises some distinct ethical questions. When the donors are related, the donation may be motivated by altruism, but it could be unduly influenced by the intense social pressures for their obligation or responsibility to the recipients. There is a blemish border between altruistic act and responsible or obligated act when it involves related living organ donation. Non-related living organ donation may be the highest level of altruistic act but its failure to improve the organ shortage is evident. The practice also raises
some social and ethical issues, such as implicit trading as the result of the policy to compensate for the altruistic act or violation of human rights.45

IV. Public Trust- a Novel Ethical Issue in Organ Donation

Chapter five outlines and deliberates the pros and cons of the current policies of organ donation. Required request policy, originally proposed by Arthur Caplan, aims at expanding the availability of cadaveric organ donation. The policy involves the available family members or legal proxy of the deceased during the procedure of discontinuing life support measures. This policy directly addresses the major problem involving family members in obtaining cadaveric organs. Still, the policy fails to acknowledge the nucleus of the event- the donor. The donorship, in fact, is transferred from the real donor to the family or legal proxy, which much likely raises numerous ethical questions around autonomy and human dignity.46 Mandated choice policy requires competent adults to make decision whether to become an organ donor after they die. The supporters of this policy believe that practicing this policy would eliminate the emotional and psychological burden for the families and healthcare teams during the sensitive and devastating moments. It also gains more positive attitudes from the public for its emphasis on individual role in decision making. Because the time waiting for the family’s consent would be eliminated, recovery of the procured organs could encounter less complication, and subsequently, improve the quality of procured organs. More importantly, the policy preserves the two philosophical foundations of organ donation: altruism and voluntarism.47 Mandated choice as the obligation to choose strengthens the individual choice and role.48 People opposing to this model contend that it poses moral, societal, and financial problems. According to standards of medical practice, there must be communication between healthcare staff and the families in terms of every aspect related to the care for the patients, before and after the patients die.
Overriding the families’ wishes would increase their frustration and create conflict between the caregivers and the families.49

Presumed consent policy, or opting-out policy is a system by which individuals are considered potential donors upon death unless they specifically note otherwise. Supporters argue that presumed consent policy is considered most effectively preserving autonomy and altruism concept through the donors’ consent. Everyone who does not wish to donate has the right to refuse while anyone wishes to donate can present the altruism through the consent.50 Although presumed consent has positive effect on organ availability, it is the most controversial and emotionally discussed policy.51 It has encountered objection for creating conflicts among utilitarian views, rights to autonomy, and justice.52 Among the current policies, although presumed consent policy shows that it has helped increase the number of donor organs, it shows a lot of ethical problems that ultimately raise doubt and erode public trust.53 This, in turn, will set back the current increasing number of organ procurement. In other words, it does not ensure a stable prospect for organ donation.

The financial incentive policy is offered as a method to use incentives to alleviate demand for organ donation. Advocates for this policy contend that the organ donation relying on altruism has failed to increase the number of organ donors.54 Commodification policy in which individuals can legally offer their organs for a fee is proposed as a policy against the existing organ black markets. The goal is to obtain organs from altruistic act but commodify the distribution of the donor organs. Some people express their favor in this policy and justify that the policy protects autonomous individuals in deciding for their own organs. An individual can express autonomy by making available a healthy kidney for a fee.55 Justification for the payment provision for this offer is analogous to the argument for the opt-in or opt-out decision.56 The
major opposing views stem from the contention for the impossibility of co-existence of money and morals. Injustice and social disparity would be the results of commercial organ donation. Additionally, it is hardly possible to create an incentive-based system without exploiting the donors. It compels people who have financial hardship to donate their organs for the compensation amount rather than for the wellbeing of the others. Moreover, the practice of this policy requires a system of price tags for donor organs, which, in turn, induces serious ethical controversies around the issues of human dignity. Alternative populations of potential organ donors include extended-criteria donors and transplanted patients. Potential donors once do not meet the eligibility for medical conditions, such as hepatitis C, HIV, etc. could become a promising source for organ transplantation.

Chapter six suggests a model for a future of sustainable sources of postmortal organ donation. The model consists of three essential components: altruism from all involved parties (including the society), autonomy, and human dignity in developing policies for cadaveric organ donations. The model encourages deceased organ donation by assurance of the core value of a donation act (i.e. altruism) and the protection and appreciation for donors as well as healthcare professionals. Most importantly, the model targets on obtaining public trust by protecting one’s autonomy and human dignity, thereby creating a sustainable source of donors.

Personal background plays an important role in awareness of altruism. When altruism means an intrinsic value of a person, it often derives from religious teaching. This value is unquestionable yet adopted and nurtured according to how much the individual abides to the teaching. When altruism does not mean an intrinsic value of a person, it can be educated and influenced throughout lifetime. Altruism is no longer a preferred motivation in organ donation; several opinions exist to lessen its role in organ donation. On the other hand, financial benefits
generally grant for medical professionals and facilities while the donors or families are the only participants who do not directly benefit from the transplantation process but are required altruism in the process. Compensations in any form for the donors, therefore, should not be unethical. A payment for cadaveric solid organs would be neither coercive nor result in loss of altruistic values.

Altruism is also needed to be reinforced among healthcare professionals because it has effect on job satisfaction, quality of care, and physician-patient relationship. In fact, care provided out of altruism creates high job satisfaction and positive affective states, resulting in better communication with patients and better quality of care. Moreover, healthcare professionals should never abandon or lessen the importance of ethics in their practice. Persistent practice on these ethics is the foundation for stability and reliability by which they would obtain and maintain public trust.

Altruism-approached system fails to narrow the gap between need and supply for donor organs. The reason for the failure lies under the lack of transparency and clarity in organ transplantation arena. There would be not a real altruistic domain in the culture of human body part exchange controlled by the governments and covered up by the economic exchanges in the field. A communitarian approach could change the moral culture in organ donation by rendering the society members to perceive donating postmortal, unused organs is morally right, and this act is what people expect from one another.

Any society, which approves organ donation from cadavers, has to confront several conflicts: the acceptance or definition of death based on medical, social, and cultural factors and the acceptance of death based on personal and familial values; the disagreement between the common medical criteria (brain death, cardio-circulatory death, and spiritual death.) It is very
important to facilitate the public’s understanding of the procedure and criteria for diagnosing death and making autonomous decisions to become organ donors. An autonomous decision on organ donation is considered valid only in the condition that the potential donor acquires comprehensive overview of donation and transplantation activity. The transparency could extend beyond the organ procurement for the donor’s families and the public in order to gain public trust, and subsequently motivate more potential donors. Such motivation from gaining public trust has more positive and extensive impact on attitude toward and causes less doubt about organ donation than romantized stories told by media or transplant centers.

Individual autonomy is not merely the independence or freedom to act; rather, it is a quality of personhood. Both internal and external constraints affect the way how it is developed, maintained and exercised. However, autonomy of healthcare professionals differs from this notion since autonomous professional practice does not define the person’s quality but the person’s professional quality; therefore, deprivation of healthcare workers’ autonomy differs from deprivation of ones’ moral autonomy.

Currently, healthcare facilities are run by business executives whose primary goal is to generate more and more money, unavoidably resulting in moral disillusion in medical practice and conflicts of interest between doctors and healthcare industry. Healthcare workers have to make care-related decisions based on the directives of their enterprises. Such operation creates barriers to the healthcare professionals’ autonomy and empowerment, which, in turn, undermines job satisfaction and leads to subsequent poor quality of care.

Human dignity is defined as the uniqueness of human beings and the individual identity which every person equally possesses. Human dignity is a morally significant human perception that expresses one’s desire to be recognized and respected as a dignified person. This
notion causes a person to respect the rights and interests of another besides the body integrity and personal property. In the medical setting, hence, it means the provision of treatment in the way that the patient wishes, also known as the application of the principle of autonomy. Acknowledging dignity inhibits mistreating or causing harm to patients.75 Per contra, some repudiate the concept of dignity for its vagueness or inconsistent or complex explanations, henceforth the author suggest the omission of this concept in medical ethics.76

The advocacy of commodification of the human body parts suggests that the policy is not immoral or a violation of human dignity; indeed, it benefits both donors and recipients for its recognition of the moral authority of the donors over themselves and efficiency of procuring human organs for the recipients.77 The policy should be allowed as it aims at preventing living organ donors and recipients from possible harms from the organ black markets. Still, the reason that organ sales meet public resistance is that such practice would put coercion on the donors, causes loss of public trust, and diminish human dignity, on the contrary to organ donation which conveys fully respect for human dignity.78 Prevention or eradication of the existence of organ trades necessitates criticisms of both organ market and its pertinent social circumstances that facilitate its occurrence and operation.79

The most common obstacle to motivation of organ donation is the integrity of the body after death. It often causes hesitance from the potential donor or the family and it could be the ultimate deterrent to donation.80 The human body and its elements make up a whole person, therefore they cannot have a price and cannot be owned by anyone else even after death if the person wishes to retain his inherent dignity and if the society is to retain and protect the human dignity.81 Nevertheless, the integrity of the human body is justified for therapeutic purposes
rather than prohibited in many cultures even though respect for the deceased differs among these cultures.82

V. The Impacts of Cultures on a Public Policy

In order to justify that the proposed model could be effectively applied for its acknowledgment and preservation of particular cultural backgrounds, chapter seven discourses how the proposed model could be applied for the organ donation issue in Iran and Saudi Arabia. The two countries share the Islamic culture; still, each has its own distinguishing religious teaching.

Islamic bioethics is based on the divine sources- the Qur’an and Sunnah.83 Nevertheless, the practice of bioethics differs in making decisions for conflicts. In Iran, in addition to the direct reference to the main sources, Grand Ayatollahs- the most qualified jurisprudents of each generation, determine the valid religious practice and provide rules on forbidden, discouraged, neutral, recommended, obligatory actions; as each Grand Ayatollah develops his own rules, Iranian Islamic bioethics owns its dynamism.84 Also, consensus is not accepted even among scholars in Iran. On the other hand, in Saudi Arabia, the main sources are the Qur’an and Sunnah, and consensus and analogy will be referred when dealing with conflicts.85

Islamic bioethics shares the four Western biomedical principles, yet it emphasizes on beneficence and justice rather than autonomy on the occurrence of issue that conflicts with public good.86 Four other principles are applied to consider for ethical decision making, including the principles of the public interest, do no harm, necessity, and no hardship. For example, in the confrontation of prohibited action like mutilation of the dead body, necessity can override this prohibition.87
In Islamic teaching, life must be appreciated and respected, killing an innocent person represents killing all human beings. One must remember death in order to appreciate his life and oblige to optimally benefit from his life. Generally, both cardiac death and brain death are accepted in Islamic law. In particular, brain death is accepted when the possibility of donating organs after death save people whose lives would not be saved if otherwise. The rejection of brain death occurs when the transplantation leads to the termination of life, justified by the maximum respect for human life.

Saving a person’s life means saving all people. Healing people is a sacred job in which caregivers need to do their best for all stages in a human life and under all circumstances but must know that the real healer is God at the same time.

Iran embraces both living and cadaveric organ donation in the organ transplantation practice. However, living organ donation considerably prevails over cadaveric organ donation due to its regulated paid living unrelated donation policy. The living unrelated donor gets paid from the government and the recipient; the amount paid by the government is regulated while one by the recipient is privately negotiable between the donor and recipient; living related or cadaveric donation receives no reimbursement as the donating act is considered pure altruism. There is no waiting list for kidneys because of the expanding donor pool and varieties of organs; the policy is supported by many people.

Utilization of deceased donors not only correlates with religious teaching but it also eliminates many existing ethical and social issues, such as adverse side effects of post-transplantation (physical and psychological impairments), violation of human dignity, and organ trades. Moreover, the monetary amount for appreciation that comes exclusively from the
government also contributes to eliminate exploitation, organ trafficking, and organ black market.96

In Iran, since both physicians and religious leaders have approved brain death,97 it is likely to make the deceased organ donors to become the only source for organ transplantation. Yet, it is necessary to establish an educational system via media campaigns, religious scholars, healthcare workers, and leaders of the society about organ donation and brain death criteria in order to raise public awareness and public trust in organ donation and brain death diagnosis.98

In Saudi Arabia, accepted organ donation sources include living donors (both related and unrelated) and cadaveric donors (both cardiac and brain death). Donors receive lifetime follow-up care due to organ donation, reimbursement for the absence from work due to surgery, and other reimbursement, the King Abdul Aziz Medal, and discount for Saudi Airlines. The disjointed condition between Islamic Jurisprudent scholars and medical experts has significantly adverse impact on the public attitude toward organ donation in Saudi Arabia.99

Similar to the case in Iran, a total shift to cadaveric organ donation would attract more public attention to organ donation matter and eliminate the issue of transplant tourism resulting from extremely low number of organ donors. Moreover, the application of the proposed model is more manageable in Saudi Arabia for its practice in accordance with the principle of public interest and the rule of consensus.100 Again, good cooperation between medical practitioners and Islamic jurists and theologians would better the public response to the policy.101

Chapter eight summarizes the discussions and arguments in the previous chapters. It concludes that organ shortage and organ donation should be acknowledged and approached as public health issues. It concludes that organ shortage and organ donation should be acknowledged and approached as public health issues. To approach ethical issues in public
health, there are several theories, utilitarianism, liberalism, paternalism and communitarianism. In public health ethics practice, there should not be priority for any single value over the other ones. Approaches to ethical issues in public health are so flexible and complicated that the ethicists ought to be able to choose to apply a sole theory or unify the theories, yet centering to the benefits for population health. Balancing the rights and responsibilities of individuals and wider populations is becoming more complex. Human rights and ethics scholars endorse public health strategies that aim to balance individual and community rights, maintaining that public health interventions that protect human rights also achieve population health.
Chapter Two: The Development of Organ Donation

I. Overview of history and current practice of organ donation

Most part of the world are facing the disparity between demand and supply for organ donation. A great deal of ethical problems in sources of organs and organ policies has accounted for such shortage of organ donors. These ethical issues accumulatively result in eroding public trust and impeding the growth of number of organ donors.

1. Organ donation before 1954 - aiming at survival

During this early stage of the field, cadaveric and animal organs were the sources. The focus was mainly the survival of the organ recipients rather than ethical debates or legal issues. During the experimental era of organ transplantation, animals provided tissues, such as skin, and parts, such as testis, and hearts for the practice. Organs and tissues were also obtained from human bodies, either alive or dead; but the donation act did not mean a willing act but commonly was obligatory act (for example, from slaves, and executed prisoners) or selling transactions. The very first body parts that were taken from living people were teeth in tooth transplantation implemented by John Hunter. The donors were the recipients’ slaves or the poor who sold teeth to the rich recipients. As only the rich could afford and had rights to medical treatments, the health status was the sole purpose; whereas, the donors were slaves or the poor who were treated less human than the other, their health conditions after the operation had no record. In experiments using animals, also only the conditions of the grafts on the recipients were concerned.

After the abolishment of slavery, the use of deceased donors increased while living donors almost disappeared, but there was not much documentation about how the deceased
bodies were obtained. The desire for a survival outcome overshadowed other values in medical practice.

2. Organ donation after 1954- the concurrence of success and ethical controversies

Not until the case of the Herrick twin brothers in 1954 started the era of ethical debates in organ donation practice. The very first debates yet still current are the violation of the maxim “Do no harm” and the consent for pediatric organ donors. The first success of human heart transplants by using the donated heart from a victim in a car accident rendered a serious contention about whether the patient was considered dead with her beating heart during procurement, leading to new criteria for death- brain death. During the 1950s and 1960s, living donors prevailed in kidney transplantation. However, the concept of brain death brought a new chapter to organ donation. The concept was initially established by Guy Alexandre- a Belgian surgeon in 1966. In 1968, the Harvard Ad Hoc Committee outlined the criteria for brain death, significantly enlarging the donor pool in the United States. During the mid-1960s, the introduction of ventilators to respiratory support for critically ill patients made an evolution in healthcare facilities. Ventilators ascertain the recovery for gravely ill patients who would have been impossible to avoid death in intensive care units. Yet, the aftereffect is without regard to the more complicated condition in which the patients do not breathe spontaneously but their respiration could be maintained forever by the ventilators. This unexpected sequel put hospital staff in a distressing position: how long should they keep the patients on the ventilators without which the patients’ death would occur. Prior to the ventilator era, doctors were the ones who decided and certified the occurrence of death which was the moment when the heart stopped; however, ventilators have blurred the line between life and death, raising ethical debates and legal issues around the ventilated patients. During this time, because organ transplantation did
not come to its popularity, organ supply was not an issue as this era when all potential organ sources, including ventilated patients, are considered.105

On the other hand, cadaveric donors were not the preferred choice in practice in the past. Using cadaveric organs was described as a chaos with the racing between legal paperwork, the constant availability of operational facilities, teams, and potential recipients and the short time of two to three hours from the death of the donor and revascularization in the new body.106

II. Common ethical obstacles in organ donation

Transplantation is one of the most multidisciplinary areas in medicine of all time. Its practice become a concern in not only religious practice but also traditional medical practice of Hippocratic Oath.

1. Traditional organ sources: living and deceased organ donors

The increasing disparity between the organ needs and supplies impels numerous policies for organ donation and procurement. The policies aim at increasing the number of organ donors, sometimes at the cost of moral standards, ethical principles, and violation of religious and community norms, resulting in the erosion of public trust.

Nowadays, the demand for transplantation has been rapidly increasing that turn the supplies to be scarce for most of the transplanted organs. Among the body parts, kidney is the most traffic, especially in Middle East and Asia regions. The scarcity is mostly caused by religious teaching and social thoughts about organ donations. In some religions, such as Jewish, Islam, or Buddhism, it is a duty for human beings that they must preserve the integrity of the human body after death. The attitudes toward organ donation are highly influenced by cultural background. For instance, Chinese and some East Asians whose life is influenced by Confucianism believe that their body parts come from, so belong to, their parents; removal of an
organ is interpreted as serious disrespect to their parents. If any organ is removed from the deceased body, it would be impossible for the deceased to rest in peace and reunite with their ancestors in postmortem life. In Shinto religion in Japan, a human body is an integration of body, mind, and spirit until after death; removal of an organ would disturb the human integration, therefore, it is unaccepted ethically. On the other hand, in Christianity, a human being is an entity of body and soul; when death occurs, the soul ascends, making the body no longer a person. Hence, donation of organs is not viewed as interference with a human beings but seen as an act of love and generosity. Nevertheless, either receiving support or encountering objections, there is a severe lack of the source of organ donation throughout the world.

When a patient needs one, they may receive the needed organ from abroad resources or he must travel abroad to have the resource and transplantation procedure instead of staying in the waiting list for the donated organs. The subsequent results are that the market prices become high as sky and financial incentives appear in the medical field. In some cases, the government legalizes the organ source from executed prisoners, such as in China. Some other nations apply presumed consents, such as Belgium or Singapore, meaning that everyone or anyone’s death in accidents are presumed to be organ donors unless they sign the opt-out earlier. In other cases, organs are obtained from crimes of kidnapping, killing, or stealing. Although there are many other different methods or policies that different countries apply to obtain donated organs, either for free or for sale, only the three mentioned above engender many urgent unethical issues relating to violation of human rights.

In using living donors, related-living donation proved its best fit in transplant practice for the favorable genetic factors. With the understanding of human histocompatibility, unrelated-living donors were possibly compatible to each other, giving more hope for expanding the donor
The use of living organ donors produces hesitance and resistance from healthcare professionals in organ procurement because it makes healthcare workers unavoidably violate the primary tenet of non-maleficence in their practice. An integration of principles and professional standards has assisted in dealing with conflicts and dilemmas in making healthcare-related decisions. Using living organ donation is unjustified because it establishes a precedent for the saving of life by putting the other lives at risk, even if it is an altruistic donation.

Since the first living organ transplantation for the twin brothers Herricks in 1954, the ethical issues of beneficence and non-maleficence about living donation remain in ongoing debates. The primary tenet of medical practice is “do no harm,” which makes the act of removing organs from a healthy individual absolutely wrong. Supporters for living organ donation contend that the risk of dying as a living donor is quite low. With the assistance of modern technology in medicine, the procedure is relatively safe to remove donor organs and the improvements in pharmaceutical drugs reduce or eliminate the complications during the screening for qualified donors and recipients, operation and in post-operative care. For any type of living organ donation, healthcare team members unavoidably cause harm to the person’s health to various levels but not for the health benefit for the person himself; the act of harm is to bring benefit to the third party, assuming the absence of financial factors during the transplant procedure. There is no guarantee of no risk for the donor; being aware of the possible risks without creating benefits for the donor, such practice is considered unacceptable in medical practice. In order to create beneficence to the recipient, healthcare professionals have to violate the principle of non-maleficence in their practice.

The practice of living organ donation induces and facilitates local and global organ black markets. Organs provided by the black market usually come from poor people in poor health.
conditions who sell their organs in disguising as organ donors. Also, the transplant procedure often occurs in a developing country with lacks of sufficient authority and policy in organ donation activity. As a result, the procedure turns to be unsafe for both donors and recipients. Since there is trading involved, the goal of cost efficiency and maximize benefit reduces the pharmaceutical use and absence of post-operative care. The harm caused to involved parties become unpredicted. The role of healthcare professionals as caring for people is likely to be corrupted. Using the sources of living donors raises a great concern about human dignity as it dishonors human dignity. More problematically, allowing selling living organs could commence an ethical debate between principlism versus communitarianism.

On the other hand, upon the consent of organ donors, transplantation of a deceased donor organ raises no doubt about the violation of non-maleficence. The result of the practice solely benefits the recipients’ welfare and the act of removing organs from the deceased does not cause harm to any individual, yet the removal must be consented. In deceased organ donation practice, the criteria of death and autonomy stay in the center of arguments. In China, it happens that executed prisoners are considered as individuals who have been deprived of their autonomy; therefore, the government allows organ harvesting from their bodies after the execution to secretly implement the procurement. Those organs are then usually sold in the markets rather than donated even though the government contends that the act benefits the worthy people. Organ procurement from prisoners who are condemned to execution violates every ethical standard. It deprives the prisoners of their autonomy and human dignity.

Definition and acceptance of death have a great impact for a person on becoming an organ donor; however, medical and social views often conflict with personal and familial values in these two matters, which create public hesitance or denial in organ donation. Two common
death criteria currently exercised in medicine include brain death and cardiac death. Discrete definitions of brain-dead criteria and miscommunication between families and healthcare team which lead to the ethical infringement and public distrust continue to be the prevalent obstacles in organ donation, either when the organ procurement occurs or not.

Nowadays, social media involves in every part of daily life, including organ donation. It benefits organ donation by increasing the efficiency of donor organ sources by bringing the potential donors and recipients together and raising awareness of organ donation in public, yet it also poses threat to fairness in organ allocation and risks to privacy of both donors and recipients. Touch up stories, loss of privacy when registering for the programs, making personal information available to the public. 114

Organ donation rates and disparity differ between developed and developing countries. In developed countries, transplant procedures are more affordable for the public which, in turn, creates grow in demands that cannot soon be fulfilled. On the other hand, in developing countries, transplants are too expensive medical procedures that they cannot be in the priority of consideration like other medical issues. Therefore, the demand for donate organs often lowers than in developed countries.115

2. Alternative organ sources: stem cells, savior siblings, xenotransplantation, persistent vegetative state patients

After the development of prednisone and cyclosporine A, the uses of cadaveric grafts and alternative resources, such as the donation from fetuses, anencephalic infants, patients in vegetative states, cloning, and animals, has added to the organ donation pool. Although they alleviate the scarcity of donate organs, these organ sources also have brought new ethical concerns to the field.116
Technically, stem cells are the cells holding reproducing ability to other stem cells or somatic cells or both. Common usages of stem cells include implanting stem cells into sick patients who may in turns improve their adverse conditions thanks to the regenerating ability of stem cells. In other words, stem cells enable tissues in human body to renew from damaged status. Stem cell transplantation faces ethical questions about the source of stem cells and the meaning of life for stem cells. Sources of stem cells include the stem cells from in vivo (stem cells harvested from within a living body), ex vivo (stem cells harvested outside a living body), and in vitro (stem cells harvested from a controlled environment). In the opposing view, as soon as conception occurs, the embryo is already a living being. To proceed with the technical procedure to obtain stem cells, the 4 to 6 day-old embryo must be destroyed. The destruction is considered as a destruction of a potential human person. Accordingly, either an in vivo or an ex vivo embryo certainly holds intrinsic value of a living human person, thus they must be protected. For their conclusion, they relate this procedure to the act of abortion. Because this early embryo is merely a potential human or not an actual human, it still must be respected for its dignity and humanity. In order to defend the research on stem cells, scientists argue that ethical debate on abortion issues and human identity are irrelevant because the path from stem cells to organ transplantation is therapeutic cloning, which should be differentiated from reproductive cloning. The group of theologians upholds the stem cell research by acknowledging the embryos used for the research as a potential person but not an actual person. Also, some supporters have encouraged the stem cell research by contending that it is expenditure without using the excessive number of embryos which are firstly created for IVF but then become unwanted and eventually be discarded. In the supporters’ view, they do respect the embryo at this stage but in the manner that the embryo may contribute to lifesaving or betterment
for human beings. Stem cells used in therapeutic cloning for organ transplantation are at the stage that cells not yet differentiate then specify; researchers will manipulate those cells to develop into the targeted tissues or organs needed for the transplantation. Moreover, scientists impossibly intervene or create human identity; cultural inheritance creates personality traits or human identity. On the other hand, reproductive cloning should not be supported when its purpose is germline enhancement, also called transhumanism, which intervenes in the germ cells to obtain desired traits; these alterations are then transferred to the offspring.

In order to study the capability of embryonic stem cells growing into neurons, a research team from Stanford University injected fetal tissue into the brain of rats. The team aims to bring hope to cognitively as well as physically impaired patients whose brains are sustained from partial or complete damage, such stroke, Alzheimer’s, paralysis. At its experimental stage, studies of stem cells focus on controlling the developing pathways of the stem cells into the specific types of cells. Besides, two major concerns for the source of stem cells include the risk of tumor growth and rejection. In ethical perspective, although receiving some support, this kind of study encounters strong opposition for the source of the stem cells from abortion. Certainly, any party that disapproves abortion would never be in favor of this source of stem cells even if the study would be successful and applied for human bodies, arguing on the role of the fetus as a human being which is used as a means in treatment for the other. Accordingly, the source from aborted stem cells cannot be ethically justified even though it could save lives. Whereas, the favoring side of this source contends that it is a potential source otherwise would be destroyed for the large number of abortion cases every year; as long as the proposal of using the fetal tissue will not be made until the abortion completes, it is justified.
Another concern is that savior siblings, either by *in vitro* or natural method. It is a technique that creates an additional child whose tissue can be used to save the life of an existing child. In this case, a child is created not for reasons connected to his own health or welfare, but for reasons related to other people’s well-being. Savior siblings would be created for the purpose of transplantation only. In fact, this method was given permission in the United Kingdom by the Human Fertilization and Embryology Authority. Savior siblings are the children who are conceived for other people’s well being rather than their own health or welfare; their existence is for another one to live. Creating savior siblings involves so many ethical debates. The idea of parental virtues and duties requires that parents must have unconditional love to their children in any condition that they come into existence. Thus, parents who have chosen to procreate their children for the transplantation purpose are unjustified because the action creates physical, and possibly mental, burdens to the future children. It is clear that future children have rights to have a healthy life and not to have a burdensome life. It deprives autonomy from the future child in making the decision of his or her purpose of being existed as an organ donor. When time comes, the organ donation procedure will inflict harm and bring no benefit to the savior sibling. Ultimately, his or her deteriorated welfare proves the injustice comparing to the sibling who receives the donor organ. Parents have involved both giving the existing child a better future and depriving it from the future baby by choosing the future as a spare for the other siblings, especially in the case that their donation causes detrimental effects on their welfare. Many people have said that the creation of savior sibling is an act that prospective parents treat children as commodities because the future child is brought into existence conditionally. In sum, for either source of stem cells, the intention of the act should account for the justification of the usage.
Xenografting practice has existed for a long time in transplantation field in the response for the shortage of donate organs. As early as the seventeenth century was the blood transfusion between human and animals in practice; while there was some success, occurrence of infectious agents in donors urged the ban for this practice. In the nineteenth century, skin xenotransplantation was quite popular; sources included frogs, sheep, rabbits, chicken, pigeons among which frogs were of the most successful use. In the 1920s, Voronoff attempted to transplant slices of chimpanzee testis into aged men for hormonal rejuvenation. In 1963, C. R. Hitchcock transplanted a baboon kidney to a patient’s thigh. The transplanted kidney functioned for three days then failed due to arterial thrombosis. Several cases using chimpanzees and baboons were reported with positive outcomes but rejection was still the main cause for the failed organ afterwards. Also in 1963, James Hardy performed the first heart transplantation between a chimpanzee and a semicomatose patient; the patient died soon after the surgery because the chimpanzee’s heart was not large enough to sufficiently circulate the blood in human body. For this experimental operation, Hardy faced strong criticism from the public and professionals and was forced to cease more attempts in cardiac xenotransplantation. In 1983, after the availability of cyclosporine, Leonard Bailey performed an operation transplanting a baboon heart into an infant girl because no infant donate heart was available then. The baby survived with the transplanted heart for twenty days then died due to acute rejection regardless of cyclosporine. On the bright side, however, the case raises awareness for the need of infant and children organ donation in public. Currently, for their similarity to human bodies, pigs, baboons, and other primates become the major subjects in xenotransplant studies. A new approach to utilization of pig organs is to genetically modify by inserting human genes into the pig organs or embryonic pigs to prevent rejection. Nevertheless, the biggest concern in this
practice is viral infection from animals. Another suggestion to take advantage of the porcine organ source is to have the source under strict monitoring for pathogenic organisms by raising the pigs for transplantation only. Some researchers believe that by housing pigs for transplantation under strict conditions, pig organs could be even safer than human organs in terms of diseases and time manner. Sources are organs from animals are often disapproved in religious practice for its chimeric products corrupting the sanctity of the human body. Still, xenotransplantation could become an advantage for patients in need or organ transplantation in countries where cultural barriers to donate human organs seriously limit the number of organ donors, such as Japan and many other Asian countries. Xenotransplantation could benefit infants and children for providing proper sizes of the needed organs since obtaining donor organs at early ages finites.

By the mid-twentieth century, the introduction of ventilators- a mechanical support for breathing, could sustain cardiorespiratory function, helping some people survive stroke and heart attacks; however, in many cases, these people fail to recover consciousness and become dependent on the ventilator and other medical technologies. On the other hand, organ procurement requires a clear definition of death for it to occur. Patients in persistent vegetative status, or irreversible coma, suffer major damage to the cerebral cortex which is in charge of mediating the sensation and thinking while their bodies maintain metabolic and physiological activities, reflex responses, and sleep-wake cycles. These activities often convince many people that the PVS patients still have their intermittent consciousness. The status of PVS patients is controversial for the permanent unconsciousness state which many people are in favor to categorize them as brain dead patients, especially for the purpose of removing organs for transplants. Still, irreversible coma people should not be treated as if they were dead because
criteria to determine the occurrence of death is far more complicated and influenced by other factors in addition to medical parameters. Classifying PVS patients as brain dead patients in order to procure organs would be interpreted as a killing act for organ procurement. The suggested source from patients in persistent vegetative state is also widely disapproved for the lack of informed consent and human dignity issues.

III. Normative bioethical background

The appearance of bioethics holds controversies in terms of its terminology and its perceptions. For people who believe that bioethics is a branch of discourse that developed from medical ethics in order to adapt the advances of science and technology say that bioethics is still a traditional discourse and is restricted to medical themes only. As being originated from medical ethics, bioethics, in this view, concerns about issues of abusive medical practices. Accordingly, protecting human rights under medical circumstances often involves protecting the rights of the sick. Bioethics becomes a means that aims to bring greater dignity, freedom, and equality to people in medical themes.

On the other hand, a group of people believe that bioethics was first coined by the biochemist Van Rensselaer Potter. He came up with the idea when he realized the necessity of combining biological knowledge with ethical principles so that humankind is protected and preserved to far future. Potter’s understanding of bioethics seems to hold a broader view. In general, bioethics is to be created to adopt ethical standards to every perspective involving humanities. He contends that bioethics should initially contain moral standards or ethical values; then, such standards should attach to biological facts. The two essential ingredients of bioethics consist of sciences and humanities, or more specifically, biological knowledge and human values, which, in turn, create a science of survival. Potter defined “wisdom as the
knowledge of how to use knowledge, that is, how to balance science with other knowledge for social good.”¹⁴³ The claim of creating bioethics as a new term and a new discipline by Potter seems to describe and include the best and the essence of bioethics. His idea of bioethics includes not only the medical ethics as many others’ opinions but also consists of all other ethical issues that take human beings in the center.

Potter envisions that bioethics would attempt to generate wisdom, the knowledge of how to use knowledge for social good, from a realistic knowledge of man’s biological nature and of the biological world. Bioethics aims to preserve human values and make man’s future come up to what it could conceivable be. Man’s survival may depend on ethics based on biological knowledge, hence bioethics.¹⁴⁴

To elucidate his understanding of bioethics, Potter defined bioethics as a bridge between present and future, nature and culture, science and values, and humankind and nature.¹⁴⁵ It is a bridge between present and future because of its purpose of existence. Bioethics is a science of survival which chiefly aims to preserve humankind not only by promoting health care but also by promoting women’s rights, preventing overpopulation, protecting the environment and biodiversity, and transforming society in such a way as to achieve the common good. Also, to protect all humankind, the conception of bioethics ought to be understood to the extent of global level.¹⁴⁶ Bioethics bridges the gap between knowledge, that is biology, and action, that is protection of human values, for a long term future; thus, it connects present and future. Moreover, humankind and their surroundings impossibly separate from each other; instead, they hold mutual effects. Thus, ecology must be considered in bioethics for such relation in order that human values are balanced with the natural world. Potter affirms that bioethics is changing according to how a particular society tests it and assesses the corresponding results in order to
improve itself by protecting and generating more human values. Such process is common for all types of sciences. Yet, bioethics is different from many other sciences in its attribute of being action-oriented.¹⁴⁷

Potter disagrees that bioethics is the field that was developed from, as a result is restricted to medical ground only. If bioethics excludes many ecological, population, and social problems which are ones of the main factors directly impacting on human values. Improving ethics in clinical scene is not a resolution for a long future because human survival is affected by many other factors.¹⁴⁸ Bioethics includes two stages which concern the relation between individuals and the relation between individual and society, respectively.¹⁴⁹ As a result, bioethics plays an important role in making recommendations in public policy.

1. Autonomy- Rights and responsibility

Some people discredit autonomy in medical practice, arguing that this concept shades other moral values and creates conflicts, because the involved parties often do not share the moral values.¹⁵⁰ Autonomy has become a slogan that is not critically used. Autonomy is an irrelevant matter that requires legal protection, because it is a moral value and depends on society. Lawyers do not suit to settle any issue related to autonomy or make any moral choices; instead, social arbiters and community should be the ones who settle such matter.¹⁵¹

One of the most controversial debates related to autonomy is the right to life. Two circumstances- comatose patients and patients wishing for voluntary euthanasia, center autonomy in justification for medical decisions for the patients. Comatose patients are incapacitated; they can no longer express their opinions about the choices between life and death. If they have advance directives, it almost guarantees that no clash between the healthcare professionals and family members would occur since the implementation is as the patients wish,
even if the wishes conflict with the families’ values. Without advance directives, families and healthcare teams should discuss further to justify for a common ground. Arguing for the validity of principle of respect for autonomy for posthumous cases, Arthur Kuflik proposes the concept of “hypothetical consent.” Upon the knowledge about the patient’s values and lifestyles, family members hypothesize what the person would or would not have endorsed if he or she had been able to make decision, then the hypothetical endorsement acts as the directive for the decision. It is the way to respect for the person’s autonomy. This concept may extend to the cases of deceased people, and other incapacitated people, such as anencephalic newborns.

On the other hand, the right to life is more problematic in voluntary euthanasia even though the patients are often competent when they propose their wishes. The advocates for voluntary euthanasia apply the principle of respect for autonomy to justify for granting the patients’ wish, arguing that autonomy exists from the start of life, so it should be at the end of life, too. Respecting for their autonomy means allowing them to choose at what moment they wish the life to end. Some supporters use the analogous relationship between this matter and committing suicide; anyhow, the analogy is invalid because the person who commits suicide is usually in an unstable mental status while the patient makes a request for euthanasia is not. Another defense emphasizes on the patients’ suffering, which, in patients’ beliefs, can be relieved only when death occurs; supporting their voluntary euthanasia not only maximizes their autonomy but also generates the greatest good for them. On the contrary, such autonomy creates unequal power relationship if the wish is granted. The autonomous decision maker does not want to share responsibilities or concern about the moral values and duties of other involved parties while, paradoxically, want these parties to respect for his or her feeling. Although the grave suffering should be acknowledged, the point cannot be justified in moral perspective. When it
comes to morality, every member of a society should not sacrifice another one’s morality in order to achieve his or her goal. In euthanasia, doctors’ and society’s moral standards are sacrificed for an individual autonomy. Thereof, autonomy enhancement warrants serious conflicts between patients and healthcare practitioners as well as patients and their community.

Another widely debated issue is that respect for autonomy creates conflicts with the patients’ religions and the treatments. For example, Jehovah’s Witness members will refuse blood transfusion even though it is life saving. Some people oppose their choice, justifying that the patients do not act autonomously. They make their decision based on setup rules rather than considering the subsequent danger to their lives or health. Still, such action is autonomous because the information is well understood and the act is intentional and free from any controlling influences. Moreover, that people act in accordance in the values defined by their religions or cultures does not make people non-autonomous. People autonomously embrace beliefs or principles upon which they validate their decisions.

Some others accept autonomy only if the exercise of autonomy brings good choices. If exercise of autonomy leads to making bad decisions or harming the other, it should not be accepted. Autonomy that renders evil or is used to pursue evil holds no value. The value of autonomy lies on its purpose of creating good and fulfilling lives. This argument is similar to the contention for the necessity of applying paternalism in some cases.

Many other scholars emphasize the importance of the right to autonomy in medical settings. Autonomy includes liberty and agency; together with the two factors, a sufficient degree of understanding makes the choice autonomous. Liberty and agency are the two required components for the existence of autonomy. Liberty is defined as the independence from any controlling factors while agency is the capability for an intentional act. According to
Beauchamp and Childress, the principle of respect for autonomy entails acknowledging people’s rights to “hold views, to make choices, and to take actions based on the persons’ values and beliefs.” Acting on the principle means elimination of any factors that could interfere with and reinforcement and preservation of any factors that could promote autonomous action. Respect for autonomy means respect for personal values and beliefs, making no interference with them as long as the individual owns the sufficient understanding corresponding to the decision that should be made. Factors that limit understanding include but not restrict to illness, irrationality, immaturity, and deficient communication. “Controlling influences include acts of love, threats, education, lies, manipulative suggestions, and emotional appeals,” which are grouped into three categories: persuasion, coercion, and manipulation. Coercion exists when intentional threat or force imposes on a person for controlling purpose. Persuasion occurs when one uses reasons to impose on another’s decision. Manipulation takes place when one is swayed to the direction the manipulator wishes. Information is a common means in manipulation.

In modern medicine, when the doctor imposes a paternalistic decision on a patient and goes against the patient’s wish, even for the patient’s best interest, the patient’s autonomy is compromised. Treating patients without respecting their autonomy is no longer consistent with medical practice in the modern time. It is required that healthcare professionals oblige to respect for the patients’ right to autonomy by understanding and allowing their patients to act in accordance with their particular values and cultures instead of assuming the patients’ values and wishes within a community. A person cannot live independently from the society, the relationship between an individual and his or her society is an interdependent one. Nevertheless, when the social values oppresses personal values, capacities, and competencies for autonomy, autonomy is impaired.
Also, acting on the principle depends on a particular situation. Considering a coercion for this principle, for instance. Coercion would be an interfering factor in some situation while a promoting factor in the other. Coercion is wrong when it harms a person or fails to respect that person’s autonomy. An individual has rights to act freely from any controlling factors on their self-chosen plan, either external or internal one; otherwise, he or she cannot be acknowledged as an autonomous individual. Per contra, coercion is justified if constraining a person’s autonomy to prevent the person from harming the public.

Incorporating medical decision making with patients’ values and wishes ranges from being unnecessary to required, depending on the patients’ goals. Respect for autonomy means allowing people to make choices that fit their goals. Some patients prioritize their health concerns to cultural beliefs while some other always put forward their beliefs in every aspect of their lives. Howbeit, to respect the patients’ autonomy does not manifest that healthcare professionals act only as informants. A successful medical encounter depends on the clinicians’ skills to validate the consistency between the patients’ values and choices, patients’ capacity in making decisions, and influencing factors, such as worries, illness, and feelings. When necessary, further information should be shared between the patients and clinicians upon mutual understanding and respect in order to achieve patients’ goals.

Disclosing information and ensuring the patients’ understanding are not sufficient to obtain informed consent in the relation to respect for autonomy. In the model of autonomous authorization for informed consent proposed by Beauchamp, he enlists the three conditions required for an informed consent, including intentionality, understanding, and voluntariness. These conditions are enclosed in two elements of an informed consent: the information and the consent. The information component refers to the information disclosure and comprehension.
while the consent component attributes to a voluntary decision and an authorization to proceed. This model serves as directives to obtain a valid consent in particular circumstances.167

Similar to autonomy, the concept of consent has its own long history but just recently became a commonly ethical practice in the twentieth century.168 In Hippocratic ethical tradition, doctors must not share medical knowledge with patients, and doctors were the ones who decided what benefited best the patients. The traditional practice of keeping medical knowledge and information, including medications, was established on the thoroughly understanding of all the aspects of the patients’ lives. At that time, doctors made visits at the patients’ houses; doctors and patients often lived in the same community and shared cultures and values. A doctor may give care for a few generations of a family, hence he knew almost exactly for what the family members wished in a particular circumstance. It was even acceptable for a doctor to use benevolent deception if it was the best for the patient. This practice sounds unacceptable and impractical in the modern medicine.169 It is unacceptable because non-disclosed information does not establish trust. It is impractical in modern time because doctors have no time to get to know their patients’ and primary care setting is not used efficiently for gathering pertinent information about the patients. Medical decisions are often made by specialists who newly know the patients, who, at best, know the patients’ medical conditions and history but not the patients’ values and wishes. The relationship between doctors and patients as well as the means and methods of medical practice significantly differ from the past ones. In standard practice, patients should know all pertinent information, including the rationales, about their health conditions, medications, and procedures. Based on the provided information, patients make decisions instead of doctors. Doctors are expected to respect any decisions, even the ones that less benefit the patients’ health conditions. Doctors’ duties are to evaluate the patients’ levels of apprehension,
recognize and predict any possible barriers to the conversation, and provide and explain meaningful and useful information, for example all available treatments with their advantages and disadvantages, or consequences resulting from the patients’ decisions. Also, in standard practice, modern doctors must ensure that their patients understand the information and their decisions are not under any coercion, persuasion, or manipulation. A valid consent is obtained not merely by providing all pertinent information and having the patient signed the paper indicating his or her consent.

Provision of adequate information for patients or family members holds a decisive role in building trust and providing effective care. So, what assists doctors in selecting what should disclose to the patients and families, especially often in hasty environment? In addition to skills, knowledge, laws, and codes, professional virtues are the most significant factors that help doctors maintain moral practice, preserve their professional principles, and achieve their goals of delivery the best care to their patients. From the arguments, why does respect for autonomy build trust and provide effective care? Because it promotes patients’ autonomy while retains practice principles and moral standards.

In the relationship with the principle of respect for autonomy, informed consent is not merely a consent obtained after providing information. Within this relationship, the disclosed information assures the decision is based upon the understanding of the given information, and the information is free from coercion, deception, and manipulation. A mere exchange of information does not warrant respect for autonomy. When a person lacks some particular knowledge necessary to make decision in some cases required professional knowledge; it does not mean that the person has no autonomy, but it is the obligation and duty of the involved
professionals to educate or explain sufficient information until that person is able to make autonomous decision.

Consent should not primarily be treated as a means of litigation protection for hospitals and doctors. It is a means of communication between doctors and patients, by which doctors provide necessary information for the patients to make their own medical decisions; it is also a means of enabling and promoting patients’ autonomy. Accordingly, if patients have poor understanding about the content stated on the consent document, it manifests an ineffective communication, which, in turn, makes the signed consent meaningless and inhibits the patients’ autonomy. Respect for autonomy should occur in a mutual relationship between involved parties. For instance, healthcare professionals should evaluate the patient’s level of understanding as well as any existing or possible barriers to the understanding. Reciprocally, the patient should express his or her cultural beliefs, values, and doubts that require the doctor to provide further information. Effective communication leads to better understanding patients. It requires time, methods of communication, and advocacy to patients.

From the moral perspective, consent functions as a protective tool to prevent unauthorized invasions for people’s bodies and as a facilitative moral power. Without a consent, an interpersonal affair would not be permitted or even be prohibited; in other words, an act initiated without consent could be a wrongful act but could turn to be a right act if being consented. Furthermore, consent facilitates cooperation among involved parties as it creates expectation for everyone’s future behavior. In the medical research, it is suggested that the importance of consent should be lessened because obtaining consent becomes an obstacle that impedes the development of research and consumes too much time. The argument, yet, limits to the research which aims at studying medical conditions, such as Down syndrome, cystic fibrosis;
the research must be motivated by a morally good science. The author who is in favor of lessening the role of consent in such research indicates that the priority of obtaining consent over other factors accounts for the delayed studies, resulting in delaying the possible benefits for people of the studied condition. In such case, the concept of consent interferes with the public interest by limiting the freedom to generate good for the public. The author does not refuse the principle of respect for autonomy, but, in some circumstances, such as people with congenital mental impairment, it is impossible to obtain consent or it would take a long time and large amount of money to obtain consent from guardians, it is ethically justified to bypass obtaining consent. Another situation is for posthumous people who consented to donate their organs or tissues but the healthcare practitioners have to act according to the family’s wishes that is against the donors’ wishes. In sum, for the public interest, it is ethical to not obtain consent. Such contention is unjustified because public interest should not be fulfilled at cost of public trust, autonomy, and human dignity.\textsuperscript{177}

Viewing respect for autonomy from healthcare professionals’ side may seem to be a legally confined act instead of a moral act. The requirement to respect for patients’ autonomy may restrict the clinicians to act according to the rules and distract them from morally acting according to particular situations.\textsuperscript{178} So, in modern medical practice, do healthcare professionals own autonomy, if so, how should it be respected, and how can autonomous healthcare professionals respect for the patients’ autonomy?

Every person is also responsible for making an autonomous decision; responsibility becomes accountability in this context because freedom comes hand in hand with responsibility. A person is responsible to learn and use knowledge as well as evaluate the corresponding consequences to make a free and responsible choice. Respect for autonomy should occur only to
a responsible autonomy that is free from immaturity, incapacity, ignorance, coercion, and exploitation. 179

2. Human dignity - the existential value

Opposition to the concept of human dignity once sides with and provides protection to the under-privileged in an absolutely different social structure. Per contra, in the modern world, endorsement of this concept functions in the same manner, extending to all other members of the society. The idea of human dignity in the past is more charged than in the presence for the serious division of social ranks in the past. In addition, the concept of human dignity founds human rights; as a result, the rights determine the status of human dignity. Defending human rights means defending human dignity. However, human rights were established by the elite group in the society, aiming to create privileges and protection for the rich, the dominant, and their allies. 180 Many scholars of the time opposed to such partial rights that did not benefit or protect the majority of social members who were the poor and the subordinate. Kantian and virtual-moral views were the two popular supporting views for such opposition. Both views oppose the adherence of social ranks to human dignity, arguing for the possibility of equal dignity for everyone. In the Kantian view, every individual has human dignity and it should be protected; yet, the concept of human dignity emphasizes on the pain and suffers, making the act causing injury or insult violate one’s dignity. On the other hand, aiming at improving individual characters, virtual-moral view grants human dignity to moral individuals while the ones who do not act in accordance to moral standards lose their dignity or their chance to acquire it; therefore, they lose their rights. 181

Some thinkers contend that dignity is not more than a popular but unclear, flawed, and unhelpful term in bioethics which renders everyone to oblige to keep it; hence, this concept
The concept of dignity is a useless because it is indeterminate, reactionary, and redundant. It is indeterminate because the concept opposes to so many bioethical matters that it becomes unreliable concept to contend for any ethical issue. The concept is reactionary because its moral argument impedes most of advances whose ultimate purpose is to benefit human beings at last. Finally, dignity concept is a redundant concept, because even if it were plausible, other ethical principles, such as respect for autonomy, should be sufficient in bioethics.

Some other scholars find the idea of human dignity unacceptable because human beings are incapable of judging the worth of each other. Some other scholars compare human beings to other species, pointing out that human beings own nothing more special than other species. In some harsher criticism, human beings are even worse than other species because human species are aggressive and destructive to other members of the earth.

On the other hand, Kateb does not embrace the idea that either the degrees of suffering, injury, or morality decides existence of human dignity. In Kateb’s view, the idea of human dignity has more roles than merely a tool to defend rights. It is an existential value rather than a moral value. It is existential because a person is born with it, does not need to attempt to have it, and cannot forfeit it. The moral values are to enhance the existential values; they do not define an identity. An individual is recognized and distinguished from one another and from other species by this existential value. Human dignity is an identity of a particular individual in relation to the others; it is the equal individual status. An identity cannot be taken away because the person acts less morally. In other words, Kateb contends that human dignity cannot be forfeited but it can be destroyed which differentiates from Kant’s idea that human dignity can be forfeited by wrongdoings. Human dignity or personal identity is deprived when an individual is
treated as less than the other human beings or when an individual recognizes himself more superior and unique than the others. In other words, the intention of inflicting suffering or injury becomes a means to degrade or re-identity particular individuals or a group of individuals, thereby depriving others’ dignity. Slavery is a clear illustration for such deprivation. The notion of human dignity as an existential value and the uniqueness of human beings serves as fundamental for the arguments throughout this work, because it fulfills arguments in both secular and theological perspectives. Human dignity is an inherent value and independent of the external values. Every person has dignity equal to another’s; human dignity is the identity of a person and must be respected and protected; no one should have to fight to claim or achieve for his or her dignity. Even if a person shares group identity, such as religious or cultural standards, he or she still owns some sort of individualization of the shared identity. Hence, one should not impose the group identity on one another but should acknowledge any level of individualization of the shared identity. It is the uniqueness of a human being. Such definition of human dignity as the uniqueness also fulfills the religious view of human dignity.

In addition, if only suffering and injury can identify the violation of dignity, a great deal of people would be mistakenly believed that their dignity is fully protected. People can be degraded without suffering, or, even worse, they do not realize they are painlessly wronged and they willingly accept the act. That is when people are oppressed by rules, disciplines, or even rewards. The dignity, hence rights, is subtly deprived without even the individual noticing.

The notion of human dignity developed by Kateb and the moral status of individual by Beauchamp and Childress protects the vulnerable groups, such as prisoners who are condemned to be executed, minorities, brain-damaged newborns, etc., in organ donation issues. The two grounds- human dignity and morality, found the idea of human rights.
Emerged long time ago, human rights have longer and more perplexing history than bioethics. Initially, human rights primarily concerned about the issues of human torturing and abolition of torture and cruel punishment, and existed mostly in the literature works. The concept of human rights was first proclaimed in document by the President of the United States-Thomas Jefferson- in the Declaration of Independence in eighteenth century: “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness.” At the same time, another declaration about human rights is also claimed but in French in the French Declaration of the Rights of Man and Citizen: “ignorance, neglect or contempt of rights of man are the sole causes of public misfortunes and governmental corruption.” This claim is remained more in the United Nations Declaration of Human Rights in 1948. Although human rights was the concern in the society a long time ago when the slavery abolishment had not occur, when most countries were under monarch systems, and when humanity and anthropology were not common studies, it becomes meaningful and is guaranteed only when it is stated in political document. The conception of self-evidence is a crucial requirement in human rights because emotional appeal is account for self-evidence. Without emotion, it is unlikely that one can realize whether his or her human rights are violated. Many philosophers are in favor of this point and that human rights are not merely a document but also an emotional agreement among the majority of social members upon their rights. In addition to self-evidence, another notion is also a significant requirement that validate human rights. A completely autonomous person is a person capable of moral autonomy and empathy. It is individual autonomy, entailing that every individual should be able to exercise independent moral judgment from right to wrong. Meanwhile, to be autonomous, a person must recognize
other people’s thought and feelings which is known as empathy. In other words, autonomy includes both self capability and interaction with people around. Since empathy is created through individual experience and feelings, perception of human rights are not immutable. It is possible that a person, a group of people, or a society change or have new their understanding or standards of human rights.\textsuperscript{193}

After World War II, an international body- the United Nations- was founded with fifty one countries as its official members. The United Nations Charter of 1945 emphasizes that human rights and fundamental freedoms must be universally respected and there must not be any distinction as to race, sex, language, or religion. The organization even established a Human Rights Commission which operates upon the bill of human rights. As a result, on December 10, 1948, the General Assembly approved the Universal Declaration of Human Rights which was favored by forty eight countries. The Universal Declaration was established based upon the notions of human rights in the eighteenth century in addition to developing more moral obligations for the world community. Moreover, the effect of the Universal Declaration is much widespread compared to the two Declarations of Human Rights in the eighteenth century, which had influence on the United States and France, respectively.\textsuperscript{194} Afterward, especially the 1970s and 1980s, concern about human rights extended and generated critical changes throughout the world. Yet, there have been a great number of incidents of human rights violations, since no enforcement is pressed on the countries which violate human rights. Some current violations occurring include the growing sexual traffic in children and women, starvation, unfair distribution of health care, etc. Some people believe that such violations are caused by the limits of empathetic understanding. Whereas the others claim that empathy has become stronger, but the countervailing effect of violence, pain, and domination is also greater than ever before.\textsuperscript{195}
By time, in advent of social and economical development, awareness of human rights has been arising and extending to more issues. Nowadays, human rights appear in every matter that is related or affects on human beings.

The definition of human rights has developed from the idea of rights distinguishing from the divine rights, to the rights to participate in politics, and to the combination of dignity and morality. The Declaration of the Rights of Man and Citizen is considered the first declaration of human rights dated back to 1789. Although the rights declared to be universal and pronounced the equality regardless the privilege based on birth, it excluded a large portion of the population who were incapable of or unworthy participating in politics. They were those without property, slaves, children, women, the insane, prisoners, or foreigners. In 1948, the United Nations state a new declaration of human rights - the Universal Declaration of Human Rights: “All human beings are born free and equal in dignity and rights.” The concept of dignity in this declaration is a Kantian formulation that prohibits to use human beings merely as a means.

Protection for human dignity, hence human rights, ensures justice in a society. Justice occurs when there is a just allocation of social burdens, benefits, and opportunities. Nevertheless, not all theories of justice are relevant to Kateb’s notion of human dignity. For instance, the theory of utilitarianism emphasizes on the greatest good, regardless of the means to obtain it. As a result, happiness and pleasure are the parameters to justify for the act and determine its morality; the more happiness and pleasure, the closer to justice the act is. In utilitarianism, there is no consideration for the distinction between persons, it concerns about the overall benefits and it allows unfairness to occur when the maximum benefit can be subsequently obtained. Advocates for utilitarianism justify for the theory by the emphasis on the benevolence in utilitarianism. This point is opposite to Kateb’s view in which he suggests the central role of
pain and suffering of others in thinking and acting; pain and suffering should be reduced or
avoided as much as possible so that no harm incurs; henceforth, justice is obtained while human
dignity is protected. Rawls’s theory of justice which requires a fair distributive system to the
disadvantaged in the society strengthens this view, especially in the organ allocation context.
Since Rawls’s theory is concerned more about the individual role in the society, his theory may
encounter the issue that the conceptions of justice are various corresponding to the background
of each person. This is the reason why Rawls strictly requires certain conditions of the society as
well as individuality upon adoption of his theory of justice as fairness. As a result, the second
condition is that a society, which is regulated by the theory of justice as fairness, is a well-
ordered society. A well-ordered society is the one in which the good of its member is improved
and is effectively regulated by a public conception of justice. 202 In addition, the primary object of
justice must be the basic structure of society which the major social institutions distribute
fundamental rights and duties and determine the division of advantages from social cooperation.
In justice as fairness, society is a cooperative venture for mutual advantage. Rawls’ theory of
justice as fairness benefits the least advantaged. 203 Applying the theory of utilitarianism creates
more vulnerable parties who are considered to benefit the others. The vulnerable could be either
the majority or the minority depending on which group creates more overall benefits. 204

Another approach to justice is paternalism which is also irrelevant to Kateb’s human
dignity notion. The paternalistic approach treats all adults as if they were children who do not
know what is good for them and must be saved and directed to certain actions defined by a small
group of people who apparently know better than them. Paternalism defines identity for other
people and interferes with self-development. It violates human dignity for imposing coercion on
individuals and forcing them to do things against their will. One might argue that some
individuals might truly need directions as they act irresponsibly and prone to self-destruction. To criticize the practice of paternalism, J.S. Mills contends that even though human beings are entitled to freedom within moral limits, dignity of a person cannot be denied for the reason that how he or she choose to grow or how well the person lives. Everyone should be free to live as he wishes.205

In order to protect the vulnerable groups by moral norms, we have to recognize who are included in the groups that deserve the moral protection. Five prevalent theories of moral status contribute understanding of and attract attention to moral status but they do not provide any adequate approach to the modal status issues. The first theory is based on human properties, stating that all humans and only humans have full moral status. Although the theory successfully include most of vulnerable individuals, such as a fetus, mental disabled people, people in persistent vegetative state, it would be likely to disapprove any chimeric research or practice regardless of the potential benefits to human health.206 The second moral status theory is based on cognitive properties, including perception, memory, understanding, and thinking, which determine the moral status of an individual. The theory aims at extending the number of individuals deserved moral protection, such as hybrid human, as long as they own the three traits of the humanlike cognition. Paradoxically, the theory excludes the vulnerable groups who have cognitive deficiency from the moral protection, resulting the violation of dignity and disrespect of autonomy to these individuals.207 The third theory is based on moral agency, referring to the capacity to act as a moral agent, who is capable of making moral judgment with moral motives. Again, the theory does not consider vulnerable people for protection.208 Another moral theory is based on sentience- the consciousness as feeling of pain and pleasure. This theory extends its protection to both human and animals, but it does not grant moral status for ones whose feeling
for pain and pleasure is not yet developed or lost, such as a fetus in early stage or brain damaged patients. According to this theory, such individuals have lower or no moral status while healthy animals could have a full moral status.209 The last moral status theory is based on relationships that establish roles and obligations between parties. The relationship dependence makes the moral status unstable because it does not provide a sufficient condition of moral status.210 It is suggested that a combination of the five theories would create a multicriterial, coherent moral status.211

3. Altruism- the universal common morality

The notion of altruism, first coined by the French philosopher August Comte in the early 1800s, is defined as a “disinterested and selfless concern for the wellbeing of the others.”212 The concern and behavior benefit ones who do not have any attachment to the actor. The foundation of the altruism varies among individuals. It could be religion, career, personality, self experience, emotion, or inspiration. To date, several theories of altruism have been proposed, focusing on the origins of altruistic behaviors. Six prevailing theories include altruistic personality, universal ethical principles, internalized personal values, the concern mechanism, the ethics of care, and the empathy-altruism hypothesis. In the altruistic personality theory, it is believed that the experiences early in life contributes to the inclination to act altruistically. The second theory- the universal ethical principles, states that people act kindly because they commit to a set of universal ethical principles. In the internalized personal value theory, some people set their own conduct standards, either for doing the right things or for the wellbeing of the others, and act accordingly. In the theory of the concern mechanism, caring is the motivational component for an altruistic act. This act develops in a process of three components: distress input, change in feeling and emotion, and the altruistic act. Altruism requires a trigger to occur in this theory.
Finally, altruism derives from the ethics of care. This theory limits to healthcare workers only. In the last theory—the empathy-altruism hypothesis, altruism is originated from the empathetic concern felt for the needy person. Application of this theory seems to be the most effective for motivating altruism, especially in organ donation, because the theory indicates the three unintended positive consequences to the helper resulting from their kind act. When acting out of altruism to improve welfare of the others, the person would reduce personal stress, avoid guilty feeling or avoid having others think negatively for not giving help, and achieve personal rewards, such as pride or satisfaction. Altruism links to elevation, and it is sometimes called life’s elixir. This theory fits well in medical donation in general, and organ donation in particular, because its content fulfills the foundation of altruism. Empathy is feelings, thoughts, or attitudes toward the other people, and altruism is concern or devotion to welfare of the other. However, altruism in medical donation differs from general altruism in the ethical requirement of a safe and beneficent practice. In other words, the motives of the donors must be ethically appropriate. Emotional or inspirational motives of altruism, hence, are not considered ethical behavior in organ donation.

In 1970, professor Richard Titmuss analyzes the relationship of altruism and social policies in his book—the Gift Relationship. He concludes that healthcare system should be protected from commercialization so that it will perform better and gives chance for altruism exercise. In his view, altruism is a social bond and altruistic exercise belongs to human rights. Commodification of health care suppresses altruism exercise, which makes commercialized health care suppress human rights. It is unlikely for market and non-market regimes to co-exist as the financial factor eventually erode the effectiveness of the other one. Titmuss claims that it is the commercialization that discourages altruistic behavior and diverts people from the
The altruism in donation is a two-way moral concept between the donor and recipient. An altruistic donation occurs if the act fulfills three conditions. First, the act is to benefit not anyone but the ones who are in need. Second, the act is free from obligation for both donor and recipient. For example, in organ donation, it is possible that the donors—either family members or friends—feel obligated to save the loved ones’ lives. Although the donation may exist only in their thoughts if there is no altruistic motivation, the obligation might overpower the altruism and initiate the act with cloudy judgment. Therefore, it is crucial for healthcare team to evaluate the donors’ motivations in order to prevent any donation act that derives from obligation rather than altruism; the team also has the right to refuse such cases. Third, the act relies on mutual respect that requires consideration for safety and personal rights for both donor and recipient.

Altruism is acknowledged as both universal and particular common morality. Altruism is a particular morality when its values require a special knowledge, or even experts or scholars to explain in the cases when the moral norms abide to religious norms. In the context of organ donation, altruism should be perceived as a universal common morality because everyone accepts it in all cultures; it is accepted and should be committed among every member of a society. This perception assists a creation of a community-benefit policy which prevents public trust erosion.

**Conclusion**

With the advances of medical and pharmaceutical practice, organ donation practice must overcome more ethical obstacles. How are we to balance the demands of self-interest with the needs and interests of others. Organ shortage and organ donation should be acknowledged and
approached as public health issues. The goal of public health is to improve public welfare, reduce inequalities, reduce and remove harms. Public health issues should be correctly defined and placed within the particular community’s cultural and social standards. To approach ethical issues in public health, there are several theories: utilitarianism, liberalism, paternalism, and communitarianism. In public health ethics practice, there should not be priority for any single value over the other ones.\textsuperscript{221}

According to utilitarian theories, standard of justice require the maximal social welfare. Utilitarianism is an impartial theory. Regardless of differences among people, its only trend is to maximize the well-being for the population. There has been no existence of preference for particular groups of people or individuals. If the population group can have the most benefits but some individuals must sacrifice their benefits or even be harmed, the action is justified; in other words, utilitarianism regardless of the means to achieve the goal of population health protection and promotion.\textsuperscript{222} The utilitarian approach does not fit in this matter because it does not consistently offer protection for individual rights. The social utility determines whether one would receive benefits or burdens and how much one would receive for the overall greatest good. Utilitarianism aims at creating the best utility regardless of conditions of social members, making it an impartial approach.\textsuperscript{223} The means to achieve overall best outcome is insignificant and there is no assurance for an equal protection according to this approach.\textsuperscript{224} If organ donation is approached by utilitarian theories, the well-being of the public comes at the expense of the vulnerable, such as anencephalic newborns, and patients in persistent vegetative state.\textsuperscript{225} Moreover, to attain the goal of maximizing the utility for communities, it is inevitable to implement utilitarian policy without paternalism, both of which focus on consequences rather than implementing means. Without paternalism, utilitarianism will not be effective; likewise,
without utilitarianism, paternalism is unlikely to be justified for infringing the individual rights. Applying the moral theory of utilitarianism in such way in public health creates one of the core issues in public health policy and practice, which is the ethical dilemma between the individual liberty and communal benefits.226

The libertarian theories, on the other hand, give the highest freedom to individuals by emphasizing on individual rights and freedom. The center of the theories is respect for autonomy. The benefits and burdens are distributed, as long as the distribution is freely chosen by the individual, it is a fair distribution. People have the rights to decide on their own acts and health. For this point, the advocates have missed a critical point which is that individuals are unlikely separated from the community, moreover, people and their community are in an interactive relationship; accordingly, the community, culture or society often impacts on the individual thought.227 Libertarianism justifies proposals of organ markets or any form of organ sales. Nevertheless, organ commerce poses more problematic issues to every involved party than the one major advantage of a temporary improvement for organ shortage. The libertarian approach is not a best option for organ donation.

Paternalism is the approach that applies coercion on individuals in order to modify their minds and behaviors to minimize the detrimental impacts. Paternalism is the most charged approach, depending on the emergent and devastating levels of the public health issues. For instance, the required immunization has prevented a large number of death tolls. In 1947, the smallpox outbreak took thousands of lives in New York and other places; after the immunization campaign was enforced, there were only four deaths.228 However, for issues that do not require immediate interventions, paternalism seems to be the least favorite approach in organ donation as
public health issue, because the matter does not cause urgent harm to the public health that requires the government to interfere or disregard individual autonomy and dignity. 229

On the other hand, communitarianism emphasizes on the mutual responsibility between community and the individual.230 Not separating the roles of community from ones of individuals, communitarianism integrates and balances the individual interest and public benefits.231 It centers on the protection and promotion of community health without intervening individual freedom. Individual values and beliefs are acknowledged and protected because communitarianism applies the social and cultural traditions to approach the community members. In addition, communitarianism is a customized approach in accordance to any particular community. 232 Communitarianism is a universal approach to public health because it fits for every particular community by placing the communal virtues and norms into the center of moral thinking. The success of a public health policy is manifested by how well the policy changes public behavior upon social norms without manipulation. Human rights and ethics scholars endorse public health policies that aim at balancing individual and communal rights.

The discourse of bioethics cannot exclude human rights from its purpose. Protecting as many human rights as possible becomes the most significant goals of bioethics. However, that is how bioethics is conceives and decides about the territory of human rights it includes. For this point, Potter’s bioethics provides more protection to human rights for its broad vision and objects compared to the bioethics originated from medical ethics. In Potter’s definition of bioethics, human values and future are preserved by biological knowledge. In other words, the survival of humankind depends on the ethics of using biological knowledge. In relation to human rights, Potter’s idea is more relevant and rational than the other conception because human rights includes not only the rights to health care but all the values that every individual holds during
their life. Every human has rights to being treated equally, even if they are good or bad, poor or wealthy, sick or well.
Chapter Three: The Evolution of Organ Transplantation

Organ transplantation has a long history since its fantasy era and experimental periods. It has become a routine treatment option in medical practice. Analysis of historical events elucidates not only the origins of ethical issues but also the evolution of public attitudes toward organ transplantation and donation. Discussion about organ transplantation is no longer about only the feasibility of the medical methods. Numerous issues of different perspectives need to be reviewed, debated, and addressed before the transplantation could actually happen. At first, a review of the history of organ transplantation illuminates the complexity of the evolution of organ transplantation along with the ethical issues the field has faced; henceforth, interested parties contrive effective approaches to potential organ donors in order to achieve the goal of sustainability of donor organ supplies.

I. The era of ideology and experiments

Before the period of Renaissance, the interest in transplantation is expressed in mythical stories; yet, the ideas represented the human free spirits and desires for defeating illnesses, physical disability, and death. These ideas have inspired generations to generations to seek for knowledge and means to turn the ideas become true. The era of Renaissance marks the very first step for humankind to make attempts to actualize the antecedent ideas.

1. The era of primal organ transplantation

The idea of transplantation continued to exist in the supernatural, legends, and fantasy across many different cultures. Before the Renaissance period, surgeries fell into disfavor, and, inevitably, transplantation shared the same repressed fate.

During the ancient time, supernatural help along with local healers played important part in healing the sick and injured. Supernatural power was believed to restore the body to its
originally healthy one. Alike many medical advancements originating from the needs of intensive medical care during wars, the history of organ transplantation is a long and distinguished one dated back to 550 B.C. when the well-known physician Pien Ch’iao suggested and operated heart exchange between two soldiers to “match their energies better.” Although the success of the switching heart surgery was not evidently validated, the idea of transferring body organs between humans was aware.

In Greek legends, the triple goddesses- Graiai shared one eye and one tooth by taking turn to use them. Another legend is the premature baby Dionysus attached to Zeus’ thigh until the child was ready to be born. Some legends even raised concerns about the subsequent outcome after transferring the body parts. When a goddess exchanged heads of a married man and his brother, the tale asked an imperative question about the identity of the husband- the body or the head? The myth that the recipient gets the donor’s personality started since medieval time. A tale was about a hand transplanted from a thief that made the recipient turn to stealing.

In Europe, the first known depiction of a human leg transplant was the black leg transplant by the twin physicians as well as saints- Cosmas and Damian. In many artwork, the leg taken from a Moor was miraculously attached to a priest by the saints. Yet, whether the Moor was alive or deceased remains uncertain. Also in the Western world, in Christian religion, Christ has a miraculous ability to heal the mutilated and diseased body parts. After a few centuries, Christian believers no longer obtained healing by meeting with holy men; instead, they sought for cures from posthumous saints who were known for specific healing powers, for example, Saint Anthony of Padua was known for his ability to re-attach a severed leg, or saint Ciaran could restore decapitated heads. The Christian legends of divine healing power not only initially recognized the possibility of organ replacement but also instructed the moral meaning in
each legend of healing power - the miraculous healing was not for anyone but for only the ones who deserved it. This point is analogous in many arguments in organ allocations in modern medicine.

Around the sixth century BCE, however, in India, a non-mythical surgical technique was introduced in the text Sushruta Samhita, written by the father of plastic surgery. In his rhinoplastic technique, Sushruta created a facial skin flap, rotated it to cover the defect on the face, and fixed it in place. The purpose of facial tissue replacement, or facial skin grafting initially aimed at the sufferers’ quality of life and dignity, because the mutilated victims would be mistaken with criminals whose noses were excised for their crimes. This technique remained in use in India for a long time and far later rapidly developed in Europe.

The decline of belief in magical cures did not occur until the medieval times upon the surge of the secular learning and humanism. The public feared of the possibility of summoning evil powers of black magic when seeking for the supernatural healing power. Surgeons during this period also hesitated to make any attempt in skin grafting practice in order to protect their reputation.

Although plastic surgery was mentioned in the surgical records as early as 600 BCE, the use of donor tissues was not of concern until medieval times.

2. From ideology to experimentation

During the Renaissance, although allografts remained infeasible in medical practice, the idea of transplantation continued experimentally but aimed at more complicated levels - transplanting an organ from one animal to another.

The Renaissance was the era of revival of medical manuscript texts and wisdom from Greece, Rome, and the Arab world. Numerous works were discovered and translated, such as the
Canon of Medicine by the Persian scholar Avicenna which was used as a medical textbook until the modern time, and many other great works about diseases and surgeries. They were widely disseminated after the invention of the moveable type writing, enabling a thrive of surgical teaching in Italy and throughout Europe. Additionally, it is believed that forgotten surgical skills, such as the Indian method of facial skin flap replacement, had brought to the Sicilian island in the fourteenth century. The original Indian technique of rhinoplasty was improved from using only facial skin flap to other regions, such as the arm. The improved technique was kept secret until a respected surgeon in Bologna- Tagliacozzi, described all the details of this new technique of attaching a skin flap on the upper arm to the bed of the defective nose. Also in this book, Tagliacozzi introduced his designs of bandaging which held the donor arm and skin flap in place and shields which protect the new nose after the surgery. Despite the significant role in autografting, Tagliacozzi stood amongst controversies when he proposed the idea of allografting of noses- grafting from one human to another based on the horticultural techniques. Still, his idea inspired the emerge of experimental biology in tissue transplantation.

In the eighteen century, John Hunter- an enthusiast of human anatomy and tissue transplantation, focused his study on the tissue vitality, mechanisms of tissue adhesion, and many experiments of organ transplantations on animals that led to his renowned tooth transplantation on human. Like Tagliacozzi, Hunter embraced and applied the principles of plant hybridization for his transplantation experiments on animals. He transplanted the chicken’s spur to its comb; the spur then grew twelve inches. In another experiment, he grafted the testes onto hens, yet, the transplanted testes failed to function. Following his experiments on animals was the tooth transplantation on human. At first, public accepted his notable tooth transplantation technique as no foreseen complications could be predicted for the new method. For the tooth transplantation
to occur and be more likely to succeed, a patient should come with as many tooth donors as possible so that the best-fit tooth would be used. The patients were often the superior in the society, such as the rich or army officers, and the donors were often the inferior, such as servants or private soldiers. These donors were to be obliged to provide teeth for their superiors. Other sources for donor teeth would be from the poor who wanted to sell their teeth, from cadavers (either from postmortem examination or grave robbers), or from dead soldiers on the battlefields. Nevertheless, the practice of tooth transplantation was discredited not for the questionable sources of tooth donors but for the serious complications after the transplants. Many patients had syphilis after receiving donor teeth. In addition to the tooth transplants, Hunter believed that the direct attachment of blood vessels would enable blood vessels between the donor and recipient to adhere and allow blood flow as the same way that sap circulates after the plant grafting. The endorsement of this assumption impeded the practice of transplantation for a long time until the mid-nineteenth century.245

In the early nineteenth century, skin grafting became surgical routine with success only in autografts. Skin replacement between two different species, such as between a cow and a horse, remained a failure despite of much effort. In London, after more than two centuries since Tagliacozzi’s work, the first human nose repair using facial skin flap was carried out and soon spread throughout European region and America. Rhinoplasty was in high demand owning to the adverse effect of using mercury salt to treat syphilis. With success of skin flap technique, skin grafting encouraged surgeons to make more attempts with larger and thicker skin and make the return of homografting idea. However, the use of thicker skin in grafting did not work while the thin skin enabled the grafts to heal easily. In the middle of the eighteenth century, there were a number of findings in medicine and biological knowledge that later played significant role in
organ transplantation, such as the dialysis principle discovered by professor Thomas Graham in London and the understanding of blood incompatibility by Claude Bernard and Francois Magendie in France. Blood transfusion remained randomly successful. In the practice of skin grafting, Paul Bert, with the assistance of the microscope, found that after grafting, the host blood vessels entered and grew in the graft, thus the end of host vessels and of the graft unnecessarily connected in order to nourish the graft. This finding disproved the adhesion theory postulated by Hunter that the vessels of graft and host rejoined in the early of the century. His finding explained the failure of using thick and large skin grafts with blood vessels and the success of using thin ones without blood vessels. Bert also studied on the vitality of the detached grafts of rats. He learned that the stored temperature determined the survival of the detached grafts: the cooler temperature extended the lifespan of the detached grafts. His work was later developed by Georges Martin who developed the method to store human skin up to five days in cool temperature. Bone grafting and corneal grafting, on the other hand, prevailed because of their special anatomy and characteristics. 

In the late nineteenth century, advances in studies of hormones and their roles initiated so many experiments on gland homografting, including retina and choroid, spleen, fallopian tube, fat, uvula. Grafting no longer limited to plastic surgery, it extended to restore physical defects even though the outcomes were not as desired. Forgetting of the proved success in using thin grafts was accounted for such outcomes. Instead, surgeons implanted the whole organs or large parts of organs in the recipient abdomen. The deepness also prevented the surgeons from evaluating and analyzing the results of the transplanted organs. Several European surgeons made the attempts in thyroid homografting during the 1880s, but no proper assessment was ensured since thyroid glands improved differently among types of thyroid deficiency. No ethical concern
was ever discussed until the work of ovarian transplant by surgeon Robert Morris in New York. The purpose of the transplant was to restore the fertility and pregnancy represented of the success of the ovarian graft. Disregarding the transplant technique, three questions targeted on the outcome of the graft- who was the mother, was the child legitimate, and should the consent of the donor’s husband- the owner of the donor’s ovaries, be obtained? By the early twentieth century, surgeons lost interest in the practice of ovarian transplantation.

Once again, the lesson learned from the syphilis-spreading tooth transplantation was forgotten. Many cases were transmitted with smallpox and tuberculosis from skin grafting.

II. The era of breakthroughs (the twentieth century)

Surgical skills had significantly improved by the early twentieth century. Surgeons performed more complicated surgeries and used the transplant technique to bridge the time needed for the original organs to recover. Still, without the discovery of immunosuppressive agents, the high susceptibility to infections remained mysterious to the professionals, which subsequently faded the hope for using transplantation as a medical method for a period of time.

Not until the early twentieth century, thanks to a great deal of effort of a large number of arduous doctors, researchers, technicians, and others who were interested in the topic and have got involved, numerous breakthroughs in organ transplantation have been made.

1. Organ transplantation as temporary bridges in surgeries

At the beginning of the twentieth century, not until did many biological advances introduce to medicine, there was no confident in animal-to-human grafts and homografts between human bodies or between animals did not survive. Ones of the advances that significantly contributed to the transplant field were the knowledge in immune mechanism,
blood types, anesthesia, aseptic principle, and blood vessel joining technique. Again, the achievements in related fields brought hope to the transplant area, especially organ transplant.

In 1900, Karl Landsteiner from Vienna discovered the individual characteristic of blood serum and the clumping phenomenon of red blood cells, leading to the discovery of major blood groups A, B, and O and safe practice for blood transfusion. The idea of transplantation continued experimentally but aimed at more complicated levels—transplanting an organ from one animal to another. Not until the early twentieth century, thanks to a great deal of effort of a large number of arduous doctors, researchers, technicians, and others who interest in the topic and have got involved, numerous breakthroughs in organ donations have been made. In 1906, the Australian ophthalmologist, Edward Zim, accomplished the first successful human corneal transplant. In the same year, Alexis Carrel, a French surgeon and biologist, was the first one surgically joining end-to-end two blood vessels by the anastomosis technique. He won the revered Nobel Prize in Philosophy or Medicine for this work in 1912. This work set a bright future for organ transplantation as it enabled surgeons to resume the normal blood circulation through the transplanted structures.

Also during the 1900s, Emerich Ullman performed an experiment in which the renal vessels of the dog’s kidney were sutured to the blood vessels of the dog’s neck; the claim for the success of experiment was based on the urine flow after the transplant. Ullman also carried out another dog-to-goat kidney transplant, which also resulted in urine flow after the operation.

Before the 1920s, more xenografting transplants between animals and humans were implemented. In 1906, Jaboulay—a French surgeon, carried out kidney transplant operations for two patients who were suffering from chronic renal failure; for each patient, he used pig’s and goat’s kidneys, respectively. Both transplanted kidneys produced urine but failed after three days.
due to clotted arteries. Three years later, Ernst Unger- a famous Germany doctor, transplanted both kidneys from a macaque to a terminally ill patient. The removal of the donor kidneys occurred at the same time to ensure the freshness of the kidneys, but the transplanted kidneys did not function and the patient died more than a day after. The continuing failure with uncertain causes in using animal organs discouraged surgeons in xenografts and brought them back to the experiments on autografting. In 1911, Hammond and Sutton in Philadelphia made an attempt to graft a testis from a donor who died from a ruptured liver to a patient with a removed tumoral testis. The procurement of the donor testis occurred soon after the donor’s death and the testis was preserved at warm temperature- the common belief of donor organ preservation then. After the grafting, the testis had normal blood perfusion for one month then deteriorated. Testis grafting made a comeback during the 1920s. In 1914, French surgeon and biologist- Alexis Carrel, made a historical statement in an interview with The New York Times about the principles of immunity and rejections which could have set an early successful path for transplantation. Unfortunately, the outbreak of World War I circumvented the path and the field did not commence this right path until forty years later. Surgeons were drafted during and after the war to treat soldiers and veterans; medical techniques serving the army replaced the organ transplantation interest. During the 1920s, the decline in interest in kidney transplants caused the high death tolls on chronic kidney failure.

In the 1930s, not so many prominent experiments on human organ grafting were known except for the operation by Yurii Voronoy- a Ukrainian surgeon. During his time of practice, Yurii encountered a large number of patients who committed suicide with poisonous mercuric salt. Approaching to the kidney transplantation for these patients, Yurii aimed at relieving the acute kidney failure for a short time, resulting in urine production as well as mercury
elimination. He had done many kidney transplant experiments on dogs before his first operation on humans. In March 1933, Yurii Voronoy, performed the first human-to-human kidney transplant. The donor kidney was obtained from a sixty-year-old female donor who died on the admission from a traumatic brain injury. The recipient was a twenty-six-year-old woman who took four gram of the mercuric poison substance and had acute renal failure. The kidney was removed six hours after death and kept in a warm temperature for some time as the current standard practice, then was transplanted into the patient’s right thigh. Although, on the first day, some urine excreted and the mercury level significantly reduced in the body system, the transplanted kidney stopped excreting urine and the patient died two days after the surgery. Many factors accounted for the undesired results, such as the warm time between the procurement and implantation and the incompatibility of blood types between the donor and recipient. Voronoy reasoned for taking the risk of using incompatible blood type organ by the doomed condition of the patient and the only one available kidney.255

It was not until 1947 when the first successful kidney transplant between a deceased donor and a living recipient happened at the Peter Bent Brigham Hospital- Boston in the United States. The transplanted kidney functioned normally but, unfortunately, the female patient died from hepatitis which she had contracted from an earlier blood transfusion. Another achievement in the field was the kidney transplant, also from a cadaver and a living recipient. In this case, the kidney worked for ten months and the patient lived for five more years after the transplanted kidney failed. The transplanted kidney bridged the time needed for the patient’s own kidney to recover. The transplant practice was recognized as a “temporary bridge” in complicated surgeries then. In addition, the high susceptibility to infections remained mysterious to the professionals,
which subsequently faded the hope for using transplant as a medical method for a period of time.\textsuperscript{256}

In the late 1940s, surgeons made many attempts for heart-lung procedures and accessory hearts on dogs before the availability of the heart-lung bypass pump in the mid-1950s. Experimental transplantation also started to use hypothermia procedure to cool entire of the recipient and donors dogs, allowing more time for the surgeons after they clamped the major vessels. Also, for the first time, in 1953, after the recipient heart and lungs were removed, the donor ones were placed in the original position for the recipient instead of being accessory. The transplanted heart and lungs functioned for a short time.\textsuperscript{257}

Another influential achievement during this period was the invention of the dialysis machine. During the time of the Second World War, Willem Kolff- a Dutch medical researcher, invented the first artificial organ- the dialysis machine. The machine was designed to remove impurities from the blood but the original design was not practical enough to be used as a routine therapy for acute renal failure. At that time, it was used for patients with temporary kidney failure for a few weeks while they were waiting for the kidney to function again. The preference regimen for renal failure patients was once a high-calorie and protein-free dietary while awaiting for the spontaneous revival of kidney function. Without focus on dealing with the immune response, there was no change in kidney transplant area during the early 1950s. The failure of kidney transplants with the resulting fatal fallout for a long period of time effectuated public belief in the transplant field; accordingly, the public criticized surgeons for unnecessary experiments on pitiful patients who sacrificed for the surgeons’ ambition and called for the surgeons to stop their experiments on human beings.\textsuperscript{258}
However, disregard of the absence of immunological resolution to graft rejection, cornea which has no blood circulation and therefore no path for white cells to attack the grafts became routine transplant practice in the early 1950s. The success in cornea transplantation in addition to the large number of wartime injuries, cornea donation became seriously short. In the campaign to increase the postmortal corneal donation, anyone who donated postmortal cornea to blinded veterans would be praised for their altruistic and worthy service to the community. Additionally, upon the advice of respected and innovative Italian transplant surgeons, Pope Pius XII supported the practice and allowed animal tissue for grafting as long as there was no subsequent genetic or psychological damage. The endorsement by the Pope marked the early cooperation between a religious leader and medical practitioners after a long history of separation from and disfavor of medical practice.  

2. Organ transplantation as medical treatments

Not until December, 1954 was the first success in transplantation between two patients which significantly changed the prospect of the field. The achievement was attributed to the surgeon Joseph Murray, who won the Nobel Prize in 1990 for this success, and the twenty-three-year-old identical twin brothers Ronald and Richard Herricks, who was donor and recipient, respectively. Richard Herrick was in end-stage renal failure, his condition improved but not considerably after dialysis. His brother insisted on donating one kidney to him even after being provided all the pertinent information about his future health. This was the first time in medical history that a healthy person was undergone major surgery for another’s medical benefit. In order to confirm the possibility of accepting the allograft, the doctor grafted skin from Ronald to Richard; the skin was not rejected. The critical contributing factors to the success were that the twins shared placenta and all blood groups. The operation proceeded on December 23, 1954. The
donated kidney was placed in the pelvic position instead of the leg. Within a few days, the kidney functioned. The ill kidney was removed to deal with the post-operative high blood pressure. Richard Herrick lived for nine more years after receiving his brother’s kidney and died of a heart attack. Ronald remained in good health after the donation. The case initiated many other transplants among identical twins in the United States and other countries. Still, the Herricks case inevitably faced ethical controversy for violating the medical ethic principle “Do no harm.” Ronald Herrick was a healthy individual who had no medical needs for an operation to incur. Yet, he was under one and had one of his healthy kidneys removed. Besides, the opposed to the case emphasized that the transplanted team forwarded the operation even though there was no obvious evidence of success or previous success. The foreseen consequence in which a healthy person became physically deteriorated after a medical procedure made the case seriously violate the maxim in healthcare practice- “Do no harm.” This issue has remained controversial until now when people argue about living organ donation. Several years after the Herricks case, new ethical issues emerged when parents endeavored one child’s organ to another child; the donor child was either under-age or mental disabled, which required the parents’ consent for organ donation. Such parents defended their wish based on the negatively psychological effect that one child might suffer if the sick child died of the failed organ. In fact, the court granted in favor of the parents in two cases in Massachusetts (1957) and in Kentucky (1969). Another ethical issue once discussed was the futility of organ transplantation as a medical treatment. Organ transplantation cost so many medical and financial resources, yet it yielded uncertain outcomes and served a relatively small patient population.

More than a decade from the first success of human kidney transplant, Christiaan Barnard, a South African cardiac surgeon, performed a heart transplant in Cape Town, South
Africa. The heart was obtained from a female who involved a car accident and sustained irreversible brain damage. The heart was transplanted to a male patient with terminal heart disease; the recipient lived for eighteen days after the surgery. His second heart transplantation was carried out after the first one shortly. This transplanted heart helped the patient live well for two years. A few months after Barnard’s first heart transplantation, Denton Cooley carried out twenty-one heart transplants and expanded his transplant unit in Houston, Texas; unfortunately, only two out of them survived. Also in the Montreal Heart Institute. Nine patients were under heart transplant operations, but only seven of them survived and for a six-month period. Elsewhere, many heart transplants inspired by Barnard’s success were performed in the same year, but no one ever gained success as Barnard did. By mid-1968, public support for heart transplantation dramatically declined for the high number of deaths and the conspicuous competition among the heart facilities. More seriously, public trust wore down after the reveal of how heart donation took place in the media. For ventilated donors, procurement occurred shortly after the ventilators were turned off; in some other cases, the surgeons waited until the hearts stopped beating, then they resuscitated the heart and restarted ventilators to maintain the heart vitality. In one case in California, a brain-dead patient was certified as dead without the ventilator being switched off, marking the first heart-beating donation case. The most lasting damage should be mentioned is the heart transplant operation by surgeon Juro Wada in Japan in August 1968. Juro Wada was first alleged to murder a brain-dead donor but then the charge was dropped. After the incidence, there was no consideration for the heart transplant practice as well as discussion about brain death until the legalization of brain death status in 1998. From the first heart transplant by Barnard in December 1967 to the beginning of 1989, in addition to the contribution of a large number- as many as more than one hundred heart transplants in twenty
two countries, the “year of the heart” ended with the poor outcomes, criticism, and unease public.263 The dissociation of medical practice from the general public contributed to the damage the public trust in medical practitioners and organ donation, causing a plummet in donation rates of every kind of organs, including the long practice on corneal grafting. The field of organ transplantation stepped backward owning to the “year of the heart.”

The heart transplant operation also caused a surge in ethical debate in several matters. That the donor’s heart was still beating during the procurement rendered a serious contention about whether the patient was considered dead, leading to new criteria for death: the brain death. Another question was that whether comatose patients were vulnerable to have their organs removed and comatose patients should be considered in organ donations? To address the issue, in 1968, an ad hoc committee of Harvard Medical School developed a definition of “irreversible coma” to justify for the use of comatose patients as a source for medical study and experimental trials; still, organ procurements would not proceed until the family’s approval was obtained. Dr. Barnard continued to his second heart transplant in which the patient lived for seventeen months. In 1968, the first heart transplant in the United States was performed by Dr. Borman Shumway, who also assisted his colleague, Dr. Bruce Reitz, in the first heart-lung transplant in 1981. The first heart-lung patient survived for five years.264 The conflict between public and healthcare profession in the matter of organ donation grew more and more in addition to the discouraging outcomes of heart transplants, heart transplants became a doubtful medical practice.265 For all that, when there was not much public support in organ donation, demand was much lower than supply, hence there was not much concern for organ shortage.

In 1963, Thomas Starzl operated the first liver transplantation in Colorado after countless successful experiments on animals. The donor was a child who died after cardiac surgery. The
child was left on the heart-lung machine to allow for procurement. Starzl operated other four liver transplantation before stopping the practice for a time due to the poor outcomes. All first five human liver transplant patients died within six to twenty three days after the operation. In his thorough study about the past operations, Starzl found that the major cause to the failure was the massive blood loss during the time procurement and grafting which damaged the organ rather than the graft rejection. Also, there was no available supporting system for the livers as dialysis for kidneys.266

In 1963, the first human lung transplant was operated by Dr. James D. Hardy in Mississippi. The recipient survived eighteen days after the surgery. Several lung transplants were performed elsewhere but all the patients died after a short time due to necrosis, air leakage, and bronchial stenosis. The procedure stopped for more than ten years. In 1966, the first pancreatic transplant occurred in Minnesota, followed by six other attempts. However, the poor results were mainly due to the digestive leakage, and discouraged the surgeons to continue the practice as well as caused the public interest to decline.267

During the early 1950s, grafting organs between a human and another human or an animal was considered impossible due to rejection, except for some identical twin cases. Surgeons started to accept the rejection of foreign tissues as an unavoidable and natural event that animal and human bodies must abide; it was futile to make any attempt to fight off the rejection.268 In the 1970s, Dr. Jean- Francois Borel, a Swiss immunologist, discovered that cyclosporine, an antibiotic- like substance extracted from a fungus present in soil, had the ability to suppress the immune system. Immunosuppressive drugs are account for the most critical breakthrough in organ transplantation. Cyclosporine blocked the production of T- helper cells (a type of white blood cells), which indentify and attack transplant tissues. The discovery induced a
greatly improved survival rates of organ transplants despite the fact that a high dose of
cyclosporine may induce cancerous tumor to grow as the side effect. Yet, the anti-rejection
drugs pose problems in many perspectives. In medical aspect, these drugs have side effects
causing the deterioration of the immune system, which makes the recipients much more
susceptible to infection afterward, or even life-threatening sepsis. In socioeconomic aspect, this
group of drugs costs a large amount of money and the recipients have to be on for the rest of
their lives.

By the end of the twentieth century, organ transplantation has no longer been
experimental; it has reached the status of a routine. Interest in organ transplantation widely
increases among related fields, inspiring ambition to create new human organs.

III. The era of feasibility, opportunities, and possibilities

In the twenty-first century, organ transplantation has taken more challenges in not only
improving new technical skills but also extending the alternatives in practice. Better post-
transplant outcomes, more types of transplanted organs, and the development of non-traditional
methods in transplant to alleviate the organ shortage become new goals for organ transplantation
field.

1. Contemporary practices in organ transplantation (the twenty-first century)

During the early twenty-first century, the practice of transplantation for kidneys, hearts,
livers, lungs, and corneas has become popular medical treatment options in most parts of the
world. With so many great improvements in related field, such as microsurgery, grafting skills,
immunology, even more attempts have also been made for other human body parts which were
not believed to be feasible in the past, such as hand transplant, and face transplant. These types
of transplants pose unique issues in the transplant field for the psychological challenges in both types and cosmetic purpose and identity in facial transplant case.\textsuperscript{270}

The first attempt to perform hand transplantation was in South America in 1964, but the donor hand was rejected after two weeks. In 1998, after the introduction of effective immunosuppressive regiments, surgeons in Lyon, France successfully performed a hand transplant from a cadaveric donor. Between 2000 and 2005, more than twenty-five hand transplants have been performed. Like other surgical procedures, before the transplantation, the patients should be thoroughly educated about risks in order to be able to weigh the quality of life against the potential hazard. Moreover, hand transplant is unique for its visibility after the transplant and the sole donor source from cadavers, psychological effect is a critical issue. In consideration of the post-transplant psychological challenge, hand transplants seem more complicated than the other types of transplants taking into account that the recipient has to face the part from a cadaver attaching to the body. In fact, the patient in the first successful hand transplant experienced psychological problem; he felt “mentally detached” from the transplanted hand, which resulted in his request to amputate it.\textsuperscript{271}

In November 2005, Professor Jean-Mitchel Dubernard- a French plastic and microsurgeon and his team successfully performed a partial face transplant on a disfigured woman in Amiens, France. The facial parts were obtained from a brain-dead donor and grafted at positions of nose, lips, and chin. After a week, the patient was able to eat, drink, and talk; nearly three months later, her facial sensation came back.\textsuperscript{272} The operation is considered a major success in transplantation even though it encloses some ethical issues. Those ethical problems comprises of the conflict of interest because the physicians, the recipient, and a film maker signed a lucrative deal prior to the surgery, and breaches of confidentiality which reveals the
recipient’s and donor’s identities as well as the suicidal incidence of the donor. These issues negatively affect the public trust in organ donation. In medical perspective, the novel facial transplant prevented the patient from a series of fifty operations in which her own skin from back, buttocks, or thighs would have been grafted on her affected facial areas with resulting limited function recovery and masklike face. Despite of its potential, nevertheless, the procedure has faced several obstacles. The most contentious issue is the weighing between potential benefits against risks. To many professionals as well as majority of the public, the improvement of quality of life after the surgery does not convincingly justify for the lifetime risks the recipient would pose. The risks include adverse effects of immune suppressants along with operational complications, opiate dependence for pain management, and psychological issue. Lack of public education on the purpose of the procedure accounts for the negative attitude toward facial transplant because the general public still categorize facial transplant in plastic surgery, hence, it holds only aesthetic purpose rather than physical function recovery. Transplant of human face poses unique issues in the transplant field. The primary concern is that whether the facial transplant is a cosmetic surgery procedure or a medical surgery treatment. It is for cosmetic purpose because it does not necessarily save a life like other transplants for patients with end-stage organ failure. It serves to ease the horrendous long-term psychological burdens experienced by people with severe disfigurement. The procedure should not be implemented unless it causes the person medical conditions, such as skin contraction leading to severe pain, speech and swallowing disorders, etc. because it bears financial burdens with little to no benefits to the healthcare system. In other words, facial transplant is to enhance, not to save a life. Another argument originates from the lack of knowledge of how the procedure works, leading to the fear that the surgery would turn the recipient’s face into the donor’s face. Actually, the
procedure does not surgically modify the recipient’s facial structure (including bones and muscles); therefore, loss of identity should not be a concern in terms physical appearance. Yet, before choosing this procedure, psychological factor should be taken into serious consideration since the recipient may misconstrue their identity due to the existing psychological disorder from the disfigurement. Also, before the facial transplant, the patient often requires to have multiple operations with use of screws and plates, which can cause chronic pain; as a result, the patient inclines to be opiate dependent for pain management. On the other hand, in ethical perspective, facial transplant does not face as many obstacles. The procedure preserves the recipient’s dignity by allowing the patient to maintain self-esteem and values besides the physical improvement, and it enables healthcare team to comply with their practice principles of beneficence and non-maleficence. Often the ethical debate is around the autonomy, or more particularly, obtaining informed consent from the recipients. Since facial transplant is still at its experimental stage but renders adversity, both known and unknown, it is crucial that potential recipient receive all pertinent information, including all potential risks and awareness of unknown complications. Potential recipient might decide to accept the procedure under coercion from healthcare professionals who over enthuse over the new procedure and might not sufficiently emphasize on the risks of the transplant, or by self-promotion fiduciaries. In social perspective, some concerns about the procedure that would turn people to the superficial interest in appearance as they view the transplant as a plastic surgery operation. Ignoring the functional limitation in the head region due to the trauma and the psychological effects due to the disfigurement, they disfavor the procedure lest the procedure would discourage people to accommodate their disabilities. As in any experimental procedure, patients of facial transplant unavoidably attract the media attention; thus, they should be well prepared to deal with and their
circumstances should be protected from the media. More attempts in facial transplants take place in the United States, France, and the Netherlands. Up to the year of 2013, there have been twenty six facial transplants around the world. The first full face transplant was operated in Spain. In April 2013, in Poland, the first immediate facial transplant was operated on a 31-year-old male experiencing a work accident. The harvest and transplant procedures took place almost simultaneously. The result is magnificent comparing to the conventional multiple operations for one facial transplant in terms of the recovery of both motor and sensory function of the transplanted face and health risks and burdens for the recipients.

2. The outlook for organ transplantation

It is suggested that the studies for possible sources for transplanted organs be implemented at different levels, ranging from cellular level to the whole human body. As medical conditions are studied at cellular level, cell transplantation, or stem cell transplantation in particular, is considered a novel field which gives hope for millions of people who suffer from cancer, spinal cord injuries, and neurological disorders. The most common practice in stem cell transplantation is bone marrow transplants. This practice has been known for more than thirty years and proved its clinical effectiveness for certain groups of patients, such as patients with leukemia. The prospect of the field focuses on using transplanted stem cells to replace damaged or diseased tissues in various medical conditions, including Parkinson’s disease, Alzheimer’s disease, spinal cord injuries, heart diseases, arthritis, diabetes. The hope for stem cell transplants to be applied in a wide range of medical conditions is based on their regenerative characteristic. Not different from other approaches, stem cell transplants face several obstacles in different perspectives. In ethical aspect, question about the source of stem cells has risen for the fear of the use of embryonic stem cells which may be acquired from in vitro fertilization. When
the donors no longer wish to use the *in vitro* fertilized eggs, they donate them for research purpose only; yet, many people are afraid that those donor cells are illicitly used for different purposes. Another concern is that savior siblings would be created for the purpose of transplantation only. In medical aspect, some studies have shown that stem cells can develop into different types of tissues from the desired ones. Also, it is uncertain that how the cells will react and function in the human body after the transplantation, and whether any possibility that those cells will overgrow and become cancerous cells. Additionally, the mechanism of rejection of the recipient’s body and donor stem cells remains unknown.283

At Pennsylvania School of Veterinary Medicine, the first successful testicular transplant was conducted between two different species. The transplanted testicular tissues from pigs and goats were hosted by the backs of immunosuppressed mice. The transplanted tissues produced sperm on the mouse backs. Even though the ultimate purpose of the study aim at preserving the animals which are at risk for extinction, a proposal for application of this study on human beings would not become a surprise. The reasons justifying the use of animals to host human sperms could be a promising future in reproductive assistance area. On the other hand, allowing the study to apply for humans could raise a serious ethical issue on human identity or the fear that humans can cheat death by storing their sperm for eternity on the mouse back.284

The urge to decline the use of immunosuppressive drugs in organ transplantation is also a future for the field. The chimerism in organ transplantation: in studies about organ recipients who survive from ten to thirty years, researchers have found that such recipients’ immune systems develop a mixture of white blood cells (blood cells that enable human body to fight off infection) from the donors and themselves, which intervenes with the rejection mechanism. Accordingly, a new approach aims to develop this intermingling white blood cells, known as
“chimerism” in order to increase the organ tolerance without using immunosuppressive medications and to avoid re-transplantation. This effect, hence, takes part in increasing the organ supply. One method to obtain the chimerism is to infuse the donor marrow during organ transplantation. Success in chimerism may have positive effect in increasing the organ supply by reducing the chance for organ re-transplantation and reinforcing public in the promising future at reduced cost (due to the elimination of an-rejection drug use) for organ transplantation. Another prospective approach regarding immunosuppressants is the development of monoclonal antibodies. After a group of scientists announced that they are able to identify particular molecules that control the immune system, a group of drugs is designed not only to specifically target these particular areas of the immune system but also assist the recipient’s body to fight off cancer which was a concern of previous immunosuppressive drugs.285

Chimerism as a new method to increase the organ tolerance without using immunosuppressive medications and to avoid re-transplantation is also a future in organ transplantation. Success in chimerism may have positive effect in increasing the organ supply by reducing the chance for organ re-transplantation and reinforcing public in the promising future at reduced cost (due to the elimination of an-rejection drug use) for organ transplantation.

The shortage of donor organs urges interested parties to seek for alternative sources of organs. Animals are believed to be potential source, which broadens the future of organ transplantation. Researchers even assert that animal organs could be perfectly replaced the organs from deceased donors for the possibility to schedule the death of an animal when the time of need comes, reducing the number of patients’ deaths while awaiting for donor organs. Currently, pigs, baboons, and other primates are the major studied subjects in xenotransplantation for their remarkably similar to human body. The dominant research lies on
modifying genes in pig organs by inserting human genes into the pig organs so that the recipients’ bodies can recognize the transplanted organs as human ones. Nevertheless, xenotransplantation remains for the viral infection, disapproval in some religious practice.286

The idea of artificial organs are not a new one. In fact, the first invention of artificial organ dated back in the Second World War- dialysis machine. Dialysis machine was invented by Willem Kolff, a Dutch medical researcher, to remove impurities from the blood. At that time, the machine was used for patients with temporary kidney failure for a few weeks while they were waiting for the kidney to function again. Up to date, the machine remains widely used for patients with end-stage renal diseases throughout the world.287 Numerous of artificial organs, including artificial hearts (heart- lung pump, the Jarvik- 7, the left ventricular assist device (LVAD)), artificial lungs (the implantable membrane oxygenator), have proved their ability to keep the patients alive while waiting for organ transplantation. Notwithstanding, permanently implanted devices to replace organ transplantation are the future of artificial organs. Artificial organs are believed to be potentially beneficial to many patients and may reduce the cost for healthcare, as well as ensure the fair allocation.288

Bioengineers have put great effort to develop bioartificial organs that biologically mimic the human organs. One of the most successful achievements is the skin substitutes in which living cells are cultured on a biodegradable fabric. A number of research focus on different human body parts, such as liver, pancreases, nerve system, blood vessels, cartilage, bone, muscle, etc. During this infancy period of the field, many people stay doubtful, fearing that bioartificial organs may turn humans into chimeric people- half- human and half- beast. Besides, the psychological impact and quality of life are of concerns.289
The invention of three dimensional printers has become one of the promising options in tissue engineering. Hopefully, in near future, customized 3-D printing organs would be used for patients in need of organs.290 So far, the only ethical concern is that cost, hence allocation, of such expensive artificial organs. Howbeit, the problem of high cost should be resolved by time as any new technology.291 The current high cost issue should not circumvent further attempts in the artificial organ field. In fact, if successful, artificial organs could be useful for patients with severe but not end-staged illness, which reduces the burden for healthcare cost, or, in other words, becomes a cost-effective method.292

**Conclusion**

Acknowledgement of the history, present, and future practice of organ transplantation plays crucial role in supporting the field of organ transplantation. It enlightens not only the path leading to the success of the field but also the obstacles the field has overcome or faced. This chapter indicates the major obstacles of all time for organ transplantation- medical, social, and ethical aspects, among which ethical aspects have intervened in overcoming several medical and social obstacles.

Public views transplantation once as a disturbing medical approach but then as an admirable field. Over time, public opinion has proved its importance generally in the development of medicine and particularly in clinical transplantation. Transplantation must include and take public opinions into consideration; if it alienate the public voice, it will lose the foundation of the field - the donors.293
Chapter Four: Living Versus Deceased Organ Donation in Social and Ethical Aspects

Two common sources of donated organs include donation after cardiac death (non-heart-beating donors) and brain death (heart-beating donors). Another definition of death is higher brain death.

Cardiopulmonary death is defined as irreversible cessation of cardiopulmonary function. This definition is endorsed for the rationales that heart and lungs are necessary for a living organism. However, this criteria limits the retrieval of viable vital organs like heart. In order to overcome this obstacle, in some countries, like Switzerland, for an organ donor after cardiac death, the cessation of cardiopulmonary function is not irreversible after 5 to 10 minutes, during this time, vital organs need to be removed to warrant the viability. In the United Kingdom, the Intensive Care Society and UK Transplant require a full 5 minutes without cardiac activity, making cardiac donation impractical. The key question in cardiac death is the appropriate time after the cessation of cardiac activity to pronounce death. The protocols to determine cardiac death somewhat vary from country to country, depending on the rationales for the two questions: how long circulation is lost to cause irreversible loss of brain function and how long it takes until the heart cannot restart itself. For the former question, the brain can stay active for a few minutes without circulation and not all parts of the brain lose activity at once. For the latter question, length of time depends on any attempt made to resuscitate.

Cardiac death occurs when circulation is irreversibly absent while brain death happens when all brain functions are irreversibly ceased. In brain dead donation, organ ischemia is minimized, hence more viable; organs from cardiac dead donors are less ideal for its prolonged ischemia. Cardiac death patients are also classified into two subgroups: controlled and uncontrolled non-heart-beating donors. The uncontrolled (or unplanned) ones suffer cardiac
arrest and are declared dead on arrival at the hospital, organ ischemia is often unknown or too long prior to recovery; using these sources of organs carries much higher risks. Controlled (or planned) ones are those who often suffer terminal illness with a severe neurological injury and have almost no chance of a meaningful recovery or survival; death occurs with cardiac arrest after the planned withdrawal of life support; the organs are less damaged due to ischemia compared to the unplanned non-heart-beating donors. The first International Workshop on donors after circulatory death (DCD), held in Maastricht in 1995, identified four categories of DCD, depending on the context in which the irreversible cessation of respiratory and circulatory functions is determined. Type I is dead on arrival, type II is unsuccessful resuscitation, type III is uncontrolled DCD and awaiting cardiac arrest, and type IV uncontrolled DCD with cardiac arrest while brain dead.

In 1963, Guy Alexandre operated the first kidney transplant in Belgium, using donated organ from a brain-dead donor, who was in profound coma regardless aggressive resuscitation and administration of drugs. In this first transplant, the team did not turn off the mechanical ventilator and did not wait for the donor’s heart to stop beating. The donor became the first heart-beating organ donor. His operation and new criteria for dead pronouncement did not receive a lot of support at the time. Five years later, in 1968, the Harvard Committee established brain dead criteria. This new definition of death is widely accepted, especially for the purpose of saving lives.

Since 1968, many controversies around brain death have not been settled. Public attitudes toward brain death vary because the concept of brain death is difficult to understand, especially for laypeople. The inconsistent rationale for accepting brain death as death among healthcare professionals has brought more confused and unease feelings within the public.
confusion about death definitions results in misunderstanding and mistrust between healthcare practitioners and the public. Public may fear that their organs could be harvested before death occurs. In some professionals’ attitude, brain death means a death of an organ, similar to kidney failure. The healthcare staff’s attitude toward brain death reflects their confidence with tasks relating to organ donation, a necessary factor when approaching emotionally strained families of potential donors to obtain their consent to donate their loved ones’ organs.

The brain death concept does not provide a certain boundary between life and death. For many patients, coma will progress to death or severe disability. Prognosis for coma patients depends on the individual circumstances. An accurate prognosis helps fulfilling patients’ wishes, providing a better and efficient end-of-life care, and avoiding conflicts and legal issues. An accurate prognosis plays a significant role in postmortem organ donation in medical, ethical, and legal perspectives. Brain death is a clinical condition of irreversible coma with the irreversible absence of brainstem reflexes, and with apnea. To diagnose a patient with brain death, after the confirmation of the irreversible coma, physicians proceed to brainstem and apnea testing.

For patients after cardiac arrest, therapeutic hypothermia and aggressive managements have brought positive outcomes with patients awakening from postanoxic coma. These patients even recover without major handicap. To avoid making false prognosis, it is recommended to include multiple predictors, such as neurological exam, electroencephlography (EEG), somatosensory evoked potentials (SSEP), biochemical markers neuron-specific enolase (NSE), magnetic resonance imaging (MRI), after the therapeutic hypothermia and aggressive treatments for comatose patients during early ICU care.

Brain death is the irreversible cessation of function of the entire brain. The brain is the central organ that controls the integration of the overall body, when the function of the entire
brain irreversibly cease, the human body loses its integration as a whole. 308 Although the donors after brain death provide more viable organs than ones after cardiac death, the criteria for brain death have raised questions within public and some healthcare practitioners. 309 Some patients who are diagnosed with whole brain dead remain many body functions, such as digestion, salt and water homeostasis regulation, wound healing, infection fighting, and even fetus gestation. 310

A rare protocol- the Exeter protocol, is applied for non-ICU patients who have stroke but are likely to die within 48 hours. If consent to organ donation is obtained from the patients or families, patients will be rushed to an ICU unit for elective ventilation therapy. This protocol raises several ethical concerns. The purpose of the treatment intends to facilitate the possibility to procure postmortal organs; it does not initially aim at benefiting the dying patients. Moreover, if the initial assessment leading to the poor prognosis is incorrect, the patients are at greater risks when staying in the ICU. 311

Higher brain death means the functioning of the higher brain responsible for consciousness is irreversibly ceased. The definition of higher brain death originates from medical findings, it does not stem from philosophical thoughts but the rationales for the criteria are incorporated with such thoughts. In some patients who meet all criteria for brain death, some neurohormonal functioning, such as anterior pituitary hormones, remains active, showed on the electroencephalographic findings. It is suggested that brain death occurs upon the loss of all the functions. The higher-brain death definition consists of four criteria, including the loss of capacity for rationality, personhood or personal identity, capacity for experience, and capacity for social interaction. These criteria ensure that death occurs only when both mind and body are gone. 312 This definition is not widely accepted because these criteria make patients in irreversible coma or persistent vegetative state, as well as severely demented people dead. Anyone
permanently lacks self-awareness would be diagnosed as being dead according to this category.313

Cardiac deceased patients have become more popular in the organ donation field for the increase in foregoing futile treatment and artificial life support among terminally ill patients.314 Organ sources from brain dead patients are preferred to organs from cardiac dead patients for they are under timely preservation.315 Still, in medical perspective, living donors provide the ideal organ sources and transplant outcomes.316 Recipients of living donor organs have fewer repeat transplants and are less likely to return to dialysis, which benefits the organ recipients and reduces burdens of cost of care for society.317 Recipients of living donor organs have long-term success because the timing for organ procurement and transplantation is under controlled.318

In general, current policies in an attempt at augmenting the number of organ donation divide into two trends, one stems from supporting living organ donation and the other derives from supporting deceased organ donation. As far as discussion and data, policies, such as financial incentive policy and commodification policy whose goals are to encourage people to become living organ donors have showed more severe ethical issues than the ones which support cadaveric organ donation. Living organ donation ensures the emergence of black market and violates the fundamentals of medical practice and human dignity. On the other hand, deceased organ donation does have some problems but they are possibly resolved by public and professional education.

I. Healthcare professionals: the ethical issues of beneficence and non-maleficence

1. Living organ donation

Since the historical kidney transplantation for the twin brothers Herrick in 1954, the ethical issues of beneficence and non-maleficence about living donation remain in ongoing
debates. The primary tenet of medical practice is “do no harm,” which makes the act of removing an organ from a healthy individual wrong.

Hippocratic tradition has been influential throughout medicine for two centuries. The Hippocratic tradition is elucidated in the Hippocratic Oath, the deontological books, Law, Decorum, Precepts, and the Physicians, each of which covers particular moral standards and teaching in medicine. All together establish the Hippocratic ethics. The Hippocratic ethics absolutely fitted the society in the previous time when physicians’ duties were merely, to provide healthcare services with their skills and sensitivity to patients and society. Many perspectives in the Hippocratic ethics have persisted in medical practice in modern era. One of them is the maxim “Do no harm,” or original version is “At least do no harm,” which is often identified as a primary principle of the medical ethics. In contemporary medicine, the maxim is commonly applied in moral discourse in medicine, in due care, and good reasons. While non-maleficence refrains doctors from causing harms to patients, beneficence principles positively express the requirement of actions of helping the patients. An important point to distinguish these principles from the non-maleficence principle is that it is either obligatory or non-obligatory, meaning that “failing to act beneficently” does not mean the act is immoral.

Supporters for living organ donation contend that the risk of dying as a living donor is quite low thanks to the modern technology in medicine. Moreover, the remaining kidney can compensate for the missing kidney in a healthy donor. Also, as long as the donor does not bear any coercion or manipulation, this practice is ethically justified. For any type of living organ donation, healthcare professionals have to violate the principle of non-maleficence to create beneficence to the recipient. With the assistance of modern technology in medicine, the procedure is relatively safe to remove donor organs and the improvements in pharmaceutical
reduce or eliminate the complications during the screening for qualified donors and recipients, operation and in post-operative care. In a healthy kidney donor, the remaining kidney can compensate for the missing kidney and be able to do the work performed by two kidneys. Since 1980s when the first liver transplantation was operated, liver transplantation has become common practice, yet the more prevalent for pediatric patients comparing to for adult patients due to the more health complications occurring for both adult donors and recipients. Living donor transplants involving a lobe of the lung are also in practice. Partial donation of the pancreas or intestine is an uncommon practice as well, but the health condition of the donor turns to be debilitated after the donation.

For any type of living organ donation, healthcare team members unavoidably cause harm to the person’s health to various levels but not for the health benefit for the person himself; the act of harm is to bring benefit to the third party, assuming the absence of financial factor during the transplant procedure. Living kidney donation is not so safe and poses some late complications. The removal of one kidney may potentially damage the remaining kidney due to glomerular hyperfiltration. Besides, if the living donors receive insufficient education about lifestyle changes after the transplantation, including diet and precise medical follow up, they are at high risk for complications, such as kidney stone and infection. Psychological effects on living kidney donors: In addition to physical harm, living kidney donors also experience psychological effects of which depression is the most common due to the loss of an organ, sense of permanent illness, and disruption of family function. There is no guarantee of risk-free for the donor; being aware of the possible risks without creating benefits for the donor, such practice is considered unacceptable in medical practice. In order to create beneficence to the recipient, healthcare professionals have to violate the principle of non-maleficence in their practice. For
this reason, the controversies about beneficence and non-maleficence in living organ donation have remained unsettled ever since its first success in 1954. No matter how pure the motive is, such as saving a person’s life, removing a healthy organ from a healthy person to attain the goal is unjustified for the violation of the principle of non-maleficence.

Another serious issue was created by using living organ donation is the existence of organ black market. Organs provided by the black market usually come from poor people in poor health conditions who sell their organs in disguising as organ donors. Also, the transplant procedure often occurs in a developing country where lacks sufficient authority and policy in organ donation activity. As a result, the procedure turns to be unsafe for both donors and recipients. Since there is trading involved, the goal of cost efficiency and maximize benefit reduces the pharmaceutical use and absence of post op care. The harm caused to involved parties become unpredicted. The role of healthcare professionals as caring for people is likely to be corrupted.

2. Deceased organ donation

On the other hand, upon the consent of organ donors, transplantation of deceased donor organ raises no doubt about the violation of non-maleficence. The result of the practice solely benefits the recipients’ welfare and the act of removing organs from the deceased does not cause harm to any individual, yet the removal must be consented.

Organ procurement must follow the “dead donor” rule, in which patients may not be killed for their organs or as a result of the organ removal. Euthanasia is absolutely excluded from organ donation. Any interventions for the purpose of organ preservation must inform to the families and implementation starts after the consent is obtained from the families; these interventions must not cause harm to the donors or hasten their death.
Some novel thinkers, such as Miller and Truog, often weigh the benefits for the recipients over the dying who are potential donors. In their position, in some cases, the “dead donor” rule affects the viability of the organs, increasing the waste of scarce sources. For this reason, when patients or families give consent to withdraw life-support measures, such as ventilator, organ procurement should be initiated before dead pronouncement so that the organs unnecessarily deteriorate. This suggestion encounters strong critics for its purpose of killing to procure. If the practice is allowed, death is caused by the removal of organs.333

Patient care team must be separated from organ transplant team to eliminate any possible conflicts of interest or public distrust.

For example, to harvest organs from executed prisoners as the cases in China, there must be involvement of physicians rather than only lay people. Such physicians violate not only the Hippocratic Oath, that is, “to benefit the sick and do no harm,” but also many other ethical principles stated in medical practice. In the mean time, it is clearly recognized that if the bioethics was originated from, hence is restricted to, medical theme only, there is not much concern about human rights. Bioethics in this perception seems to be the conception for only health care professionals with their obligation and duties, and human rights is specific only for the sick. Subsequently, the executed prisoners are not the sick therefore they do not have human rights that need to be protected by physicians. Likewise, in other cases, most of people who are kidnapped, stolen, or killed for obtaining their organs are not the sick, so physician who operate on them do not need to protect the integrity of their bodies. For this point, bioethics in Potter’s idea provides more protection of human rights to not only the sick but to all humankind. Overall, bioethics as being defined as the predecessor of medical ethics presents no connection to the human rights protection for all human beings.
Lack of consensual standards for brain death criteria has a great impact on healthcare practitioners. Without common clear criteria for brain death, some doctors are afraid that they may involve killing if the organ procurement occurs. Due to such confusion, many of them express hesitance and lack of confidence when communicating with the deceased’s families, resulting in the likelihood of refusals to donate organs. The reported public fear that organ harvesting could start prior to people being pronounced dead is what public understand concerning organ donation.\textsuperscript{334} It is very important in facilitating public’s understanding of the procedure and criteria for diagnosing death and their decision to consider becoming an organ donor. Negative beliefs in relation to donation and lack of understanding of organ donation procedure led to mistrust of healthcare professionals and induce refusal to organ donation. Wills regarding posthumous disposal of organs are met donation can only be presumed when death occurs.\textsuperscript{335}

Practicing on deceased organ donation, healthcare professionals could violate the principle of non-maleficence without being aware of the act. In some cases, it is because they are so enthusiastic. In some other cases, they lack sensitivity to the public and culture, making their act damage public trust and causing detrimental effect on organ donation field. For example, in Japan, a heart was removed from a drowned man who could have been resuscitated. This incident has caused strong public opposition toward brain death and heart transplant practice.\textsuperscript{336}

II. Individual level: the ethical issues of autonomy and human dignity

1. Living organ donation

In order to protect the autonomy in living organ donation, donors must make their informed decision free from any form of coercion. Potential donors must truly understand the risks of being a living donor and the long-term impact it may have on their health, longevity,
comfort, and overall quality of life. It is true that every individual has autonomy over his or her body, yet it is unethical if choices are made without being fully informed. A valid autonomy is obtained only when the patients recognize their legal and ethical rights to control over their own bodies.

Human dignity is an existential value which is the identity of a person and the recognition of what a person is in relation to all other people. Every person has his dignity equal to another, to a community, among communities, and among humankind. Accordingly, recognizing human dignity results in the respect of human freedoms, and protecting human dignity assures the protection of the equal rights for every individual to the benefits of science and technology in improving human welfare. Living organ donation might be justified by its distinction of respect for human freedom since it comes from personal choice. Nevertheless, it does not demonstrate the protection of the equal rights for every human with respect to the individual welfare. Besides, living organ donation enables the existence of organ trades or organ black markets, subsequently widens the disparity between the rich as potential recipients and the poor as potential donors. The inherent values in this case have shifted to extrinsic values.

To protect the autonomy in living organ donation, donors must make their informed decision upon their act at will, meaning free from any form of coercion. Potential donors must truly understand the risks of being a living donor and the long-term impact it may have on their health, longevity, comfort, and overall quality of life. The risks for health may start as soon as the screening procedure and may last unpredictably. It is true that every individual has full autonomy over his or her body, yet it is unethical if he or she makes choices without being fully informed. Autonomy is obtained only when the patients recognize their legal and ethical rights to control over their own bodies.
Human dignity is an inherent value and independent of the external values, such as age, sex, talents, health conditions, socio-economic status, social or ethnic origin, political ideas or religion. Every person has his dignity equal to another, to a community, among communities, and among humankind; no individual is more valuable than another individual.337

In related living donation, responsibilities could blur the donor’s autonomy.

A more detestable way of obtaining organs is called “reproductive altruism.” The future child is imposed to have duty to rescue his siblings or parents by donating his tissues or organs when the time comes. A well-known case is the case of the Ayala family in California, the United States. In this case, the Ayala couple conceived a child in order to have a bone marrow donor for their 18-year-old daughter, Anissa, who has chronic myelogenous leukemia.338 Not only does the method deprives the child’s dignity for such purpose of his existence, it also violates the principle of respect for autonomy when he does not have any choice other than losing his body integrity, giving out his tissues or organs, or living with guilt for not fulfilling the purpose of his existence. In comparison with the other sources, organs sources from siblings or children hold so many medical advantages, making this way is tempted in organ donation field. Procreation for the sole intention of harvesting organs is immoral and should be condemned.339 Permission of having a child to save a child would open a much more controversial door to the possibility of having a pregnancy to sell organs and tissues or cloning a child to save a child.340

When using living donations for transplantation, it is required more effort to protect vulnerable group, including children or mentally incompetent people, who are easily compromised their dignity. Children normally lack sufficient psychosocial maturity to give valid consent to donate organ,341 but they will eventually gain it with aging. When definition of death
is the endpoint of personhood or personal identity, for instance the higher-brain death, this group is at high risk because they fulfill the dead criteria.  

An example of using living organ donors to manipulate public is to teach patients to tell their stories in media.

2. Deceased organ donation

So many perspectives have impact on the perception of death. In Terri Schiavo’s case, in medical view, the patient existed in a persistent vegetative status and she was not dead, but to many people, she was for her permanent motionlessness, lack of self-consciousness and capabilities to communication. To other viewers, in addition to those characters, death occurs when breathing ceases and putrefaction takes place.

In many cultures and religions, breath represents spirit of the human body or soul, making the last breath the sign of the departure of the soul. In Jewish religion, the “breath of life” is compatible with criteria for apnea in brain death. Yet, this view is not accepted in Orthodox Jewish practice. The orthodox views life as a continued circulatory and ventilatory activity, even maintained by machines; therefore, as long as the heart beats, the person is alive; discontinuing the person from machine is a killing act.

In Hinduism religion, death is associated with respiratory failure. Some people claim their support for brain death based on the folklore that, at death, breath (prana) escapes from the brain. There is no formal resistance to death as criteria for brain death in Hinduism.

In China, current issues around decision making at the end of life are subjected to social and cultural background. Their views of death have been under influences of three traditional views for many centuries, including the Confucian ethics, Daoist views, and Buddhist views. Confucian ethics, appeared more than two thousand years ago, sees death and life as assigned
and related events in the human life cycle, nobody can avoid death. People should not be afraid of death if they live in good human nature and gain respect from the society. Similarly, Daoism holds the same view of death as Confucianism. It adds the teaching that people should think less about the fear of death in order to overcome the limitation and anxiety of both death and life. In Buddhism, for the belief that happiness is impossibly existed in life but only beyond the realm of illusion, death is a chance for human beings to escape from the unhappy life and enter a new better life. 347

In Roman Catholic religion, human persons are created by God. Human persons are sacred and it is our obligation to respect and preserve the creation of God. Human beings are sacred because they are created by God and in the image of God. God created human beings with the unity of body and soul, and in dignity and of grace of human freedom. Human soul is actually the spiritual creation by God, and human body is the form of the sacred human soul. Human body is created to confirm the presence of human soul which is image of God. In Catholic viewpoint of health care, the unity of body and soul is considered in healing acts. The Catholic approach, which has insisted on sanctity of life and on quality of life, is based on the theology of the meaning of human life in its dignity, its destiny, and its integrity. Catholic ethicists have eliminated the absolute sanctity-of-life position from their approach to ethical issues. For them, it is unlikely that practitioners must take all possible actions to save human life in every case. On the other hand, the absolutists affirm that regardless of quality of human life, all actions must be taken to prevent human from any kinds of harm. Roman Catholic thinkers hold opposing views in some specific cases because they intuitive that the ultimate value for human beings is not solely physical life and that humankinds are created by God as a unity of body and soul. Although human life should be sustained at any costs, there are some exceptions
which are justified along with the concept of quality of human life. Roman Catholic ethicists are keeping up with development of medical technology to balance the sanctity of life and quality of life.  

In Islam, death marks the transition from one state of existence to the next rather than the end of the existence of an individual. Life on earth is taught as being an examination for human beings, and the afterlife is everlasting. Death is seen as a passage into the eternal life; therefore, death is not to be resisted or fought against but to be accepted as part of the divine plan for every individual. In a hadith narrated by Abu Hurairah, the Prophet Mohammed (S.A.W) said: “None of you should wish for death, nor should he call for it before it comes to him; because when he dies, his actions are terminated, and certainly the age of a Believer adds nothing but good.” Death itself is not a punishment but just simply an event that brings a particular stage to an end and starts a period of probation which prepares for the day of resurrection and the final judgment. Death is like an entrance which has no coming back but moving on to the next phase. Some Muslim scholars are in favor of transplants but disapprove brain death. The resistance to brain death is reasoned by the point that brain death does not eliminate the heat of life, which indicates the presence of the soul: the heart beats and the kidneys and liver still function. In addition, international literature indicates the possibility of a return of cerebral activity after its interruption. This is the difficult relationship existing on transplants between the Medical Association, the political world, and religious authorities. All Middle Eastern countries except Egypt passed laws allowing deceased organ transplantation and regulate living donations.

In Japan, despite the fact that the Japanese Medical Association has adopted brain-dead criteria since 1988, there has been strong resistance to brain dead criteria and organ procurement.
Its hostility to deceased organ removal can be traced back to the first transplant from a person who died of drowning in 1968. The resistance may also come from the traditional Japanese thought that the belly is associated with the soul. When a Samurai warrior commits ritual suicide (hara-kiri), he plunges his sword into his belly. Such belief creates a barrier to the acceptance of brain death. Organ sources for transplantation is confined to living donors and foreigners. In the advent of modern technology in medicine, determination of the occurrence of death becomes more complicated when mechanical interventions decide the moment that heart and lungs cease. On one hand, modern medicine saves lives, on the other hand, it interferes with personal matters in lives and deaths.

In organ donation, people’s welfare and lives are decided by the moment of death of the donors. The ideal moment of death is when the donate organs remain viable while the organ procurement does not cause death to the donors.

Two common death criteria currently exercised in medicine include brain death and cardiac death. Discrete definitions of brain-dead criteria and miscommunication between families and healthcare team which lead to the ethical infringement and public distrust continue to be the prevalent obstacles in organ donation, either when the organ procurement occurs or not.

While an individual making his own choice about organ donation increases the likelihood of donation, thinking about becoming an organ donor implies contemplating ones’ own death. Some individuals might be reluctant to decide about becoming an organ donor since it requires thinking about an event they would rather prevent and not acknowledge its possibility of occurrence. Thorough understanding of death in various aspects that possibly impact on one’s definition and acceptance of death, social, and cultural factors, personal, and familial values should be required for any party involved in all organ donation activities, so that they are able to
more effectively communicate to potential donors and families. Any society which approves organ donation from cadavers has to confront the big and common question: what is an acceptable death? The conflicts for an acceptance of death are often between groups: the acceptance or definition of death based on medical, social, and cultural factors and the acceptance of death based on personal and familial values. Resolving this problem requires cooperation of every member in a society rather than only healthcare team. Death should not be avoided discussing in both healthcare setting and in society.

Before the Middle Ages, in Western societies, the attitudes towards death and dying of the knights and pious monks were the standard for the social attitudes. Death was a simple and inevitable phenomenon when human beings aged. Nobody refused or avoided the occurrence of death, and they even prepared for the coming death, yet the dreadful causes of the death would not be mentioned. People showed no fear of death that was in contrast to the contemporary time when people are usually afraid of even speaking the word “death.” Moreover, death was defined as a natural order which did not separate from human beings. People would experience dying and death as other natural laws and they had no intentions to escape from it. When the time came, they would simply accept it. During the Middle Ages, the perspective of death moved from the idea of the collective destiny of the species to the idea of individuality. Death would occur but the moment of death was no longer important; instead, the end-of-life moment, when everyone resurrected and would be judged for the good and bad deeds done by each individual during his life, became more important. In brief, from the twelfth to fifteenth centuries, there was no change in the idea that death was merely an unavoidable phenomenon that no one refused or avoided it; yet, the awareness of death shifted from all human species to individual level, creating the idea of personalization of death. Between the time of sixteenth to
eighteenth centuries, death was described in association of more emotions though the
descriptions were found mostly among art or literature works. Death was firstly assimilated with
a break with its own beauty in life which aimed to bring human out of daily life or unwanted
feelings. Still, death caused no fear to people but it became an important event for people.\textsuperscript{362}

Attitudes towards death were critically changed in the end of the eighteenth century and
in the nineteenth century. The fear of death illustrated in the attitudes of the dying person and his
family. Death and dying were accepted more difficultly than in the past and people expressed
their sorrow for the separation from their loved ones around the deathbed. People tried to hide
the reality from the dying person; they considered the act of telling the truth of dying condition
to the dying ones as being cruel.\textsuperscript{363} The thought considerably changed in the second half of the
nineteenth century that the presence of death was the ugliness in the beautiful life, which
required people to avoid their emotion for the dying ones not only for the dying one but also for
the society and the relatives of the dying ones. Death was a disturbing phenomenon.\textsuperscript{364}Before the
twentieth century, most people experienced death at home. However, since the twentieth century,
site of death has shifted to the hospital along with the relocation of healthcare provision from
homes to hospitals. When a person dies, he is no longer surrounded by relatives and friends and
experience ritual ceremony; instead, his death is decided by doctors and hospital staff and death
is defined as a technical phenomenon.\textsuperscript{365} Death is accepted and tolerated by the others but
sentiment for it should be avoided for the sake of the society. Showing sorrow or despair is
understood as against and threatening the happiness of people around or the society. Covering
sadness becomes social obligation to contribute to the collective happiness.\textsuperscript{366}

The thoughts of death have changed since beginning of the twentieth century. The
contemporary attitudes towards death and dying are related to the industrialized societies.\textsuperscript{367} In
the modern time, longevity has been significantly extended which takes away the readiness for death among people. People are not willing and confident to receive the unavoidable event of life- death. 368

Brain death is the irreversible loss of all functions of the entire brain that provides the physiological mechanism for the living body. The definition of brain death as “death” has challenged a large number of people who practice or are concerned about organ donation. One argument against this definition is that when the brain irreversibly loses the electrical activity, it dies but as an organ fails rather than the person dies.369 It is important to understand that in the Harvard criteria for brain death, irreversible coma is one of the criteria for brain death, it is not the synonym for brain death. Neither irreversible coma nor persistent vegetative can be defined as brain death because they do not have complete loss of all brain functions. PVS goes through sleep-wake cycles while irreversible coma is in a sleep-like state.371

The definition of brain death, however, has become one of the most controversial issues in healthcare ethics area as the death of a person is acceptable in respective medically (legally), scientifically, socially, as well as personal and/or familial values. Many people believe that the brain dead criteria are to make use of organs from donors after brain death.372 In the past few decades, many medical researchers have showed that the occurrence of death may not be exact the moment of declaration of death by doctors. The moment of death may occur long after the person is declared dead. In an illustrative way, Teresi has described the relation between the point at which a doctor formally pronounces one’s death and the point at which death actually occurs. He construes that the disagreement between the common medical criteria of death, meaning brain death, and other criteria of death, such as cardiocirculatory death has created a gap called “the undead zone gap.” This gap tends to be more and more widening proportion to
the aggravating debates around the acceptable definition of death.\textsuperscript{373} To advocate for brain death, brain is the only organ that determines a person to be dead or alive. Loss of brain signals death no matter how healthy other body parts are. The brain death should not be the sole criteria to make a person legally death.\textsuperscript{374}

The introduction of brain dead criteria has not only caused disputes in scientific, medical, and political areas but also induced public distrust in medical practice and political policies. People fear that when they fall in the unconscious state, whether they are judged as being dead or not would be dependent on whatever the criteria of death on which their doctors practice. Death would come to them in too easy ways without much effort of bringing them back to life. The current perception of the occurrence of death is believed to based on too few simple criteria, which far differ from the past when deciding that a life just came to an end had never been easy.\textsuperscript{375} The change of what defined death has a long history. In classical Greece and Rome, a personhood was the unite of the soul and body; therefore, death occurred when both soul and body die. In another way of saying, a person was made of the vegetative soul of nourishment and growth and the animated soul of motion and sensation. If he lost his memory, it did not bring about death; or if he lost his sight, death was not implicated. A person was dead when he irreversibly lost both vegetative and animated souls.\textsuperscript{376} Likewise, among European countries, for centuries, it was believed that sight, taste, intelligence, and strength compose a live human. Accordingly, declaring people dead must be made in an utmost prudent manner. Heart, lungs, and brain were not dependable signs to determine death. Numerous methods were used to make certain upon a person’s death. For instance, a finger must be cut off before cremation, the bodies should be left until it decomposed, or calling the dying’s name in an attempt to revive him is a part of the funeral. The criteria of death, such as stiffness, coldness, and lack of breath, heartbeat,
pulse, and movement were not easily to be the sole determinant. To ensure the death, before burial, people bathed or rubbed the body with hot water trying to revive the person. In addition to the physical absence of the body, escape of the soul was also an attribute of death. However, a person’s soul varies among cultures and religions. Death was determined by physical benchmarks of being dead, including stiffness, coldness, and lack of breath, heartbeat, pulse, and movement in accompany of spiritual factor- the soul. Most of these methods have become ritual traditions and customs, yet some are currently remained being practiced in funerals nowadays, like crying out loud, calling the person’s name, keeping the body for two to three days, or kissing the body.

A suggestion for a new definition of brain death- the higher brain death, aims to extend more requirements for brain death. In this definition, death occurs at the time of an irreversible loss of personality, cognitive functions, and ability to make choices. As this definition, PVS patients and people with dementia and retardation could be counted as dead. Kateb’s notion of human dignity appeals particularly to the matter of organ donation because it requires fair treatment and protection for every human being, including ones who are disabled or in any medical condition. Accordingly, the proposal for utilizing patients in persistent vegetative state or anencephalic newborns cannot be justified.

Conflicts exist between healthcare professionals and laypeople because medical and lay perspectives hold different views on human bodies or cadavers. From a medical perspective, cadavers is viewed as a source of knowledge; from learning the cadavers, healthcare staff can learn about the causes of death, and the effectiveness of therapy; cadavers are also sources of organs to benefit the others. In this case, medical people objectify the cadavers. In a different manner, the bereaved families view the deceased as the people who they cared for and who they
have lost. When this conflict occurs, it is likely that the families refuse to give consent to donate their loved ones’ organs. To prevent such conflict from occurring, besides the medical knowledge, when approaching the families of the potential donors, healthcare team members should acknowledge the perception of human persons as a uniqueness entity and treat the deceased with highest respect for their dignity.380

In China, executed prisoners are considered as individuals who have been deprived their autonomy; therefore, the government allows organ harvesting from their bodies after the execution.381 Those organs are then usually sold in the markets rather than donated even though the government contends that the act benefits for the worthy people.382 Organ procurement from prisoners who are condemned to execution violates every ethical standards. It deprives the prisoners’ autonomy and human dignity. The reason that Chinese government use to defend their action is not justified. They contend that the criminal should condemn himself for a worthy citizen. Employing Potter’s idea of bioethics may give strong contention to against this act because his idea acknowledges human values of every individual. It violates principles of bioethics if the organs harvested from the executed prisoners without informed consent to either the prisoners or their families or relatives. The Chinese government made a commitment to exclude the executed prisoners from organ donation and would rely on a system of voluntary donations by mid-2014.383 This does not promise a bright future for organ donation in China due to the cultural understanding of the sanctity of the body, causing hesitance to donate organs in public. Some pilot programs for compensating the deceased donors’ families have been implemented in five provinces (Zhejiang, Tianjin, Jiangxi, Jinan, and Liaoning). In China, the non-profit organization Red Cross Society is responsible for implementing the donation policy and raising and managing funds for financial compensation. Organ procurement can proceed
only if the deceased consented to donate in either living will or written form, or if his closest relative provides written consent for organ donation. The compensation includes cost of purchasing grave plots, allowance for the families, and extra amount to help the families if the deceased donors face hardship. Despite the generous amount of compensation and appreciation, the outcomes did not meet the expectation. Majority of the donors are the poor, indicating that the families give consent to donation for their need of financial assistance. Besides, some families are under great stress as they are thought to sell their loved ones’ organs for money.  

It is difficult to die in the era of medical advancements from the perspectives of patients, healthcare professionals, and healthcare system. Places where people spend their last moment of life have shifted from home to hospitals and other healthcare settings. In developed world, how people spend their aging life is often prescribed by the medical protocols and doctors. In developed countries, when and how to die are no longer a personal matter, regardless the person’s attitude toward death. The closer the death moment comes, the more aggressive measures and effort the healthcare industry provide for the patients. It is a battle between the natural process and medical technology and professionals, or between the natural process and the doctors who do not want to accept the normal matter, because they do not want to be defeated, they do not want to feel they are incompetent in the field. In the middle of the two sides are the dying patients whose death depends on who their doctors are, where the hospital locates, and how much they or their families can afford to prolong the battle. The battle is too intense and frenetic for the patients’ values and wishes for their last moment of life to be recognized and acknowledged. On the contrary, in developing countries, since access to health care is limited, confronting death seems less complex. People with terminal illness usually do not go to hospital. Their death seems more prepared and certain.
III. Social level: the ethical issues of justice, organ markets

1. Justice

Supporting for living organ donation in the view of utilitarianism, some people contend that the survival of two people with possible limited physical ability is better than a healthy person and a dead person. Such supporters should be likely to be in favor of the idea that one person could save multiple lives by distributing more or even all his organs in order to maximize the utility. Yet, every human being owns equal status and moral equality, thence there should not be any gain or advantage (the recipients) at the expense of the other’s health (the living donors) or moral value (the healthcare practitioners).

Generally, discussion about justice often weighs between the benefits for individuals or the benefits for the society. The two creditable theories of justice are postulated by Mill and Rawls. While Mill approaches the justice conception from the utilitarian idea, Rawls’ idea of justice as fairness is clearly on the contrary to the utilitarianism. The difference may result from the objects who their theories aim to serve, that is, Mill concerns about the overall benefit while Rawls aims to protect those who are least advantaged in society. The core of justice in Mill’s theory is the maximizing of utility. Equality occurs at most when there is a sufficient balance between benefits and burdens in the society. The most important is the ultimate net of benefits distributed among social members. Actions should attempt to maximize the overall utility so as to obtain the equality. In contrast, Rawls does not consider this social distribution as equality. To him, the way to shorten the gap between unfairness and fairness is to benefit the least advantaged. The core point that creates this difference is that utilitarianism does not respect the individual differences but more for the demands of social net utility; accordingly, it is justified that the disadvantaged or less advantaged may have to sacrifice their benefits for the
better ones if it is the way to increase or meet the social overall utility. This is absolutely opposing Rawls’ point of view. Mill’s theory is based on utilitarianism while Rawls’ point of view contraries to utilitarianism.391

Living organ donation when applied to Mill’s theory seems to be justifiable for meeting the goal to maximize overall utility, but when applied to Rawls’ theory, it is unjustified for the potential occurrence of abusing the least advantaged who give away their organs owing to financial need.

When living organ transplantation is allowed abroad, it creates the transplant tourism industry. Transplant tourism is happening in both developed and developing countries, either for obtaining organs, having the transplant operations, or both. Many patients with end-stage-renal disease do not want to stay on the waiting list for cadaveric donor organs for years; they are willing to pay to get kidneys from strangers. The common destinations for transplant tourism include China, India, Pakistan, the Philippines, and South America. The practice is illegal in these countries but the brokers manage the transactions to pass loopholes in the regulations. For instance, documents are professionally prepared to prove that the donated kidneys are from altruistic act from families or acquaintance. A complete tour could be so complex that it could happen in three continents, making it hard for the local authorities to be aware. In one case, a broker from the United States matches a patient from Italy to a donor in the Middle East, the operation is then proceeded in a hospital in Eastern Europe. In another case, when the patient prefers to have the operation in the home country- the United States, the donor from Moldova will come to America with student or tourist visa so that the operation is implemented in the desired location. Some hospitals conduct the operations as long as both recipient and donor sign document attesting that no money is involved between them.392 The incoming foreign recipients
who are able to get sufficient funds for the procedures compete with the domestic recipients and lessens the number of organ donors, which is already unsatisfactory, in the host country. The allocation of organs becomes more unjust to the domestic recipients who are still on waiting lists. Besides, those recipients technically hold two spots on the two waiting lists, reducing the chance to get organs to more people.393

A new issue that has emerged in the era of media is exploitation. Exploits of donors become more complex and could be in both explicit and implicit forms. Exploits occur not only to poor people but also to people’s altruism by using touched and sometimes professional edited personal stories to attack emotionally vulnerable group394. Such exploits have caused injustice in organ allocation.395

On the other hand, deceased organ donation when applied to both theories is justified. The recipients will have better health while no other’s health is debilitated in the transplantation procedure. Also, the chance of organ trading is much less likely, meaning to lower or even eliminate the chance of abusing the least advantaged.

2. Organ markets

The very first market for organs dated back to Hunter time of tooth transplant when the recipients came to the transplant clinics with their potential donors, either their slaves or ones who were willing to sell their teeth. This model appeared again in Chicago in 1903 when people could buy an ear at a cost of five thousand dollars, but the donor would be attached to the recipient for days until the graft healed. This attaching technique originated from Taghacozzi skin flap technique in rhinoplasty. The government did not put the market to an end not until there were some reports on testis sales.396
Another serious issue was created and facilitated by utilizing living organ donation: the operation of organ black markets. A great deal of writers strongly disapprove the existence of such markets for they devalue the human bodies. Organs provided by the black market usually come from poor people in poor health conditions, the unsafe transplant procedure often occurs in a developing country where lacks sufficient authority and policy in organ donation activity, as well as post-operative care, the role of healthcare professionals as caring for people is likely to be corrupted. Trading a human organ is the act of objectifying a human person, thus organ trade is not only exploitative, it is morally wrong. 397

In black organ markets, the insufficient physical screenings and organ matching of potential donors engender more harm to the recipients. The recipients may receive not only the organs but also some transmissible infections, which, in turn, can cause a public health hazard. 398 Also, many studies indicate that the post donation outcomes for paid donors tend to be poorer health and financial condition. Their families are often worse off after the operation for losing the labor support of the families. 399

In India, in 1994, the Transplantation of Human Organs Act illegalize buying and selling organs; living donation permits only between immediate relatives, spouses, and those who are unrelated but in relationship of affection or attachment. Organ trafficking, however, has chance via the legal loophole about the unrelated relationship, requiring the amended act initiated in 2008. According to this new act, if donors or recipients are foreigners, they are required to obtain approval from their embassies. In 2011, all unrelated transplants between Indians and foreigners are banned; violation renders fines and jail time. 400

Pakistan is one of the well-known destinations for transplant tourism. Commercial transplantation just became illegal in 2010. Earlier, in 2003, eighty percent of the transplants
were unrelated living cases, of which fifty percent of recipients were foreigners. Private hospitals often offered transplant package. Under international pressure regarding the organ trafficking, the country criminalizes transplantation of organs from Pakistanis to foreigners in 2007, ratified as law in 2010. The law proves its effectiveness for a drastic change in numbers of foreigners coming to Pakistan as recipients. Still, the practice is believed to go under the ground. 401

On the other side of the organ markets - the buyers, Israel plays a significant role in the markets. In Israel, brain death is not approved by Orthodox Judaism, making the organ donation rate extremely low. This limited organ source forces people in need of organ transplants participate in transplant tourism. However, since 1994, the transplant tourism is assisted financially by Israeli government. The government covers the costs even if the operation occurs in a country where selling organs is illegal. In 2008, the government’s funding for transplant tourism has ended, yet the government still reimburses the transplants abroad if the transplants obey the law of the host country and no compensation for the donors involves. 402

Iran so far is the only legal organ market in the world. The market is the government response to the organ shortage and previous expensive funding program for transplant abroad. In Iranian organ market, in addition to a certain amount of funding from the government and nongovernmental organizations, vendors and purchasers arrange another amount in discrete. Therefore, the price for organs vary in Iranian market.403

One of the reasons for the existence of the organ markets is to provide the poor their chance to improve their lives. It is not easy for people from other cultures to understand the economic pressure and lack of social support that may render a mother to sell a kidney to feed her child.404 In many studies of kidney vendors in India, although they can pay off their debts as their primary purpose of selling their kidneys, their health condition declines after the operation;
in some cases, they do not receive the amount as promised by brokers or clinics. Although this justification is proved otherwise, some people do not see a better escape from their current hardship except for selling their organs. These people are vulnerable and must be protected; they are not to blame for the existence of black organ markets.

Using living donors allows organ markets to either illegally or legally operate throughout the world. Although the majority of ethicists reject the existence of organ markets regardless of their forms, some are in favor of them because of the ultimate goal that meet the demand for donor organs. M. Goodwin suggests bringing the existing illicit organ markets into light and forming a regulated market for cadaveric organs. Such market would save many Americans with terminal illnesses and eliminate the organ black markets. Some debaters are in favor of organ trades to some extent because of the ultimate goal of meeting the demand for organs. The market also eliminates the familial coercion in living donation.

The major reason for people who support for the organ market is the failure of altruistic system in increasing the number of organ donors. Altruism is vulnerable to coercion, pressure, and threat, thus it is likely to be corruptible. Also, the current existence of organ markets should be acknowledged as an existing phenomenon, as Goodwin advises. It is unlikely to eradicate the organ markets when the organ shortage remains critical. Therefore, we had better create a regulation system for these existing markets instead of making ineffective effort to remove them. Making lofty moral arguments in an attempt to exterminate black organ markets only lead to unnecessary death of thousands of people each year on the waiting list. When it comes to saving human lives, people should be less sensible and act in greater common sense. The author suggests a successful organ market is achievable if all pertinent procedures and information of organ donation and transplantation are transparent. One of the most serious issues created by
black organ markets is the potential harm caused to wellbeing of both donors and recipients since they often enter blind transactions without trustful reports on the vendors’ health status and procurement conditions and sufficient techniques and care provided for both vendors and buyers. Another issue in black organ markets is that they diminish respect for voluntary consent, compromising individual autonomy, and create injustice by exploiting the poor who are often the major vendors in the markets. 407 A regulated market resolved all these issues.

However, the emergence of profit-seeking bodies that specialize in organ acquisition would be an inevitable result from the nature of trading. Out of question, this suggested policy should be against for its commercial characteristic.

IV. Humanity level: the altruism

Either related or non-related living organ donation raises some distinct ethical questions. When the donors are related, the donation may be motivated by altruism, but it could be unduly influenced by the intense social pressures for their obligation or responsibility to the recipients. There is a blemish border between altruistic act and responsible or obligated act when it involves related living organ donation.

In the case that the donors are the relatives or friend of the recipients, the donation may be motivated by altruistic concerns, but it is likely that the decision to donate their organs unduly influenced by the intense social pressures that, as the related, they should have moral obligation to donate an organ to another in order to keep the ill family member alive. The feeling of responsibility obscures the full consideration of the consequences as a living donor.408

Non-related living organ donation may the highest level of altruistic act. Some countries allow the practice of donation to strangers; still, it has not improved the existing issues in organ donation. The failure of the practice shows in the low number of non-related living organ donors;
or if the number has risen, the raise comes along with social and ethical issues, such as implicit trading as the result of the policy to compensate for the altruistic act or violation of human rights. If there is no trading involved the organ donation procedure, the donate act of either living or cadaveric organs is the act of altruism.

It is common that donate organ from family members is unproductive although this organ source is one of the best quality sources for transplantation. The reason is that the ill family members do not wish their loved ones to donate organs to them. They do not want to jeopardize their loved ones’ health while they can pay for unrelated people to get their organs. The transaction with strangers enables them to live freely from guilt. However, in the countries where adopt kinship organ donation policy, such as Israel, using living organ donors could abet exploitation of altruism; the policy turns kinship to be an instrument to get donate organ instead of encouraging altruistic action. To obscure the financial transaction between donors and recipients, kinship relations are often created and tailored by agents after the confirmation of organ matching. Recipients and organs match not only clinically but also their fictive relatedness. The shared history of relationship to convince the committee is invented and scripted; then, the donors and recipients will be trained until their performance is good enough to convince the committee members of the true nature of friendship and their genuine altruism. Fictive relations are assorted and perplexing; they could be acquaintanceship, legal relationship (marriages of convenience, paper sons), or extended families. The fictive relatedness with psychologically tailored stories clouds the perception and acceptance of real altruistic act, making true altruism an eccentric act that requires further psychological evaluation. For this case, living organ donation not only abets organ trafficking but also corruptions the concept of altruism. In fact, this path of donate organs is a well-known secret.
Besides, exploitation that is more complex exists in both explicit and implicit forms. Exploits occur not only to poor people but also to people’s altruism by using touched and sometimes professionally edited personal stories. Such exploits have caused injustice in organ allocation.

**Conclusion**

In general, current policies to augment the number of organ donors divide into two trends: support for living organ donation and for deceased organ donation. Living organ donation greatly contributes to the emergence of organ black markets, disgrace of the fundamentals of medical practice, and dishonor of human dignity. Using living donors dishonors human dignity because it inflicts suffering to the donors. Transplantation practice using living donors causes healthcare professionals to violate the principle of non-maleficence in their practice, since it causes foreseen harms to individuals - the donors.

While living organ donation poses numerous ethical issues, post-mortal organs have become more favorable for its potential sources and being less problematic, which can be resolved by effective communication and education in healthcare and public settings.

Still, receiving donor organs from the deceased poses a major issue: what are the criteria for death? The most common criteria include brain death and cardiac death. It is not uncommon that there has been a lack of effort in communication about perceptions of the quality of life and acceptance of death between healthcare professionals and ones under their care. Potential donors or relatives often receive insufficient information pertinent to death, subsequently rendering fear, misinterpretation, or mistrust about the procurement of organs, ultimately deciding not to donate the post-moral organs.
Yet problematic, this matter can be resolved by effective communication and education in healthcare and public settings. Moreover, resolving this issue entails gaining, retaining, and increasing public trust—the essential factor to increase the number of organ donors. Acknowledgment of individual perceptions of death is essential for a conversation about death, especially while discussing the organ donation option.

When an individual decides to become an organ donor after death, the decision is made on the basis of the personal/familial values. When patients and families take responsibility for their own dying and death, autonomy and human dignity are more likely to be respected and protected. On the other hand, when an individual decides to become an organ donor upon their death, it requires the potential donor to consider fewer factors before making own decision. The decision is on the basis of the personal value or belief of the donation act; in addition, the potential donor has option to discuss about his or her wish with the family or loved one if familial value imposes on the individual value.

On the contrary to the attributes of death in the past, present criteria of death originate from the condition of body organs, entailing the heart or brain. Dying is no longer a cultural and religious affair but becomes a medical one. However, in the advent of increasingly advanced medical technologies along with the lack of consistency in adapting criteria for determination of death, the boundary between life and death has become confused resulting in the public fear of being prematurely dead. Besides, the acceptance of death has already divided the public on one side and medical professionals and policy makers on the other side. Consequently, as long as talking about death remains an avoided topic, the division would become more widened.

Accordingly, in order to gain public trust in the matter of organ donation, an ascertain of a transparent and consistent definition of death which is culturally acceptable is necessary. Elicit
talking about death would be an effective way to bring together the medical professionals, policy makers, and the public and create the harmony between medical and cultural aspects.
Chapter Five: Pros and Cons of the Current Policies and Proposals on Organ Donation

Introduction

Altruism, autonomy, and voluntarism account for the current policies for organ donation. The same policies could result in different outcomes in different countries as they may be modified according to their own cultural, social, and political characteristics.

Up to now, altruism, individual autonomy, and voluntarism are the three main influential factors upon which existing policies and law are constituted. Accordingly, to many policy makers, relying on these three factors would not effectively alleviate the shortage of organ donation. New policies are established with or without the three factors in attempt to increase the number of organ donation, yet the same policy could result in different outcomes in different countries as it may be modified according to their own cultural, social, and political characteristics.415

In essence, the implication of proposed policies revolves around the matter: who has the rightful authority over the body after death and the ultimate goals of narrowing the disparity of organ supply and demand. Permission of those who have rightful authority over the body after death is required for the lifesaving uses of human organs. Ethicists have long debated the rightful authority over the dead and the morally correct way to impose this right.416

I. Current policies for organ donation

1. Required request policy- the central role of potential donor’s family

Required request policy, originally proposed by Arthur Caplan, aims at expanding the availability of cadaveric organ donation. The policy involves the available family members or legal proxy of the deceased during the procedure of discontinuing life support measures. According to the policy, the request for organ donation must not be made until the death is
legally declared, and respirator is in use only after the legal pronouncement of death. The rule is to ensure that the declaration of death has no connection to the need for organ donation. In the case of no available family members or legal proxy, no organ could be procured without the deceased’s donor card or relevant document.\(^{417}\)

This policy directly addresses the major problem involving family members in obtaining cadaveric organs. It also emphasizes on building and bolstering public trust in posthumous organ procurement, a necessary element to the success of the policy. With a standardized and routine process, the policy may lessen psychological and emotional burden for not only the deceased’s family but also healthcare professionals in such a sensitive situation.\(^{418}\) Advocates to this policy contend that the benefits of this policy in increasing the supply of cadaveric organ donation definitely outweigh the loss of individual freedom to the body and clinical decision making.\(^{419}\) The policy of required request became legislation in the United States in 1986. Despite the long time of its introduction and practice, it has not significantly contributed to increasing the number of donor organs. The subsequent existence of organ black market is unavoidable.\(^{420}\) Still, the policy fails to acknowledge the nucleus of the event - the donor. The donorship, in fact, is transferred from the real donor to the family or legal proxy, which much likely raises numerous ethical questions around the autonomy and human dignity. The policy may be able to gain public trust but, eventually, the public trust would be eroded by the loss of public confidence resulting from the ethical controversies. The policy would become more practical if it also focuses more on public education and the role of the donor in cadaveric organ donation issue.\(^{421}\)

Some people view the required request policy as a policy that violates the donor’s autonomy, because it does not respect the person’s wish about what will happen to his body. The family’s opinion trumps the donor’s decision. This policy is justified when the donors do not
have provided consent before their deaths. Nevertheless, the policy is not a successful approach to increase the number of donate organs. Perhaps, it succeeds in increasing the number of chances to request, but it fails to reduce the refusals from families.

2. Mandated choice policy- the mandatory awareness of organ donation

Mandated choice policy requires competent adults to make decisions whether to become an organ donor after they die. The supporters of this policy believe that practicing this policy would eliminate the emotional and psychological burden for the families and healthcare teams during the sensitive and devastating moments. It also gains more positive attitudes from the public for its emphasis on the individual role in decision making. Because the time waiting for the family’s consent would be eliminated, recovery of the procured organs could encounter less complication, and subsequently, improve the quality of procured organs. More importantly, the policy preserves the two philosophical foundations of organ donation: altruism and voluntarism. Mandated choice as the obligation to choose strengthens the individual choice and role.

People opposing to this model contend that it poses moral, societal, and financial problems. According to standards of medical practice, there must be communication between healthcare staff and the families in terms of every aspect related to the care for the patients, before and after the patients die. Overriding the families’ wishes would increase their frustration and create conflict between the caregivers and the families.

Mandated choice policy also targets toward the expansion of the pool of cadaveric organ donation. It requires competent adults to make a decision whether to become an organ donor after they die or not. The concern about obtaining the potential donors’ explicit consent, instead of the families’, wins more advocates than the required request policy. The favoring side of this policy also points out that the word “mandated” should not cause any confusion as coercion.
to donation; it is to require everyone to answer if they would give consent or not to be an organ donor after their death. In other words, it requires the awareness of an organ donation possibility from everyone. The policy has been in legal practice in some states in the United States in the Uniform Anatomical Gift Act, applied for all competent adults to decide whether or not they wish to become organ donors after their deaths. Despite the determining characteristic of the donors themselves stated in the Act, the organ procurement teams still ask the family members for their consent about the deceased’s wish for being an organ donor in the devastating situations; furthermore, in many cases, families are not aware of such wishes. Subsequent rejection is an expected outcome. In this manner, family members take control just alike in the required request policy option. In order to take advantages of this policy, more specific instruction and broader public education are necessary to bring back the control to the donor, also to respect and honor the deceased’ wishes. It is suggested that all competent adults would be required to decide and record whether or not they wish to become organ donors upon their deaths by indicating on driver’s license applications, tax returns, or state identification cards. The directives could be easily re-stated at anytime during the life time, as long as the families cannot override the decisions. The policy has received a large supporting group for its advantages. It also gains more positive attitudes from the public for its emphasis on individual role in decision making. Public awareness of organ donation could elevate as every competent adult has to make decision about the issue, either acceptance or rejection, resulting in the increase in organ donation participation.

The policy of mandated choice respects and protects individual autonomy as well as increases public commitment to organ donation, yet the involvement of family members has prevented the policy from achieving its goals. Therefore, it is suggested that before making
decision whether or not to become an organ donor upon death, one should spend sufficient time reflecting self, discussing the issue with families or friends so as not only to inform their wishes with the families but also to receive more useful insights prior to making such decisions. An ultimate decision should be made upon these deliberations. The roles of the donors and family members are clearly defined. The donors are the sole decision makers to be or not to be organ donors while their families play supporting and assisting roles, acknowledge and respect for their loved ones’ wishes. The parts of the deceased’s families would not be neglected but would be respected also when they are informed every plan of the organ retrieval of their loved ones by healthcare teams. The team should offer emotional support to the families to help them grieve and deal with the enormous trauma caused by the unexpected loss of the loved ones. Although it appears to many parties that the deceased’s families impede the accessibility to the potential cadaveric organ sources, redirect the focus away from the family and back the individual does not seem to be easily acceptable solution in most cultures for the bonding and irreplaceable involvement of families in their loved ones’ lives.

On the other hand, some people oppose this model, contending that this model poses moral, societal, and financial problems. Instead, they suggest that the organ shortages would be better alleviated by finding out why people refuse to donate. They are concerned that the policy of mandated choice puts too much effort on the individual donors and elimination of family roles that the potential cadaveric organs donated by the deceased families would be overlooked; as a result, the shortage of organs would not be fixed as expected. Moreover, according to standards of medical practice, there must be communication between healthcare staff and the families in terms of every aspect related to the care for the patients, before and after the patients die. Overriding the families’ wishes would increase their frustration and create conflict between
the caregivers and the families. In addition, there has been no evident statistical fact that the families who refuse to donate their loved ones’ organs are not aware of the wishes to become organ donors upon their deaths. The reasons under this rejection could be from various aspects. Distrust of the transplant process is still a barrier to gain the support of the family for the pre-indicated consent. Understanding the causes of family refusal of cadaveric donation requests offers more ways to increase donation rates than does ignoring families at devastating moment. The success of mandated policy is also dependent upon how well educated and informed the public is regarding the purpose and importance of organ donation. Whether or not mandated choice would actually increase public commitment to organ donation?

In Scotland, the policy for organ donation on the basis of individual consent is similar to the mandated policy but without the modification of the involvement of the donors’ families. The organ donation register relies on altruistic behavior of individuals and a public understanding of organ donation. Cadaveric organ donation in Scotland is dependent on the individual’s willingness choosing opting-in and donating organs upon death. Individuals’ wishes to donate their organs upon death must have legally written documents indicating their intention, such as donor cards, driving licenses. Although the donation comes from individual altruistic intention, before the procurement, healthcare professionals must obtain consent of the next kin for an assurance of a donation without objection. Henceforth, healthcare professionals prevent possible legal issues as well as being criticized as paternalism by the public. Any trading activities involving organs are considered a criminal act in Scotland. Living genetically related donation is permitted while living unrelated donation is permitted only if there is an emotional relationship between the donor and recipient.
In a recent survey, approximately 87% of the UK population expressed support for organ donation but only 37% of the Scottish population are on the Organ Donor Register in October 2010. There have been recent improvements in raising awareness of this issue, and there has been an increase, particularly in young adults (16-25 years old) in the number of people registering as organ donors. However, Scotland continues to lag behind other European countries and there is an ongoing shortage of cadaveric organ donation each year. The National Health Service Scotland has recommended that organ donation routinely forms part of the discussions surrounding end-of-life care when appropriate. Over the past ten years, the number of organ donation from brain death (DBD) has remained approximately 40-60 patients per year in Scotland. Nonetheless, this source of donor organs is unlikely to increase for the continuing improvements in neurosurgery and intensive care as well as public education about road safety to prevent accidents. The average number of solid organs retrieved per donor is 4.1 for DBD compared with 2.1 for donor circulatory death (DCD) in 2009. Donation after circulatory death is currently regarded as the route with the greatest potential for increasing the number of available organs for transplantation. The drive to increase the number of organ donations following DCD has been challenging for many healthcare professionals since there has not always been clear ethical and legal guidance. Cultural differences has been attributed to the low number of cadaveric donate organs.

Managing the organ donation process following DCD requires considerable resources and experience. Excellent communication skills are required by the medical team: the patient’s family must be able to make informed decisions regarding donation at a time of extreme emotional distress. Everyone involved in the process must be aware the time matter in organ retrieval and in procedure of identification of suitable recipients.
3. Presumed consent policy - a presumed personal choice in organ donation

Presumed consent policy, or opting-out policy is a system by which individuals are considered potential donors upon deaths unless they specifically note otherwise. Supporters argue that presumed consent policy is considered are most effectively preserving autonomy and altruism concept through the donors’ consent. Everyone who does not wish to donate has the right to refuse while anyone wishes to donate can present the altruism through the consent. Presumed consent policy poses significant legal, moral, religious, and social challenges.

The presumed consent policy is quite popular in many European countries, such as France, Austria, Spain, Italy, and Belgium; still, the outcomes of the policy vary among these nations. Belgium and Spain have seen increases in the supply of organs while France has not. Similar to the mandated choice, it eliminates the burden of requesting donation for healthcare professionals, and the frustration of decision making for the families, and improves the quality of the procured organs by avoiding the delay for waiting for the families’ consent. The key to success of this policy is to create and enhance the acceptance of the presumed consent throughout the society. The attitudes of healthcare professionals and the public must be directed toward the moral good of organ donation. Since attitudes are shaped by ages, cultural, educational, and economic factors, individual perception, and ability to manage stressors, all these elements should be taken into consideration in the effort to mediate the acceptance of the policy of presumed consent.

In Belgium, this policy became a law in 1987 and has demonstrated its positive impact on the number of available cadaveric organs. There is no legal obligation to inform the family of the intended organ procurement; however, no procurement proceeds if the family explicitly opposes organ recovery. Physicians may act according to their own ethics, within the limits of the
recorded decision of the donor and the right of the family to object. This physician freedom is one of the crucial components of the program’s success. Pure presumed consent policy operated in Norway is another example for the success, yet it is ethically controversial because no actual consent necessarily needs to be obtained if brain death is established, only immediate next-of-kin can withhold the procurement. To promote transplantation, some European countries cooperate to ensure the efficiency of transplantable organs. If an available organ cannot find a suitable recipient, it can be used elsewhere. In Belgium, individuals register their decision regarding donation in a computerized central registry which can be accessed only by the transplant centers. This policy has demonstrated its positive impact on the number of available cadaveric organs in Belgium. Compared with international data, Belgium has been in the top ten of donor and transplant activity with a stable number of donor organs (e.g. 90 organs per million inhabitants in 2008) for years. The presumed consent law is applied for not only Belgian citizens but also for non-Belgium citizens who reside in the country for more than six months. Everyone has the right to decide to be a donor or to refuse donation and no one can override this decision. The will of the deceased is absolutely prior to everyone else. During the lifetime, they can modify their decisions at any moment. There is no legal obligation to inform the family of the intended organ procurement. However, if a family member explicitly opposes organ recovery, the doctor cannot proceed the procurement. Physicians may act according to their own ethics, within the limits of the recorded decision of the donor and the right of the family to object. This physician freedom is one of the crucial components of the program’s success. Prior to the presumed-consent law, burden of responsibility for the decision was put on the family; now, the primary responsibility is put on doctors who are responsible for the patient and the patient’s family. In Belgium, transplantation of living organs is allowed only when using the cadaveric organs.
cannot bring the comparable results. Presumed consent policy aims to discourage living organ donation. After many years of introduction of presumed consent policy, organ shortage in Belgium has not ended.

Another country exercising this policy is Singapore. It is the same policy as in Belgium, yet is fundamentally based on different ethical and social values. Since its introduction in 1987, presumed consent policy has not yielded increasing number of donors as expected owning to the traditional beliefs of different ethnic groups toward death and the wholeness of body after death. Opting-out system was first introduced in Singapore in 1987. The policy presumes consent to removal of organs for transplantation upon death. Objectors have to opt-out by filling in the objection form. The original policy was applied to only death due to trauma and for non-Muslim Singapore permanent residents and citizens; only kidneys were allowed to procure. In the amended Act in 2004, all causes of death are included; heart, liver, and cornea are also allowed for the procurement. In 2008, the Muslims are included in the opt-out system, requiring them to opt-out if they object to donating their organs upon death. Singapore is the only country in Asian Continent put presumed consent of organ donation in legislation. The major concern raised from this policy is that it gives people the opportunity to opt-out on religious or moral grounds. In the case of Singapore, a presumed consent system is in operation but excludes all Muslim citizens as they prefer to exercise the right of opting-in. Another issue pertaining to this policy is that in order to make decision to opt-in or opt-out of becoming organ donors upon death, it is required sufficient education to ensure that people make informed choice and act autonomously. For this point, poor and uneducated people would not have the same autonomy as they do not have adequate information upon which their decisions are made. A mass information campaign would help the policy operate more effectively.
Singapore applies a point system in organ allocation in which the patients on top of the waiting list are required to have forty to fifty points. Waiting-list patients can accumulate points by, for example, social criteria (5 points for full time professional employment), age (under 31 people receive five points), or one year on waiting list gives 2.5 points. The system automatically deducts sixty points if the patient is Muslim since the Muslim community opt out the donor pool; however, other citizens do not receive this deduction if they choose to opt out from the donor pool. Not any country has been known to punish their citizens for not wishing to donate their organs after death. In Belgium or in the United States (New York state), the governments respect the choice of the Jewish communities not to be donors but only recipients because they reject the concept of brain death. Although presumed consent has a positive effect on organ availability, it is the most controversial and emotionally discussed policy. It has encountered objection for creating conflicts among utilitarian, rights to autonomy, and justice.

The exclusive roles of autonomous decision and human dignity in organ donation are either obscured or ignored in presumed consent and mandated choice policies. Among the current policies, although presumed consent policy shows that it has helped increase the number of donor organs, it shows a lot of ethical problems that ultimately raise doubt and erode public trust. This, in turn, will set back the current increasing number of organ procurement. In other words, it does not ensure a stable prospect for organ donation.

Presumed consent policy, in fact, empowers and protects transplant team to remove organs and tissues from a deceased patient without prior consent. It prevents the awkward moment when a request for organ donation has to be made to the distressed family. Avoidance of awkward moments and distress family, however, is an irrational justification for this policy and is not compatible with the standards of medical practice- veracity, compassion,
and empathy. The policy seems to favor the healthcare workers but shows disrespect for the deceased and the families for seeking consent to procure organs. Furthermore, by presuming that the deceased would give away the organs and presuming that the families would revoke that presumed consent, this practice might deprive opportunities for the families to express altruism.

Many studies about the factors that cause the families to refuse to donate their loved ones’ organs indicate that the lack of support and appropriate information about the organ donation procedures provided by healthcare team link the high refusal rate. After a short time the families receive the news of their loved ones’ deaths, the clinicians approach to inform the “presumed” consent of the deceased to donate organs after death, or, in a better scenario, to request the family to make decision about whether to allow the procurement. Such behaviors only aggravate the frustration level of the families and warrant refusals or resistance from the families.

Presumed consent may risk the trust relationship between patients and healthcare professionals; consequently, it not only fails to improve the organ supply but may also reduces it.

The disfavor of the presumed consent policy has become more and more common. Veatch and Ross contend that the policy, by using the word “presumed” obscures its real purpose of eliminating the obtainment of consent in preserving for procurement or procurement of organs. In other words, this policy circumvents the nature that consent must be exclusively explicit and obtained. It is indefensible that presumed consent violates the principle of respect for autonomy and disadvantageously targets the vulnerable groups as well as ones who have limited to no access to the information about the policy. In fact, the introduction of presumed consent or opt-out concept undertakes the failure of informed consent or opt-in system. In countries
exercising the opt-in system, the number of citizens registering to be donors are low because individuals tend to fail in actively making decision, especially when it requires some effort, i.e. reading the rules and filling the form; therefore, they end up not to make any decision regarding their wish to donate organs. According to such observation, presumed consent or opt-out comes around, taking advantage of people who become organ donors because they lack effort in reading rules and doing paperwork.\textsuperscript{461} In presumed consent policy, silence means consent.\textsuperscript{462}

In addition, if only suffering and injury can identify the violation of dignity, a great deal of people would be mistakenly believed that their dignity is fully protected. People can be degraded without suffering, or, even worse, they do not realize they are painlessly wronged and they willingly accept the act. That is when people are oppressed by rules, disciplines, or even rewards.\textsuperscript{463}

Presumed consent violates autonomy because it does not allow autonomous action. In fact, the policy practiced in Singapore and Sweden controls individual decision making by impose threat or punishment on the citizens for their refusal to participate in the donation program or for the values and beliefs they hold.

Presumed consent practice in Singapore is called libertarian paternalism, meaning that the government runs the choice architecture system.\textsuperscript{464} Libertarian paternalism is ethically justified when the design of choice architecture system excludes harms and aims at assisting people to choose what is in their best interest. However, it becomes a manipulative and coercive tool when it imposes values on particular targets by rendering disadvantages to individuals if they make choice according to their values or beliefs.\textsuperscript{465}

Advocates for presumed consent dispute that presumed consent does respect for autonomy as long as the people have rights to it. When people are alive, they have the rights to
register their objections to the organ procurement after death; when they die, they no longer have rights over their bodies, therefore, consent is unnecessary. 466 On the contrary, there are many reasons to respect for the individuals by acknowledging their ownership, respecting the integrity of the body, respecting for their personal values and religious cultures, and honoring their wishes about the bodies’ treatment after death. In either religious or secular perspective, it is unjustified to deprive the rights over the bodies after people die so that their bodies can benefit for strangers.467

Presumed consent is not an autonomous consent. It violates the rights to autonomy of a person. The policy could be justified only when people receive all needed information before they make their choice whether to opt out. “The presumed consent policy shifts the default so that an individual’s silence, or failure to register his or her dissent counts as consent. The policy is not ethically acceptable because consents and refusals shift over time, beliefs and choices shift over time; however, the policy does not give people chances to change their mind in the future.” 468 Determining appropriate consent in particular circumstances may require giving different weights to the different values.469

In utilitarian view, presumed consent creates great good without harm because the organs come from cadavers. Therefore, it is justified for society to routinely take unused organs without the owners’ formal consent. To create a net good within the society, useful body parts of the deceased should be treated as state properties to serve the state service. 470 Not only does presumed consent benefit individuals, it also benefits the society by reducing cost of care.471 This practice is morally inadequate; nobody’s body parts should be used for the others without permission. Moreover, organ transplantation is a medical practice that provides treatments for patients of end-staged illness; it is not a state service.472
Some people defends the presumed consent policy by comparing the presumed consent in organ donation to the emergency situations when presumed consent is often applied for unconscious patients. In the emergency setting, when a patient is unconscious, all recommended lifesaving treatments are implemented, presuming that every person would want to be treated and saved from trauma or death. In fact, presumed consent practice is strongly supported in ER departments because the medical interventions, presumably consented, benefit for only the person himself; all rights of the ER patients are respected and protected. Moreover, empirical data often indicates the patients’ agreement with the medical treatments provided without their consent. Therefore, such defensive comparison is irrelevant. 473

The concept of “presumed consent” misleads public to the idea that authorization to organ procurement exists in such policy. For organ perfusion before procurement and organ procurement, presumed consent concept is unjustified. Only explicit consent fulfills the requirement for a valid consent in which the person acknowledges the issues as well as his rights to the issues. 474 Some strong critics claim that presumed consent must be correctly understood as a routine salvaging, or even organ conscription for its nature of practice.475 But if such names are used, it is much likely to encounter strong public opposition; in linguistic view, the word “salvaging” makes an impression of disintegrating a human body, which is not permitted or encouraged in many religious traditions and cultures; resulting in the violation of individual rights and values. In like manner, the word “conscription” indicates the state authority to control over the deceased bodies; the individual rights is seriously infringed. Softening terms, such as opt-out or presumed consent, are to prevent public objection or might beguile the public.476

Another term for presumed consent is opting out, whereby a person can make noticed his objection to the routine procurement. This method ensures to exclude those who strongly object
to organ donation and collect all who are willing to donate but have no means or motivations to record their willingness. Another supporting argument analyzes the difference between opt-out and presumed consent concepts, which makes opt-out policy more justified than the presumed consent one. Presumed consent means a mental consent, expressing the willingness to the action. Whereas, opt-out registration is a consent to act upon the willingness. Accordingly, people should endorse the opt-out policy for it maintains and respect for autonomy. However, this justification for the policy is not sufficient because it mistakenly assumes that all non-responders are willing to donate their organs after death. There are at least two scenarios which one does not respond to the opt-out system: either the person is not aware of the policy or the person does not have an opportunity to express their refusal on documents. Some people have limitation to education, learning ability, or media; they are unlikely to learn and understand about the policy. Some other people do not have sufficient means to the registry system to opt-out the routine procurement. This unfair policy allows a group of people to benefit from the others’ ignorance or the unfortunate.

Upon death pronouncement, time is a critical parameter to preserve potential donate organs to ensure their viability. Many transplant team members suggest perfusion following death should be permitted before the consent could be obtained from the family for preservation purpose only; no organ is procured prior to the consent of the family. However, this practice would risks the chance to get consent from the family who is experiencing a devastated moment. The family would feel being betrayed and lose trust in healthcare team members who, they believe, only aim at harvesting their loved ones’ organs. Without a consent document, the body must not be violated for any reasons.
Presumed consent is a compulsory method by which state imposes their judgment on individuals that anyone who does not make his objection aware wants to donate their organs after death. Supporters of this policy claim that the policy does not violate individual autonomy by providing the opt-out option, and that everyone has rights to refuse. Certainly, people who formally refuse to have their organ procured after death gain respect for their autonomy; for the rest of the citizens, including ones who agree with organ procurement after death, are unaware of the policy, unable to comprehend the policy, and lack means to make their objection formal, it is presumed that the state respect their autonomy.

Presumed consent policy holds account for the high rates of refusal of bereaved families to donate organs from their loved ones. The policy also meets strong opposition from critical care staff since they have to deal with angry and frustrated families.

Presumed consent policy is currently known as one of the most effective policies in alleviating the shortage of donor organs. Many countries have taken this policy into consideration in effort to improve their current condition of organ donation. For the forementioned reasons, although presumed consent policy is known as one of the most effective methods to increase donate organ pool, it is less likely to maintain the positive outcomes for a long run for it erodes the public trust. Without provision of a real opportunity to refuse donation, presumed consent becomes a form of forced acquisition of organs.

The discussed ethical issues accumulatively result in eroding public trust, which, in turn, engender the reduction in number of organ donors. Erosion of public trust not only widens the gap between organ need and supply but also has counterproductive effects on policy currently known as an effective one- the presumed consent policy.
Mandated consent and presumed consent policies are the attack on the status of individual in the form of painless oppression, in which people may live in false consciousness and do so comfortably.

4. Financial incentive policy - a way to erode altruism

The financial incentive policy is offered as a method to use incentives to alleviate demand for organ donation. Advocates for this policy contend that the organ donation relying on altruism has failed to increase the number of organ donors.

The very first market for organs dated back to Hunter time of tooth transplant when the recipients came to the transplant clinics with their potential donors, either their slaves or ones who were willing to sell their teeth. This model appeared again in Chicago in 1903 when people could buy an ear at a cost of five thousand dollars, but the donor would be attached to the recipient for days until the graft healed. This attaching technique originated from Taghacozzi skin flap technique in rhinoplasty. The government did not put the market to an end not until were some reports on testis sales.

Iran is known to be the only nation practicing the financial incentive policy in the form of a regulated organ market for living organ donation. In 1997, a new law was approved in order to increase the number of organs available. Kidney donors should receive, after the operation, 10 million rials (about $600) from the Charity Foundation for Special Diseases (CFSD) financed by the government. Along with this official compensation, there is often a personal and uncontrollable economic negotiation between the donor and the recipient. In addition, the costs for pre-operation tests on the donor are the result of negotiation. Even donation between relatives is often accompanied by a payment of money. The government provide the expenses for medical services and a particular compensating amount, while the incentive that is usually negotiable is
covered by the recipients. The financial incentive policy has created or faced its own disputes. Whether the incentive is given to the donor or the family or some other party, and whether it is given upon receiving consent or procurement of organs. Nevertheless, it is widely in agreement that a regulated market as Iran’s organ donation policy should receive societal support at least until the availability of alternative cures for organ failures.

The government provided only the expenses for medical services, while the incentive that was usually negotiable was covered by the recipients. Usually, the donors were not emotionally or financially satisfied and the parties involved believed that the incentive to donors should have been covered by the government not the recipients.

In order to avoid transplant tourism possibly resulting from the financial offer for donor organs, the largest number of foreigners who underwent transplant in Iran consists of Afghan refugees, who were allowed to receive kidney transplants from Afghan donors; they were not allowed to volunteer as donors to Iranians. Before the prohibition, despite scrutiny to, there were reports of foreign nationals receiving kidney transplants from Iranian paid donors. Data from one of the largest programs indicate that approximately 2.5% of the kidney transplants were performed on foreigners, including refugees, Iranian expatriates, and others. Citizens from neighboring countries with inadequate or nonexistent kidney transplant program, mainly Afghanistan and Azerbaijan have undergone living unrelated renal donation transplantation in Iran without supervision of the authority. It is suspected that brokers inside Azerbaijan made arrangements for many patients from Azerbaijan to receive kidneys from paid Azeri donors in Iran. In 2008, the Ministry of Health closed a university transplant unit owing to allegation of irregularities.
In Iran, paid donation has raised a lot of issues to the nation. Even with the acceptance of brain death, the number of organs received from the deceased has not grown as expected, which primarily blames on the financial incentive for living organ donors. The first kidney transplant in Iran was performed in Shiraz in 1967. To accommodate the large number of patients with no living related donor, and owing to the lack of legislation for deceased donor kidney transplant, Iran instituted a government-funded compensated living unrelated kidney donation program in 1988. End stage of renal disease (ESRD) patients without living related donors will be on the waiting list for deceased donors for 6 months, then be referred to the charitable organization Dialysis and Transplant Patients Association (DATPA). On the other hand, potential donors also register with the DATPA and undergo evaluation in the foundation’s clinics. The kidney transplant candidates and their living non-related donors (LNRD) are referred by DATPA to the kidney transplant teams. DATPA receives no incentives for identifying or for referring the donor-patient pair to KT teams. KT teams belong to university hospitals and all expenses are paid by the government. The LNRD receive a fixed award from the government (approx. $1200) and 1 year of health insurance. The donor and recipient meet at DATPA before donation to negotiate the amount of supplemental “rewarding gift” (U$2300-U$4500). The living unrelated renal donation (LURD) program has succeeded in increasing the number of kidney transplantations. Iran has one of the largest numbers of living donor transplantations. Despite the success, the system has definite flaws and limitations. The negative effect of this policy of paid donation has been proved in a recent study. About 40% of donors consider financial factors as the sole motives for donation. Most of the donors are facing financial hardship a few months before the decision of donation.
Moreover, the paid LNRD program is likely to lead to the ceasing status of the deceased donors programs even the brain death is a legal notion as well as reduce the number of living related donor transplants. Throughout the country, in 2006, deceased donor kidney transplants account for 5% to 10% of the total annual kidney transplants, much declining compared with the review of 10-year data from Shiraz shows that 38% were from deceased donors. Also, only 15% of kidney transplants are from living related donors.\textsuperscript{492} In fact, the compensation for organ donation has created more burdens to the recipients. The recipient bears the major burden of payment rather than benefit from the donors because the paid rate of the organs has been competitive among recipients in order to receive the organ as soon as possible. The combination of a LNRD program and the deficiency of national infrastructure for deceased donation (DD) transplantation has impeded establishment of the latter. DD transplantation has lagged behind total transplants, with no noticeable efforts toward public education about DD and LRD transplantation, and the proportion of LRD KT has progressively declined. A goal of the model was to provide transplantation to patients with no LRD. However, 81% of LNRD kidney transplant recipients have a potential LRD.\textsuperscript{493}

The adverse outcome of the Iranian model to the country is the underdeveloped cadaveric program regardless the high incidence of traffic fatalities. The low number of cadaveric organ donors creates a critical shortage for other vital organs that can obtain only from cadavers, such as hearts, lungs, and corneas. \textsuperscript{494}

To defend the Iranian model, the supporters suggest organs should be seen as a donated gift that deserves compensation. Some people avoid the influenced role of incentive for fear of encountering the accusation of manipulation. It is important that incentives should be acknowledged as a means to alter people’s decision toward the desired ones. However, the
compensated amount should be moderate; if it is excessive, it would undermine personal values and make the decision-making toward the compensation only. Compensation should not be the only factor that attempt to alter the person’s decision regarding organ donation. It should be accompanied by virtuous motivations. A virtuous intention of the donation act is required to make the compensation for a good act ethically justified. Other proponents for financial incentives illustrate incentives as very last and small reason to move the potential donors to the acceptance side. However, this claim makes assumption that their target group strongly want to favor donating their organs, almost all obstacles have been overcome, all influential factors are set aside, the only thing, which should be the determent for their decisions, is finance.

Financial incentives could be in other forms that arguably should be done before the suggestion of monetary incentives for the donor organs. Such incentives include providing healthcare coverage for the complications of living donation, guaranteeing job positions during the donation process, covering expenses (e.g. lodging, lost wages, child/elder care) during the donation process. These types of incentives are justified as long as they maintain justice and equity of access, and prevent bias. It is recommended that any kind of incentives should never come from the recipients and should be legalized and well-controlled to prevent illegal activity.

The financial incentive policy is offered as a method to use incentives to alleviate demand for organ donation. Advocates for this policy contend that the organ donation relying on altruism has been failed and will fail to increase the number of organ donors. Moreover, the altruistic act in organ donation puts the potential recipient’s family or friends under pressure to oblige to offer their organs to the loved one, as people may believe that their loved ones have privilege to benefit from their altruistic act. Under this circumstance, altruism changes into coerced will. This argument, however, is somewhat not convincible because it defends the idea
of offering incentives for potential living organ donor or donor’ family on the account of potential donors whose loved ones are potential recipients.499

Additionally, it is hardly possible to create an incentive-based system without exploiting the donors. It compels people who have financial hardship to donate their organs for the compensation amount rather than for the wellbeing of the others.500 It also leads to the decrease of organ donors who desire to donate their organs for free due to the financial attraction. Moreover, the practice of this policy requires a system of price tags for donor organs, which, in turn, induces serious ethical controversies around the issues of human dignity. 501 A human person is inevitably objectified and priced in an organ market.502

Altruism is the noblest form of giving and should not be abandoned in organ donation, but, to many scholars, it is too fancy to stay in organ donation arena. Its presence only costs human lives and wellbeing.503

Nevertheless, from a psychological perspective, altruism is an intrinsic motivator while a financial incentive is an external motivator. Intrinsic motivator is inherent in a person and it is not under influenced of external stimulus like rewards or punishment. When the act is initiated by the intrinsic motivator, people are doing it because they enjoy it or for a personal accomplishment. Acts motivated by an intrinsic motivator are free from coercion or influence because the actors can only be motivated when they feel competent for it. When financial incentives, which must be a considerable amount, as the external motivators, become the only purpose for potential donors or their families to give consent to donate organs, their donation is not for personal accomplishment or enjoyment of the act. 504 Whereas, when the donation is out of altruism, as the intrinsic motivator, donors or families enjoy the donation and achieve personal fulfillment. Acting by the external motivators does not warrant the recurrence of the act without
the external motivators while by the intrinsic motivator does. It entails that the introduction of
the external motivator would eliminate the intrinsic motivator. When financial incentives are
offered to obtain organs, altruism can hardly motivate organ donation. Financial incentives could
make altruism vanish.\textsuperscript{505}

Altruism is the foundation of organ donation; such altruistic act is selflessness and the
donor does not expect any rewards because he already feels rewarded by his good act. \textsuperscript{506}
Additionally, financial incentives are likely to become manipulative tools for its initial purpose
of bringing about the required behaviors. The opponents also emphasize the importance of
educational campaigns as an effective way to make people voluntarily donate their organs
without remuneration.\textsuperscript{507} In several studies on attitudes toward financial incentives, it is
interesting that favoring incentives is generational, the younger, especial between sixteen to
twenty four years old, is more likely to donate with financial incentives, but this favoring is
diminishing with ageing.\textsuperscript{508}

Finance as a sole incentive for organ donation erodes the foundation of organ donation-
altruism. Altruism is a concern or devotion to welfare of the other. Altruism is motivated by the
donors’ feelings, thoughts, or attitudes toward the other people. Making money the only
incentive for the organ donation disqualifies the act as donation; on the other hand, offering
compensation on the side of the virtuous motivation, the donation act is authentic. \textsuperscript{509} When
virtuous motivation is excluded from organ donation, financial incentives diverts public from
practicing altruism.

It is suggested that the barriers for living donors include lack of funding to cover their
lost wages, traveling, living expenses, and lack of support and accommodation from employers.
Some donors could lose their jobs for their extended time absent from work for organ donation
procedures. Therefore, in order to expand the pool of living organ donors, besides the financial incentives, such obstacles should be removed. 510

The financial incentive policy has created and faced its own problems. Whether the incentive is given to the donor or the family or some other party, whether it is given before or after death, and whether it is given on consent or recovery of organs.

II. Proposed policies for organ donation

1. Commodification policy- trading human dignity and autonomy

Commodification policy in which individuals can legally offer their organs for a fee is proposed to against the existing organ black markets. The goal is to obtain organs from altruistic act but commodify the distribution of the donor organs. Some people express their favor in this policy and justify that the policy protects individual autonomy in deciding for their own organs. An individual can express autonomy by making available healthy kidney for a fee. Justification for the payment provision for this offer is analogous to the one in the argument for the opt-in or opt-out decision.

According to many thinkers, since blood can become a commodity, human organs, such as hearts, kidneys, eyes, etc could be treated as other commodities, too.511 The argument is not plausible because it neglects the most significant factor that distinguishes blood from the other organs- the detrimental consequences resulting from the transactions of organs. It takes one or two days for the human body to replenish the blood plasma and several weeks to regenerate other blood products while there is no re-generation for other organs. 512 Another bolder suggestion is to treat ethical behavior as a commodity, because such moral sentiment as altruism is a scarce source and used up. A free market allows people to self access to the organ sources; they do not need to rely on the other parties’ limited virtues.513 In other words, when people need organs for
transplants, they had better chance when relying on markets than on morals. The source of altruism is fixed.\textsuperscript{514} This view is somewhat pessimistic to social prosperity. Altruism, or other moral values, is not fixed or a scarce resource; in fact, such moral value can be inseminated throughout the public.

Ones who support organ markets but disfavor of black organ markets often argue for the necessity to repudiate the concept of human dignity, because the idea of human dignity could not allow the existence of either market form. Overall, on any stances for the meaning of human dignity, the notion of dignity gives one to feel his value as a uniqueness.\textsuperscript{515}

Many thinkers argue against the operation of black markets and organ markets by the consideration for the coercion or exploitation for the poor. Yet, the argument is defeated by the contention that the selling act is voluntary act that results in a living standard improvement. Although organ markets are considered unethical, they bring a win-win situation, especially in developing countries whose dialysis service severely unmeets the demand. It is a win-win situation for the recipients, who would die due to the insufficient provision of dialysis but now can live after the purchase of the kidney, and for the donors, who would financially benefit from the transaction.\textsuperscript{516} Supporters of the sale of organs dispute that the organ is the property of the donor, so it can be also sold if the owner does not want to give them for free. It is the right to ownership. However, the opponents of markets could support their point with stronger justification by pointing out that the financial transactions are a form of painless oppression that make the poor potential donors willingly harm themselves by selling an organ.

The major opposing views stem from the contention for the impossibility of co-existence of money and morals. Injustice and social disparity would be the results of commercial organ donation. Additionally, it is hardly possible to create an incentive-based system without
exploiting the donors. It compels people who have financial hardship to donate their organs for the compensation amount rather than for the wellbeing of the others. Moreover, the practice of this policy requires a system of price tags for donor organs, which, in turn, induces serious ethical controversies around the issues of human dignity. Moreover, as the nature of the free market, price tags vary, depending on the qualities of the commodities or the affordability of the buyers. It is true that more ill people can access the organ sources if organs are up for sale, but the safety for the people who are already in grave conditions but cannot afford high quality organs are of a great concern. These people might accept to buy organs of marginal quality, accepting to shorten their survival for the market rule: you get for what you pay. The poor who agree to sell organs for improving their lives destine to health deterioration; the poor who can afford only low quality organs also expect for a shorten survival. Injustice would become a serious issue when organs become commodities. A free market is not a market of free choices but a market of free price ranges. Justice occurs to only the rich which turns back to the original reason for the proposal of commodification of organ policy. Organ black markets exploit the poor, put coercion on the poor, risk people’s health, and create injustice; a free market where people freely sell and buy their organs would eliminate those issues. Yet, it has been proved otherwise.

Commodification policy is proposed to come up against the existing bad issue of organ black markets. Initially, the policy emphasizes only on the commodification of the organ procurement to prevent the inefficiency of the procedure. However, eventually, the majority of donors will be the poor in the society who give away their organs by the economic forces. In the new form of the policy, it has shifted to commodification of organ allocation that makes money a significant role in gaining access to transplantation. Some people express their favor
in this policy and justify that the policy protects individual autonomy in deciding for their own organs, yet the justification is invalid since the donors have no role in allocating their own organs. Some other supports for this policy but for the case of cadaveric organ donation only. The major opposing views stem from the contention for the impossibility of co-existence of money and morals. When a person considers to sell a body part, even in the best scenario that they are well informed about the post-procedure risks for health, it is possible that the action is initiated by altruism- the act for the welfare of others at will and within ability. The term “selling” intrinsically means making money. If altruism is claimed to exist in this transaction, it is only an account to lessen the guilt of receiving money for the organs. Injustice and social disparity would be the results of commercial organ donation.

Commodities are instruments for using and creating profits in transactions. In history of slavery, human beings was once treated as commodities and were bought and sold at auction, depriving their dignity.

Beyond the question, this policy should be against for its commercial characteristics. The emergence of profit-seeking firms that specialize in organ acquisition would be an inevitable result. Just in similarity to any goods or services which can generate benefit, brokers will appear to match the providers and the one in need. Especially, the scarcity of the organ supply would make it more attractive to brokers. It is the nature of trading. Besides, healthcare professionals should not abandon their traditional support for the current altruistic organ procurement policy over this alternate policy that imposes their own moral and philosophical attitudes. Altruism should not be excluded from medical practice. It is hard to find it acceptable for the idea of commercializing donor organs medical ethics arena. The fundamentals of organ market and medical practice cannot be shared. The principle of market is demand-supply; the benefit is
determined by the relationship between demand-supply while the organ transplantation should not be controlled by such relationship, many other determining factors for the organ allocation. The highest bidder is the one who receives the organ, which become another advantage of being rich. Finance rather than justice is the determining factor for organ allocation. Besides, brokers would create campaigns or strategies to attract more suppliers. Is it commonly known that this group is often willing to increase their supply in order to decrease the price for the products? Also, if the supply is increasing, the price paid for suppliers will decrease, leading to the reduction of supply, which comes back to the starting point of the issue. The goal of organ donation is to at least balance the need and the supply, or even better, to obtain surplus of the organ donation. However, market system often takes advantages of the scarcity of the supply to generate high benefit. When supply is too much more than the demand, or in commercial term, when the market becomes diluted, it is the sign of failing business which requires the brokers to find a way to boost the demand. This is impossibly ethically acceptable in medical practice to create more demand for organ transplantation. Although commodification of organ donation has not been in practice but remained a suggestion, it has showed more potential issues than reasonable resolution to the current situation of organ donation.

When a subject becomes a commodity, the value of the subject is decided by the seller. Not every part of live can be commodified and belong to the market economy; they are better to be distanced from the market. 523 In a healthy society, moral judgments set the moral limits of markets so that not anything is treated as commodities. For instance, it is unacceptable, morally and legally, for parents to sell their children.524

Those who propose the commodification policy for organs justify for it on the utilitarian ground. Organ transactions generate benefits to both sellers and buyers, thereby improving social
utility. However, this argument assumes that sellers are merely the owners of the organs and buyers are merely the ones who need organ transplants. Commodification means a free market where the values of the commodities are mediated by many factors, such as situations, locations, and, most importantly, brokers. It is certain that brokers in either roles, buyers or sellers, benefit the most from the organs while it is uncertain for the owners of the organs and the ones in need organs for their transplantation. On the other hand, some people argue for the policy in the libertarian view, by which people should be free to buy and sell anything in the condition that they do not infringe the others’ rights. This contention is unconvincing for the obvious infringement of individual’s rights to justice. In a free market, the highest bidder often gets to buy the commodity.525

Most economists admit that there is no crossing point for economics and ethics because, to them, morality idealizes the operation of economics while economics is a real world. They even refuse the relevance of utilitarian moral theory for economics, because the theory requires to maximize the social satisfaction of preferences while economics only focuses on consumer preferences of material goods. In other words, economics operates according to price effect while a utilitarian market operates in accordance with moral worth.526

The relationship between paid and unpaid donation systems is not merely mutually exclusive. In fact, “altruistic donation and commerce can be considered to be the opposite poles of a grey continuum, with various coexisting donation forms between them.”527

Commodification of health care suppresses altruism exercise, an essential component to establish social bonds. It discourages altruistic behavior and diverts people from opportunity to act altruistically, hence destroying social bonds. Loss of public trust is inevitable.
The boundaries of individual liberty cannot justify for turning human organs into commodities. Every society commits to protect its member’s body and values to ensure the social bonds among human beings. A society with a good regulated system puts the people’s values forward the need for obtaining organs for transplantation by the ways that diminish these values. For example, in living organ donation, if a choice must be made, promoting the altruistic donation of organs is morally justified while promoting organ sale. Commodification should never be approved even if it were in critical organ shortage condition.528

2. Extended donor pool- taking risks for the shortage

Alternative populations of potential organ donors include extended-criteria donors and transplanted patients. Potential donors once do not meet the eligibility for medical conditions, such as hepatitis C, HIV, etc. could become a promising source for organ transplantation. In many countries, transplantation of HIV-positive donors to HIV-positive recipients is outlawed.529

Proponents for this approach claim that the source of marginal donors should be used for transplant patients who do not have any other alternatives; besides, the outcome is still better comparing to dialysis treatment or death on the waiting list.530 This claim is unsupported because there is no data that proved the grafts from extended-criteria donors are not inferior and recipients of these grafts do not pose to any life threatening consequences. Other support for the use of organs from high-risk donors, because it fulfills the duty of care for doctors who, otherwise, have to watch their patients deteriorating and die. Doing something is better than doing nothing.531 As a matter of fact, this practice would be likely encounter objection of medical practitioners because it compromises their practical principle- non-maleficence. The chance to cause harms is foreseen but the possibility to create benefits to the patients is
unsupported. Moreover, the public could view this practice as inconsiderate medical practice for using diseased organs in transplantation.

Nowadays, the group of high-risk donors become more attractive to transplant teams for the high number of brain-dead patients due to drug overdose. Potential donors who overdosed prescribed drugs are considered as lower risks for the accessible to their medical history. On the other hand, transplant team more hesitate when considering the organ sources from potential donors who overdosed illicit drugs. Rigorous screening for the latter group will create an inefficient cost of care for the likelihood of organ discard. 532

Criteria for ages could be extended to allow elderly more than 65 years old to become organ donors due to the growth of elderly population. In a study conducted in Germany, organ transplantation with donors older than 65 years old provides positive outcomes. However, this suggestion requires more consideration for co-medical conditions in addition to the common causes of strokes for this particular population. 533

Proposals of using marginal donors, either living or deceased, aims to resolve the organ shortage issue. This suggestion is favored for its possibility to expand the donor pool and respect for autonomy by allowing the recipients to make informed choice. Nevertheless, this proposal encounters ethical controversy since this solution could even worsen the problem of organ shortage. 534 Transplantation of organs from high-risk donors creates the greatest chance of a worse outcome. The grave condition of the recipients would be aggravated; the best outcome for the recipients is to be listed back to the waiting list or the worst outcome is death.

Conclusion

Current policies or proposals regarding organ donation demonstrate their pros and cons in individual and social aspects. Organ donation from the living poses many threats to the medical
practice as well as the stability of societies. Policies should be established in order to increase the number of cadaveric organ donation rather than from the living. Although some countries, such as Belgium and Singapore have succeeded in increasing the number of deceased organ donation, they create some ethical issues along; still, educating public and professionals about the fundamentals of the act of donation enables such policies to become more successful and sustainable.

Also, in most current policies, altruism- the foundation of a donation act, has been set aside from the organ donation arena for its ineffectiveness in increasing the organ supply. The altruism-based policies for organ donation have no longer been widely favorable.

In essence, the implication of proposed policies revolves around the matter: who has the rightful authority over the body after death and the ultimate goals of narrowing the disparity of organ supply and demand. Respect for autonomy plays a central role in donation. Donation is the right of the individuals by which the others must permit and respect the person’s planned lives.

It is reported that a considerable proportion of the population is in favor of organ donation, yet this does not result in a large number of registered organ donors. This may be a product of apathy concerning the need for organ donation, lack of knowledge, or public mistrust of the system. Accordingly, it is the time to put things together into a public education strategy aimed at improving knowledge and understanding of concepts such as criteria of dead declaration, combined with knowledge of the appropriate legislation. This illustrates the importance of alignment between public attitude and behavior toward organ donation: if the policy is able to change only the attitude, the rate of organ donation is likely to be low. Individuals’ awareness of the organ donation legislation has a significant effect on willingness to donate, indicating that efforts to improve educational programs and informational campaigns on
the social and health benefits of organ donation could contribute to increase the number of donations. Increases in knowledge about organ donation can positively influence the likelihood of registering for organ donation.537
Chapter Six: A Model for a Sustainable Source of Postmortal Organ Donation

Introduction

Current policies or proposals regarding organ donation demonstrate their pros and cons in individual and social aspects. Organ donation from the living poses many threats to the medical practice as well as the stability of societies. Accordingly, most current policies have the tendency to increase the number of cadaveric organ donations rather than from the living. Although some countries, such as Belgium and Singapore have succeeded in increasing the number of deceased organ donors, they create some ethical problems along; still, educating public and professionals about the fundamentals of the act of donation enables such policies to become more successful and sustainable.

A model with a possibility to inspire people to become organ donors after they die includes the three components: altruism from all involved parties (including society), autonomy, and human dignity. The relationship of these three components are secured by their influential factors, such as culture, bioethical principles, transparency, medical practice, etc. The more strongly the relationship is secured, the more likely to obtain the overall result of a sustainable post-mortal organ source.

Why should not an elicit appreciation be offered to the act of altruism? Why do all the involved parties in the transplantation procedure, including physicians, surgeons, and hospitals gain financially but donors and donors’ family do not? Should altruism come from all the involved parties, yet by distinguishing acts as each party’s ability? The donor donates his/her organs upon death, healthcare team members donate their time, skills, and care, the hospital administration donate efforts to find a match between the donor organs and people in need. As every involved side is willing to work at will and free of charge, the cost of a transplantation case
would significantly decrease. The ultimate fee, then, would not be a concern for the party who cover all the transplantation procedure, either the organ recipients, the government, or the insurance company. It is the original perception of donation: a voluntary act as one’s ability at will for others’ wellbeing. Only the altruistic act from the deceased donor is financially compensated since the donor no longer lives to receive the social acknowledgement and appreciation of his/her good act for other parties. This way of expressing appreciation to the organ donors would not cause a reduction in the number of donors who wish to donate their organs for free, because the donors have the option to again prove their generosity by donating the money to other parties, either individuals or organizations.

Moreover, the combination of altruistic acts from all involved parties would eliminate the question that whether the inefficiency of the donor organs would receive the financial gratitude thanks to the reduction of the fee for transplantation procedure. The donors should receive the appreciation for the purpose of their generous donation act, regardless the outcomes of the procedure.

Personal background plays an important role in awareness of altruism. We usually subconsciously introduce or assume that altruism is a common perception which should be accepted by everyone. As a matter of fact, altruism is nurtured by numerous factors and accepted in different levels. Altruism is not an intrinsic value of a person but it is the product of education and influences throughout lifetime. Even if a person perceives the concept of altruism, he or she may or may not act in an altruistic manner in certain areas. For instance, people hold different knowledge and corresponding thoughts about organ donation. Some people believe that organ transplantation benefits only medical professionals; organs procured from deceased donors are to
generate financial benefit to the organ transplantation team. A death benefit payment for cadaveric solid organs would be neither coercive nor the result in loss of altruistic values.

Similarly, culture determines one’s perception of autonomy and human dignity. Autonomy possibly mean the shared decision among family members, the paternal role in the family, or only for the individual himself. The human dignity may pertain to one’s spiritual practice, secular standards or tradition, or familial values.

Typically, policies often aim at informing and creating a positive attitude to the public. However, general public campaigns often do not address the cultural diversity in the population; therefore, a part of society may be excluded from the campaign. Tailored education for specific targets has turned out to be more effective. For example, teaching about brain death concept, organ donation and transplantation would be conveyed in special design for secondary schools or university students, resulting in improved opinions about deceased organ donation and a higher intention to donate organs. An educational program and training of intensive care healthcare professionals, on the other hand, definitely differentiates from the former programs, still all the programs aim at improving knowledge about donor identification and transplantation as well as changing attitudes toward transplantation.

Persistent and systemic media campaigns and educational programs inducing the familiarity of talking about death bring about a prepared death or a plan to die. What are the good things of having a plan to die? Successfully educating the idea of a prepared death will encourage more people and give them a sufficient amount of time to think about whether to donate their organs. Procurement levels from presumed consent policy are higher than ones from the informed consent policy. The idea of a prepared death would be a sound explanation for this difference. Under presumed consent legislation, individuals tend to experience the thinking
about death; the ultimate decision is the result of the active decision-making effort. If anyone does not have a planned to think about the event, the government presume that those people have already planned to donate their organs and consent to the procurement by their silence. In presumed consent, silence means that thoughts are given and decisions are made; silence does not mean a lack of awareness or means to have voice heard. “An autonomous consent is a consent referring to an individual’s actual choices, not to presumptions about the choices the individual would or should made.”

Since culture is an influential factor on individual perception of altruism and acceptance of death, doctors or organ transplantation team members should be trained for effective communication corresponding to the potential donors/families’ values and cultures. The religious tradition has shaped people’s perception and values and provided social norms in the particular society.

Information relating to the prognosis of death facilitates transparency in clinical practice and reduces public fear that organ donation is being considered at the expense of patient care. This would indicate that in implementing organ donation legislation, in addition to providing the public with education regarding legal and administration aspects, there is also a need for public understanding of both the technical aspects of organ donation and eligibility for donor status. Any organ donation strategy developed to support families would also require recognition of religious and cultural sensitivities related to this issue in order to establish trust and facilitate successful organ donation. The involvement of families in the organ donation decision-making process also holds considerable implications for the preparation of healthcare professionals to enable them to approach and adequately support families.
In this model, the provision of compensation is morally justified because it does not corrupt moral standards. It aims to change public attitudes and behaviors toward the targeted issues—sustainable sources of postmortem donor organs that result from the public trust. The donation act is from the willingness of the donors, causes no harm to the donors, and brings benefits to the recipients as well as the donors’ beneficiary.

I. Altruism

When altruism is perceived as an intrinsic value, likely, it encounters challenges from arguments that blame altruism on the failure to motivate organ donation; from this perspective, altruism fails and, because it is intrinsic, it is unlikely to improve the current conditions of organ shortage unless altruism is less of concern or eliminated. In fact, some people suggest a replacement of the intrinsic value by an extrinsic value—the financial incentives. Nevertheless, without altruism, this transfer only has adverse impacts on social relationship and social welfare, as well as causes detrimental effects on medical field.

Per contra, personal background plays an important role in awareness of altruism. When altruism does not mean an intrinsic value of a person, it can be educated and influenced throughout lifetime.

1. Altruistic donors

Altruism is no longer a preferred motivation in organ donation; several opinions exist to lessen its role in organ donation. Donors should be able to direct their organs toward recipients that they feel solidarity with. The solidarity-based policy should focus on the solidarity feelings that can motivate a particular community rather than emphasizing on altruism.

Altruism is not necessary for organ donation because most of organ donors act on solidarity rather than altruism. Altruism-based policies often fail because there is no consensus
about the meaning of altruism and its scope is too broad, making its motivational force weak. On the other hand, solidarity can be understood as a form of altruism but such altruism is restricted to a certain group or identity; solidarity is a conditional altruism. In organ donation, however, the perception of solidarity as a conditional altruism is irrelevant because altruism is a selfless act. Moreover, in a standard organ allocation, it is not likely for the donors to direct the donated organs to a certain group. The donation is blindly made and the allocation principally depends on medical indicators. If solidarity is allowed and used as a motivator for organ donation, it would become a counterproductive motivator for it creates conflicts among solidarity groups and injustice in society. In the proposed model, solidarity exists only when the donors direct their compensation amount to a certain group of beneficiary.

Altruism is the essence of a donation. It has failed to gain public trust in attracting organ donors. The reasons for its disfavor in organ donation system have been discussed in many texts. M. Goodwin indicates the observation that altruism-approached system fails to narrow the gap between the need and supply for donor organs. The reason for the failure lies under the lack of transparency and clarity in organ transplantation arena. According to M. Goodwin, there would not be a real altruistic domain in the culture of human body part exchange controlled by the governments, and the governments and current system cover up the economic exchanges in the field. The notion of altruism in organ donation is too ideal and no longer sufficient measure for human sacrifice and compassion.

Altruism under the metaphor “gift of life” has diverted the public away from other significant ethical issues, such as selection criteria and quality of life after transplantation. Moreover, this metaphor puts more pressure on both donors and recipients: potential donors may donate out of guilt and recipients may live with guilt and feeling of indebtedness for not being
able to pay back the invaluable “gift of life.” Most of the surveys around the world conclude that there is no correlation between the willingness to donate organs after death and the consent to donate when being asked. Some people blame the failure to obtain consent on the ineffective strategies to approach the families. On the other account, some people contend that the cause to such failure is a tandem of matters that originate from the perception of donate organs as the gift of life. Although the initial reasoning for such perception is that giving gift reflexes altruism and voluntarism, the concept has created burdens for recipients and donors. The argument is based on the theory of gift exchange, which stipulates the obligated and reciprocal relationship created by gift-giving culture in the society. To the donors or their families who are still bereaved, when the transplant team approach them and make a suggestion for them to donate the organs, the donors or families would feel guilty, because the suggestion implies that their gesture means giving a gift of life. The matter of life and death is placed on their hands, all they are asked is a gift object so that someone will live. The metaphor makes the donors and families feel rather obligated than voluntary to give. From the recipients’ perspective, naming the donation of organs a gift brings about the feeling of indebtedness to the recipients; the recipients carry not only the donors’ organs but also the burden to find a way to pay back, in either a direct or indirect way. More difficultly, it is not hard enough for them that they are obliged to fight with critical illness for the sake of their loved ones and doctors, they have to long for someone to die so that they would live, and they have lived in guilt to know that the gift they receive is the result of someone’s death. In a worse scenario when the transplant or the grafts fail, some patients feel devastated for thinking the donors have died for the second time. On those accounts, treating organ donation as giving a gift of life tends to generate counterproductive outcomes for organ donation. The act of giving a gift is no longer voluntary; the gift is given because the gift giver is asked or imposed a
duty of giving gift. This thought holds the account for the low rate of acceptance of deceased organ donation for the culture of giving back in Japan. Japanese organ recipients hold much stronger feelings of reciprocal duty to the deceased and the deceased’ families than any other recipients in the world.

In organ donation, financial benefits generally grant for medical professionals and facilities while the donors or families are the only participants who do not directly benefit from the transplantation process but are required altruism in the process. Compensations in any form for the donors, therefore, should not be unethical. A payment for cadaveric solid organs would be neither coercive nor result in loss of altruistic values.

Another advocate for the financial role in organ donation in alleviating the failing system of pure altruism accepts the financial compensation in the form of funeral reimbursement. This small reimbursed amount offered would not convey the selling impression but rather deliver the appreciation for the donation, thereby, essentially, preserving the altruistic core of the system. However, such small amount insufficiently motivates the donation and it would eventually make the policy become ineffective in increasing the number of organ donors.

After all, the impure altruism seems to be more intuitive and practical when establishing a policy for organ donation because individuals are often not indifferent with gifts offered by other individuals or the government. Money in combination with altruism becomes the most efficient motivation in organ donation; that is how the financial involvement improves the failing purely-altruistic-based system.

In the model, if impure altruism, it is indicated that people are not indifferent with gifts, either made by themselves, i.e. self-rewarding from altruistic donation in the case of organ
donation, by other individuals, or by the government. However, people act out of altruism should receive more rewards than the others in order to attain the desired effect. 561

Compensation should not be the only factor that attempt to alter the person’s decision regarding organ donation. It should be accompanied by virtuous motivations. A virtuous intention of the donation act is required to make the compensation for a good act ethically justified.

The purpose of incentives is different in the dissertation. It is to show gratefulness and appreciation. Donors or their families can use the compensated amount as they wish (donation or keeping it). If it is an act out of altruism, it is not necessary to be revealed if they do not wish to do so. Altruism is an intrinsic thought that belongs to personal affair. Therefore, it is hard to judge one’s act is whether altruistic or not but only oneself may judge the act is out of altruism or not. Altruism is an abstract notion. It should be included when encouraging the donation but it should not be used to judge one’s act. A person may receive financial compensation for the donation but it should not be necessary that the donation is not out of altruism. In sum, altruism is a personal affair, and receiving financial compensation does not correlate with altruism, it is merely to receive the appreciation for their acts. These two notions, altruism and financial compensation, should be understood separately, there is no connection between them. The means of a personal act is only known by the person himself. Also, the person himself absolutely owns the decision on his act and the outcome of his act, which is the financial compensation in this context. The amount of compensation should be used as his wish. Receiving money may enable the donor to multiply his altruistic act by helping more people (familial or non-familial parties). The altruistic act should be dedicated to any party of the donor’s choice, which could be the family members, an acquaintance, or strangers.
When applying the proposed model, it is justified if the donors donate their organs after death to help their family with financial hardship. While there is no harm caused to the donors, the postmortal organs benefit not only the recipients but also their families or the beneficiaries of choice. It is the willing act within the donor’s ability that all is for the welfare of the others. Such donation is an altruistic act to the families, the needed, and societies.

The model does not turn cadaveric organs into commodities because it does not operate like a free market where commodities are priced, brokered, bargained, and bidden. After receiving corresponding information, the potential donor makes a formal informed decision to donate his organs, the criteria he prefers to have his organ procured, and his designated beneficiary. More importantly he can review and adjust his advance directives during his lifetime, similar to how advance directives for end-of-life care work. Less ideally, with the absence of a formal consent document from the deceased or power of attorney, the families or healthcare team should work together to make a decision based on the deceased’s verbal living wills and best interest. At this point, the intention of the surrogate decision maker is accountable for ethical consideration.

Financial compensation corrupts the donation act when it influences the donors or the deceased’s families on making decisions, such as to prematurely withdraw care, or to hide critical information of medical history that could prevent them from donating. 562

In the suggested model, compensation for donated organs will not negatively affect the altruistic purpose of the donation act. Because there is no option for the donors to donate their organs for free. Every donor will receive compensation after their death occurs and organs are procured. If the donors do not wish to pass over the money to their loved ones, or they do not have families or relatives, or they simply want to give without receiving anything in return, they
have a chance to amplify their altruistic act by choosing the option to forward the amount to their designated unrelated beneficiary. Such donation strongly raises public awareness and inspires the public to get involved more in organ donation without any effort to touch up stories.

2. An altruistic profession

Altruism is also needed to be reinforced among healthcare professionals because it has effect on job satisfaction, quality of care, and physician-patient relationship. In fact, care provided out of altruism creates high job satisfaction and positive affective states, resulting in better communication with patients and better quality of care.\textsuperscript{563}

Moreover, healthcare professionals should never abandon or lessen the importance of ethics in their practice and should make great effort to obtain and maintain public trust in medicine. The professional ethics is not the standard for individuals. Rather, it guides both patients and healthcare professionals as members of the public and of civil societies to make decisions. The professional ethics would help healthcare professionals approach and manage encountered ethical problems in medicine while balancing the conflicting responsibilities.

It is not required that healthcare professionals work free of charge. A compassionate and virtuous practice sufficiently validates the healthcare providers’ willingness for the welfare of the others. Altruism would be corrupted if they are forced to receive no or unfair compensation for their laborious work. Yet, they have a choice to offer \textit{pro bono} service at any moment they wish. Altruism must come at will and for the others.

Persistent practice on these ethics is the foundation for stability and reliability by which they would obtain and maintain public trust.\textsuperscript{564}
3. Altruistic societies

Policies usually fail and encounter large objections, or stir controversies because the goals do not include public trust. In organ donation, the public is the direct source of organs. Public trust should be the primary goal for a public policy. When trust is gained, the willingness to give will increase.

Altruism- approached system fails to narrow the gap between need and supply for donor organs. The reason for the failure lies under the lack of transparency and clarity in organ transplantation arena. There would not be a real altruistic domain in the culture of human body part exchange controlled by the governments and covered up by the economic exchanges in the field.

The proposed model ensures everyone to have equal power in making decisions related to organ donation. It also secures the core value of donation- altruism, and provides donors more opportunities to make their altruistic acts grow, benefitting more than recipients. Moreover, it preserves the professional virtues of healthcare providers, removes the obstacles of conflicts, and brings back the traditional teaching in medicine- the altruistic practice.

Public trust is built on a reciprocal relationship between a society and its healthcare professionals. Healthcare providers hold the duties that reflect what their society expect and practice in a proactive manner to preserve the social values as well as their virtues of trustworthiness, altruism, prudence, humility, and compassion. On the other hand, society acknowledges and endorses such effort.
Although altruism becomes less commonly preferred in organ donation, its communal acceptance is undeniable, either in a religious or secular society. Altruism as a universal common morality establishes social bonds and strengthen public trust. 567

A communitarian approach could change the moral culture in organ donation by rendering the society members to perceive donating postmortal, unused organs is morally right, and this act is what people expect from one another.568

II. Autonomy

Autonomy encompasses freedom with responsibility; therefore, a person must hold accountability for his autonomous action. An autonomous action requires one to have ability to process received information and use knowledge as well as evaluate possible outcomes, so that the person can make a responsible choice. Such responsible autonomy should be encouraged and respected.

1. Moral autonomy of organ donors

Any society, which approves organ donation from cadavers, has to confront several conflicts: the acceptance or definition of death based on medical, social, and cultural factors and based on personal and familial values, brings about the disagreement between the common medical criteria - brain death, cardio-circulatory death, and spiritual death.

Many studies indicate that the poor acceptance of death has led to the refusals of organ donation. Often, poor acceptance is due to the lack of pertinent information and compassion from healthcare professionals toward the patients and families. 569 Such causes of refusals are easier to eliminate by improvement of communication between the two sides.

To many people, they prefer to have control over the timing and circumstances of their own death; they believe that modern medical technology has prevented people from dying
peacefully. People who believe that quality of life outweighs the quantity of life often have earlier acceptance of death.570

Views on death are affected by medical status, family, class, and religious values. There is no consensus but often disagreement about how death is accepted.571

The disagreement can be between healthcare members and laypeople. To many people, each body part symbolizes a sentimental meaning of the deceased. For instance, eyes are the windows to the soul and hearts are the emotional center. Therefore, the common reason for the families to donate is the wish for parts of their loved ones to live on in others. However, medical professionals view organs as potential objects or means to save others’ lives.572

The discord can be among healthcare professionals. In medicine, it is the duty of doctors to use forceful interventions to save patients’ lives, avoid preventable death, and improve and restore their health. However, when the patients no longer achieve the goals of treatment corresponding to their preferences and values, doctors should allow the patients’ deaths. 573

In the same country, it is common that death is determined by the territory. For example, in the United States, a person could be pronounced dead in Oregon but still alive in Colorado; or, in Thailand, urban hospitals adopt brain dead criteria while rural hospitals remain to embrace the cardiac dead criteria.574

Most significantly, death is accepted differently in every culture. In Eastern countries that embrace Confucian moral teaching, all decisions related to healthcare must include a familial emphasis. Family, not the individual, is the primary source of authority in making every medical decision, especially in end-of-life care. Accordingly, Confucian or family-oriented approach should be an appropriate and effective way to educate the public.575 Confucian values in medicine require physicians to do their best to rescue the dying and to heal the wounded.
Paternalism is accepted in Confucian teaching that the doctor has the heart of a father and a mother. In Singapore as well as many Asian countries, since doctors belong to the highly educated class, they believe that many of their patients are incapable of making rational decisions in treatment. Therefore, they give their patients a reasonable amount of information but not the whole truth to prevent patients from making poor decisions about treatments. Patients’ decisions are often influenced by the doctors’ persuasion. Also, the role of families is important in cooperating with the doctors to reach consensus when dilemmas or conflicts occur. Yet, they are aware of the concept of respect for patient autonomy and the obsoleteness of paternalism in modern medical practice.

In many Asian countries, Buddhism is the most common religious practice. Buddhist teaching defines death as the death of a person with the simultaneous cessation of mental and physical functions rather than concerning about the cessation of organs. Another teaching in Buddhism is that the breath is the last part of the body to die, which may construe the withdrawal of ventilator as pulling out the patient’s soul. The teaching has significant impact on doctors and families who adopt karma as their moral law; the act of “pulling the plug” would be a bad karma that would negatively affect their current and future lifetime. Often, when this dilemma occurs, families could summon a religious figure, i.e. a monk, to help the patient’s soul depart in peace without interrupting the medical interventions. In Karma doctrine in Buddhism, the deed in the past decides the lifespan; hence, if the time has not yet come, the person may come back to life after many hours after the cessation as long as the body has not been deteriorated. By this way, either the doctors or families would not compromise their karma. In this culture, the roles of families and doctors outweigh the patients’ autonomy in making decisions related to medical intervention.
So, what are the consequences of those disagreements? Time is a critical factor for organ viability. There is too much effort made that transplant team cannot afford to receive organs that are not transplantable. In current standard practice, after death is pronounced, suggestion for the option to donate organs is brought up to the family, with or without the deceased’s prior consent. Then, the procuring surgeon starts to perfuse to preserve the organs; sometimes this step is done before permission for organ donation is obtained. Knowing how the person wishes to die can overcome such a hectic and frustrating scene, hence obtaining the best quality organs for the recipients.

The disagreement with criteria of death accounts for the low number of deceased organ donors. If the disagreement is viewed from medical perspective, incessant debates are inevitable in organ donation area. However, when confronting a bioethical issue, the disagreement should be perceived as a moral disagreement (not a moral violation) of various decisions that should be defended, not reproached, by the concerned parties. Moral disagreement may arise in the following scenarios: factual disagreements, disagreements due to insufficient information or evidence, disagreements on norms and their application, disagreements about the relativity or norms, disagreements about specifications or balancing, the presence of moral dilemma, disagreements about weighing the importance of involved moral agents, and conceptual disagreements. There is no single solution to such disagreement. In fact, assessment of different views and provision of arguments are effective approach to lessen the disagreement and reach to the common ground on the issue. Recognition of and respect for one another’s values and beliefs are the requisites for valid critiques of each other’s action. Moreover, concerned parties should initiate their arguments based on the common morality. 581
Accordingly, respect for autonomy, effective communication, and public education will ensure an effective discussion about death.

*Respect for autonomy:* Respect for autonomy means respect for patient’s values and actions and obligations of veracity, fidelity, and confidentiality. Doctors have the duty to ensure that patients make choice competently, voluntarily with understanding before obtaining their consent. This requires deliberate and considerate conversations between doctors and patients. Especially, on the issue relating to end-of-life care and criteria of death which the patients and their families embrace. For this reason, primary care is the ideal setting for such conversations because it assures that a valid consent is obtained. A valid consent requires all its essential elements, including competence, voluntariness, and information.

In assessment for the criteria of competence, a person who is competent to express his moral views should be free to determine what constitutes his good and how to achieve it. Yet, his will is challenged if his understanding results in mistaken beliefs about how to fulfill his wish, which, in turn, causes him harm. For example, when a live person decides to sell one of his healthy kidneys, one would argue that if he is fully competent, he is free to get involved in the transaction. It is otherwise since the donor makes up his mind to sell the kidney without full comprehension of lifetime effects on his health condition and the significant impacts on his lifestyle and families. The agreement does not meet the criterion of competence.

The second criterion is the voluntariness, meaning that the obtained consent is free from coercion. When an organ is treated as a commodity, the needing levels of the buyers determine the values and the agreement of the seller. The more tempted the price is, the less likely the seller is to refuse. Ultimately, the offered price would reach a certain amount that makes the deal unrefusable. In a similar manner, the operation of the black organ markets induce the poor to
agree to sell; yet, it is a worse form for the price is decided by the brokers or the market values. Overall, although the above donors give consent to sell their organs, it is invalid consent; it is coerced or manipulative consent. 585

The third criterion is that a valid consent is obtained based on provision of adequate information. When the target is financial benefit, obscured information is inevitable. Whereas, when the target is the person’s health and values, it is likely for the person to receive adequate information that benefits his health and protects his values. Concealed information does not bear a valid consent. 586

In healthcare settings, consent represents the outcome of communication between the patients and healthcare providers. It represents a responsible decision made by the patients and the compassion care provided by the healthcare providers. 587

In primary care settings, doctors and patients have sufficient amount of time to build their relationship, enabling doctors to thoroughly understand patients’ personal backgrounds and values. If the primary care setting isn’t used efficiently for gathering pertinent information about the patients, then medical decisions are often made by specialists who newly know the patients, and, who, at best, know the patients’ medical conditions and history but not the patients’ values and wishes. In other levels of care, the goals of care now significantly change from one in primary care, the conversations are directed by the medical conditions and the severity of the diseases. Moreover, at the level of primary care, patients are often at their best ability to process information provided by their doctors and can have critical judgment and decisions. Frustration and hecticness are eliminated. Primary care with its preventive role now includes planning role for their patients. For this reason, it is urged to acknowledge primary care as the foundation supporting for the next levels of care; the stronger the primary care is, the fewer ethical issues the
other levels of care encounter. Consequently, the next levels of care can focus on the patients’ critical conditions as their designated roles. In many developing countries, the public does not recognize the importance of preventive care and they perceive that healthcare facilities are for the sick only; therefore, primary care is not efficiently used. It is necessary for such countries to raise the public awareness of the crucial role of primary care as primary care is suggested to provide not only preventive care but also care planning.

An autonomous decision on organ donation is considered valid only in the condition that the potential donor acquires a comprehensive overview of donation and transplantation activity.

It is very important to facilitate individuals’ understanding of the procedure and criteria for diagnosing death and making autonomous decisions to become organ donors. In organ transplantation, the principle of respect for autonomy should be included in every pertinent step, such as making decision to be donors, endorsement of death criteria, and the use and compensation of donated organs. The transparency could extend beyond the organ procurement for the donor’s families and the public in order to gain public trust, subsequently motivating more potential donors.

The highlight of the significance of autonomy in procurement of donor organs is the endorsement of payments by the donors. In this point of view, the determining role of autonomy in organ donation is limited to only the decision of the way to give organs. As the matter of fact, the role of autonomy extends to every aspect of organ donation. Respect for autonomy could mean respect for the freedom to choose the moment when the person wishes to donate the organs. That moment is not necessarily the occurrence of death because every person perceives quality of life in different ways. The presence of autonomy in the matter of death ensures the autonomous decision made upon adequately informative knowledge on very criteria of death that
provided by healthcare professionals. Such approach promotes trust between healthcare system and the public, which subsequently assure a sustainable source of organ donors.

A valid consent is not a mere tool to express authorization and to protect the involved parties, consent defines the boundary of individual control. When a consent is required for a certain act, the boundary is set: without obtaining a consent, the act becomes an offensive act and unacceptable; with a consent, the act is acceptable.

When consent for organ donation is normalized in routine health care, i.e. primary care settings, not only does it improve the awareness and maybe acceptance of organ donation but also reduces the likelihood of conflicts between healthcare professionals and the deceased’s families when death occurs.

*Effective communication:* When educating patients about the procedures of organ transplantation, doctors should elucidate all pertinent steps to avoid future conflicts with the donors’ family and transplant team. Trust is the crucial issue with regard to supply, especially in relation to the deceased. Attitudes and decisions relating to donation will frequently be influenced by broader considerations, such as how the individual will be treated prior to death, whether the person will be dead when body parts are removed, and how organs and tissues are allocated afterward. Patients should be aware that perfusion following death is required before the procurement; perfusion includes life-prolong treatments, mechanically and pharmaceutically, with the side effects of prolonging life. Therefore, if the patient does not endorse the uses of modalities, such as ventilators, blood pressure regulators, to preserve organs, the organs could deteriorate and become unviable. What is crucial is that the system as a whole is perceived to be fair and transparent. Trust and good will are multi-faceted in this connection. Where individuals
wish to express such benevolence toward others we must ensure that their wishes are properly concerted and respected. 589

Everyone involved in the process of making informed decisions must be aware that organs will not be viable if the warm ischemic time is prolonged. Also, the families will not be able to decide when the withdrawal of life-support treatment starts. It may take some time for multiple tests, identification of matched recipients, and arrival of the procurement team and facilities. The life-supporting treatment is withdrawn after the procurement completes, but death will not occur within two to four hours after the withdrawal. Inclusion of such information in the process of obtaining consent to donate would prevent the awkward moment when the healthcare professionals have to confront with families who are in extremely emotional distress.590

A deliberate training on the death and dying process should be widely delivered to healthcare professionals. Death should not be construed as failure of the healthcare givers; death is a part of life. Moreover, healthcare team members should be comfortable with death. All patients and families deserve consistent and honest information. Ideally, death should be prepared well before the event so that a good death will occurs with all the wishes of the deceased are fulfilled.591

The knowledge of patients’ attitudes about death is important for healthcare professionals to understand and acknowledge. Dying and death are highly individual, entailing that dying and death correlate with the personality of the patient. The concept of personality does not limit to a person’s characteristic, it encloses a person’s characters, values and belief, needs and wants, ways of interacting with others, cognitive competence, cognitive styles, ways of expressing himself, etc. In fact, several studies prove that patients’ behaviors when dying greatly vary and do not correspond to known defined psychological stages, such as the Kübler-Ross’ five stages
(denial and isolation, anger, bargaining, depression, and acceptance), and Weisman’s four stages (existential plight, mitigation and accommodation, decline and deterioration, and pre-terminality and terminality).

Recognizing the individualizations and cultural differences will prevent misunderstandings and lead to sensitive and effective communication in medical settings.

The majority of healthcare professionals become “informative” rather than “interpretative” in communicating with patients or their families, resulting in a mistrust relationship and obstacles for the acceptance of death. There are three common types of relationship between doctors and patients: the paternalistic, informative, and interpretative relationship. The most traditional type is paternalism in which doctors make critical choices to ensure that patients receive what their doctors believe best for them. This relationship is no longer in common practice but remains in some developing countries. Second, the informative relationship gives patients complete autonomy but disrupts the caring attribute of the doctors. In this affair, doctors merely are to supply information, knowledge, and skills while patients receive and process the information to ultimately make decision on their own. Doctors focus on improving their knowledge and skills rather than on learning about their patients’ other aspects. This relationship is mistaken with patient-oriented care, but, in fact, only the diseases and information pertinent to the diseases stay on the doctors’ view; the patients as people who need more than medical information are left out of the scope. Nevertheless, this relationship is quite common in medical settings. The third relationship- the interpretative relationship, balances the roles of doctors and patients, respectively. The doctors’ role is not only to provide skills and knowledge but also to explore, interpret, and sometimes challenge their patients’ wishes, thereby assisting their patients to determine what they want and serving the needs adequately. What
patients really need is the information and the meaning of the information, healthcare counselors instead of healthcare technicians. 594

Additionally, the goal when conversing with patients is to understand the stories behind the lives of the patients. Interpreting the patients’ stories in order to apply ethical rules is not sufficient to constitute the effectiveness in communication; the stories must be understood from inside and interpreted the meanings to the patients and the families. Yet, it requires time, compassion, and receptive skills.

Compassion is a duty of all physicians and it plays significant role in the physician-patient relationship. Compassion is composed of two elements: the ability and willingness to acknowledge people’s suffering, and the desire to relieve people’s suffering or even go through the suffering together. Compassion includes the common sense idea of kindness and sympathy among human beings.595 Compassion embraces beneficence, non-maleficence, justice, and other moral worth.

A virtuous practice requires honesty, loyalty, prudence, and altruism. Honesty and loyalty motivates healthcare providers to do the right things. Prudence keeps the practice abide to the principle of non-maleficence, accordingly, provides due care with diligent deliberations and actions. Non-maleficence does not limit to only avoiding physical harm, it also considers any interference with liberty and threats posed to patients’ values and social relationship. 596 Altruistic practice means putting patients’ interests forward, which ensures the healthcare providers to fulfill the principle of beneficence and justice. 597
Apart from the professional ethics, key ethical principles and values, such as trust and mutual respect cannot be ignored, especially in hard times. In fact, persistent practice on these ethics enhances the foundation for stability and reliability.

Trust must be won. Doctors need to provide necessary information, options during the visits. Truth telling creates and maintains trust in physician-patient relationship in contemporary era. In the past, paternalism prevailed in the medical field. Physicians did not share information about diseases and treatments with patients. However, nowadays, the principle of respect for autonomy is one of the core principles in medicine. Patients are informed about the information pertinent to their cases and are encouraged to actively get involved in decision making. However, the sense of the patient autonomy may differ among cultures. For example, in Western societies, patient autonomy requires the healthcare professionals to provide all pertinent information and the patients make decisions for themselves. In Eastern cultures and some religions, on the other hand, patient autonomy requires healthcare professionals to acknowledge the involvement of their guardians or families in decision making; how much information delivered to the patients depends on the patients and families’ preference. Accordingly, when approaching patients, healthcare professionals should be culturally sensitive and respect for their patients’ preferences and values. Healthcare professionals should develop skills of communicating and consider cultural differences. 598

Public education: It is important that the public need to be aware of all approved sets of criteria for death including the processes of organ procurement applied for each set of criteria. Discussion of these issues in an honest and transparent manner can reassure the public that the criteria are established based on deliberate considerations and thorough studies about the moment of irreversible dying process leading to inevitable death. Understanding and accepting
the dying process are crucial for the first step of organ donation. Professionals should promptly study any doubt or uncertainty more thoroughly before disseminating to the public. For instance, in patients or families that consent to withdraw life-supporting treatment, it is essential for healthcare team to explain that the brain can stay active for a few minutes without circulation and not all parts of the brain lose activity at once. In one study about brain activity at the moment of withdrawal of life-supporting treatment conducting on four patients, only one patient has an evidence of brain activity after cardiac and circulatory cessation. The study has not yet claimed the certainty on the phenomenon in larger population of studied population; still, the findings have raised concern about the necessity to further study for the current test required for death pronouncement.

One of the most infamous incidents that have caused severe and long-term damage to public trust is the Wada case in Japan. Japan has the severest organ shortage in the world due to cultural barriers and the infamous Wada case that has caused a great deal of public mistrust to brain death definition and organ transplant team. In 1968, doctor Juro Wada performed the first heart transplant in Japan. The heart donor was a drowning victim who was still alive and might have recovered with more sufficient medical intervention. The victim recovered spontaneous breathing in the ambulance but was given muscle relaxant by Dr. Wada so that he could harvest the heart when arriving in Sapporo Medical School Hospital. Dr. Wada was charged with murder but the charge was later dropped for lack of evidence because he destroyed all the documents about the case. He was legally innocent but guilty in the public opinion. The Wada case halted all organ transplant practice (heart and liver) throughout the country for thirty-one years. During this time, the Japanese had to use the abroad sources of hearts and livers for transplant and source of kidneys from familial living donors. The Wada case not only adversely affects Japan
but also greatly contributes to global organ trafficking and transplant tourism. In 1997, the first organ transplantation law was enacted, claiming that brain death is considered human death if the person donates organs. Despite the introduction of the law and endless effort of the transplant team who mainly work for free, the second transplant from a brain-dead person took place two years after; a total of 204 brain-dead transplants are performed from 1997 to 2014. In Japan, recipients often feel guilty toward the donors and the donors’ families, so they try to become donors themselves.

Motivation from gaining public trust has more positive and extensive impact on the attitude toward organ donation and causes less doubt about organ donation than romantized stories told by media or transplant centers. In organ donation, if a policy makes the public feel threatened, the public would comprehend the policy as coercive policy. Therefore, it is necessary to provide all pertinent information to prevent this from happening, to eliminate fear of organ conscription or exclusion from receiving organs, such as the Swedish model. Policy makers must abstain from controlling influence by not including any threat and punishment when proposing any new policy to the public.

Many studies have been conducted worldwide to find out the correlation between the cultures and the organ donation rates. As results, among Asian populations, religious or moral prohibition, cultural myths, and a distrust of the medical system account for their critically low donation rates. Therefore, policy makers should explore the cultural diversity and assess the educational needs within their community before initiating any program to promote and improve organ donation. A cultural-directed program predicts potential or existing complex matters, thereby coming up with corresponding resolutions. When possible, the religious or community’s leaders should hold significant parts of the campaign for their strong influences on
the community. For example, in Malaysia, the majority of the population includes the Malays, Chinese, and Indians. The majority of Indian Malaysians are Hindus while Chinese people are predominantly followers of Buddhism, and most of the Malaysians are Muslim. Accordingly, a campaign to promote organ donation in public should call for the participations of the leaders of those communities, such as a Swami, a Bhikkhu, and an Imam. On one hand, the medical team is responsible to provide medical knowledge applicable to organ procurement and transplantation. On the other hand, the leaders will contribute their religious knowledge and understanding of their communions. Such cooperation would bring about a correlative approach of the public regarding organ donation. Depending on the characteristics of the particular communion, messengers and educators for the campaign could be the religious leaders as well.

2. Moral autonomy of healthcare professionals

Individual autonomy is not merely the independence or freedom to act; rather, it is a quality of personhood. Both internal and external constraints affect the way how it is developed, maintained and exercised. However, the autonomy of healthcare professionals differs from this notion since autonomous professional practice does not define the person’s quality but the person’s professional quality; therefore, deprivation of healthcare workers’ autonomy differs from deprivation of ones’ moral autonomy.

It is not uncommon that the notion of moral autonomy is confused with that of autonomous professional practice. Moral autonomy is considered in making moral choices that reflect the person’s understanding of right and wrong, good and bad. Autonomy is not synonymous with freedom. One may have freedom but may not be an autonomous being because autonomy is responsibility. An autonomous person holds responsibility for his autonomous action. Accordingly, when a healthcare professional cannot exercise his professional
autonomy, he should not be held responsible for the decisions; if otherwise, he is coerced to hold responsibility for the action that he follows the healthcare facilities’ rules. When doctors have autonomous practice that is based on their medical expertise, they are motivated to utilize their best knowledge and skills as they will take full coercion-free responsibility for their actions. As a result, trust between patients and doctors become more secured as patients believe that their doctors are under no coercion to give them medical information with fully direct responsibility. Direct responsibility motivates self improvement for quality of practice.

*Healthcare professionals within a healthcare organization:* A healthcare organization is a managed care organization that has a patient care function, such as a hospital, nursing home, home health agencies, and healthcare system. A healthcare organization holds multiple roles within the organization and in the society it serves. In addition to provide health care to patients, the healthcare organization has to maintain its economic stability and develop its economic condition, as well as the accessibility for community and public health. Therefore, the healthcare organization has a wide range of relationship with healthcare professionals, patients, managers, and the community, who should hold their own responsibilities in order to put health care services in the highest effect. Healthcare organizations currently operate in more complex mechanism in which ethical tensions are resulted from healthcare cost, quality of care, and professionalism.

Organizational ethics is a process by which an organization’s consistent values and positions are articulated, applied, and evaluated. The definition is also applied in healthcare organizations. Because the primary mission of a healthcare organization is to deliver health care to patients or a population, organizational ethics of a healthcare organization is somewhat different from other organizations, such as addressing ethical issues about professional and
medical ethics. Moreover, a healthcare organization holds more social responsibility than the other business organizations. In order to operate effectively, the healthcare organization should create and maintain a cohesive and integrated internal ethical climate, which is constituted by excellent care provision, strong support for professionals, and its major responsibility.

Organizational ethics for a healthcare organization is inclusive of multiple ethical obligations of the organization. Organizational ethics examines how the healthcare organization can maximize the ability of the organization to meet them in a way consonant with the professional obligation, while protecting the clinical arena in which the organization fulfills its primary obligation, which is to the patients and populations that it serves.

There has been critical change in the notion of professional ethics in health care. Traditionally, professional ethics required healthcare professionals to advocate for their patients’ best interests. Professional ethics emphasizes on the essential qualities for healthcare professionals, such as responsibility, virtue, special knowledge, and other obligations. They had an obligation to provide all availability of medical intervention for their patients. Nonetheless, nowadays, healthcare professionals have to practice under contractual obligations with particular healthcare organizations. This has caused obstacles for their ability to solely act for their patients’ benefits. Organizational ethics plays an important role to help healthcare professionals overcome such obstacles so that the organization maintains its highest priority of provision of the best healthcare services to patients and/or community. Although professional ethics is distinctive from organizational ethics, these qualities should be fostered and improved in organizational ethics. Organizational ethics should integrate with professional ethics by maintaining the traditional professional ethics that healthcare professionals must advocate for their patients’ interests and values. This tradition should be built upon trust between healthcare
professionals and patients. Trust can attain when the healthcare professionals are completely honest with the patients and the patients understand the context of the medical, financial, and administrative situations.

The integration of professional ethics into organizational ethics is consistent with the idea that an effective healthcare organization has the provision of high quality of healthcare services as highest priority. When the traditional medical ethics that primarily concerns about the patient’s health becomes the core mission of a healthcare organization, organizational ethics supports and reinforces the professional ethics, as a result, conflicts between professional duties and contractual obligation would be lessened, or even removed.

*The conflicts in the profession:* Currently, healthcare facilities are run by business executives whose primary goal is to generate more and more money, unavoidably resulting in moral disillusion in medical practice and conflicts of interest between doctors and healthcare industry. Healthcare workers have to make care-related decisions based on the directives of their enterprises. Such operation creates barriers to the healthcare professionals’ autonomy and empowerment, which, in turn, undermines job satisfaction and subsequent poor quality of care.

In recent decades, significant changes within the medical field have not only facilitated healthcare professionals to conduct their duties but also have created conflicts among healthcare professionals when they make the decision to provide medical services to their patients. The major conflicts which physicians commonly confront are the financial conflicts of interest and the conflicts of conscience.
The two types of conflicts are unavoidable and impossible to be eliminated, yet it is possible to remedy the conflicts; thereby, both physicians and patients have benefit in the medical settings. The ultimate consequence will be an effective operation within healthcare organizations since the foundation of the success for organizations is a healthy doctor-patient relationship.

The new complex financial ties between the practicing physicians and their organizations have caused conflicts of interests to the healthcare professionals. Even though, according to medical ethics, law, and social norms, physicians have to act in their patients’ interests, their obligations to their patients have recently divided between their patients and other involved parties. The financial conflicts of interest have effects on the most essential relationship in health care — the patient-doctor relationship. Financial conflicts of interests are inevitable, yet there still have solutions to remedy the conflicts.

The reason for the failure of the coping strategies with the conflicts is that the strategies do not place the essence of health care services which is the physicians and the patients in the center. In the conflicts, physicians are the direct moral agent. Therefore, professionalism, along with other factors, plays a crucial role in confronting with the conflicts of interest in particular, and with any conflicts in medical settings in general. In other words, professionalism would be an effective tool to cope with conflicts of interest. When professionalism is central, it overrides the existing legal standards and third-party oversight; as a result, physicians are able to regain professional trust, have autonomy, and practice at best without obstacles, then conflicts, in turn, will be relieved.

The conflict of conscience: In the past, the common relationship between doctors and patients was known as paternalism medical practice. Patients followed any instructions of their
physicians without asking about the alternatives or risks and benefits; also patients did not have convenient access to any type of medical information. Physicians acted on behalf of their patients under any circumstances and patients put absolute trust in their physicians. Conflicts occurred infrequently. Since the 1960s, the idea of patient autonomy has widely spread throughout the healthcare field, the medical decision making has significantly changed so that patients’ decisions usually override the physicians’ decisions. Physicians have become patients’ agents and are expected to comply with patients’ requests, disregarding their own moral agency. This current trend has created a challenge to the autonomy of physicians. What physicians believe to be right is intruded.619

Besides, advance medical technology which facilitates doctors in healthcare services has created more controversies about the physician’s duties. As professional conscience, the physician should take advantage of the technology at best to preserve the patient’s life, but such conscience often encounters many obstacles since his or her decision is no longer made solely by him or her; patients and their family or relatives as well as healthcare organizations and insurers take part in the decision making process, too.

The new trend in doctor-patient relationship has created another sort of conflicts that occur to practicing physicians- the conflicts of conscience. Conflict of conscience is derived from within the physicians themselves. The conflicts are between the professional’s personal moral belief and the responsibilities for the patient. 620 The conscience of the physicians may be based upon the religious beliefs, secular moral beliefs, and medical expertise. 621

To resolve the conflicts of conscience, physicians should hold roles as social gatekeeper. This suggestion originates from the gatekeeper model- one of the best, most pragmatic, and most
widely accepted models for medical professionalism. The model defines physicians as social
gatekeepers. The model provides protections the most to both patients and physicians. Physicians
are responsible for the services to be available to patients, and prevent conscientious refusal from
burdening patient access, yet they are not forced to sacrifice their moral autonomy except when
absolutely needed. They can refuse to provide objectionable services but should clarify the
alternatives to the patients; thereby, patients know that other physicians may be able to satisfy
their requests. The interests of both physicians and patients are balanced in this model.622

III. Human dignity

1. Human dignity in different perceptions

The concept of dignity seems to be unstable and inconsistent to many people, perhaps
because its evolution corresponding to the vulnerable group who need to be protected at the time.
For instance, in slavery time, the vulnerable include slaves, women, foreigners, people without
properties, etc. In the modern time, the vulnerable becomes more contextually specific; for
example, in organ donation, the vulnerable are the poor, patients who are incapable of giving
valid consents, etc. It has been indicated that the notion of dignity is not applicable as foundation
for bioethics on the account of its three features: relativity, replaceability, and possibility of
repression. The notion is relative and replaceable because it is perceived differently by an
individual; its notion tunes with personal values and beliefs. It possibly becomes repression when
the state or leaders enforce a conception of dignity on the citizens.623 On such account, the Kateb
notion of human dignity eliminates those features by emphasizing on the existential value of
human dignity. A person cannot attempt to have dignity or nor can he forfeit it. A person is born
with human dignity. The moral values do not define human dignity; these values are to enhance
this existential value. Moreover, human dignity as an individual uniqueness is the identity of
each person by which he is recognized and distinguished from one another. Human dignity is defined as the uniqueness of human beings and the individual identity which every person equally possesses. 624

Macklin repudiates the concept of dignity for its vagueness or inconsistency or complexity henceforth the author suggest the omission of this concept in medical ethics. 625 On the contrary, human dignity cannot be neglected in a good medical ethics. Human dignity is a morally significant human perception that expresses one’s desire to be recognized and respected as a dignified person. The notion of human dignity causes a person to respect the rights and interests of another besides the body integrity and personal property. In medical setting, hence, it means the provision of treatment in the way that the patient wishes, also known as the application of the principle of autonomy. Acknowledging dignity inhibits mistreating or causing harm to patients. Therefore, it is principal to acknowledge and act accordingly on different perceptions in particular matters, such as body integrity after death.

When a person dies, to his loved ones, the deceased body represents the past memory of him. Disrespect for the body means disrespect for the deceased as well as his families in most cultures. However, in many religious teachings and cultural practices, if the violation of the body integrity is necessary in medical settings, it is not prohibited. 626

In many religious traditions, mutilation is prohibited for the preservation of the human body integrity. 627 In Jewish religion, without the purpose of saving lives, this prohibition is for both the dead and alive bodies, making even autopsy unacceptable. The amputation of the diseased body parts, however, is allowed to save the person’s life. The removal of an organ to benefit another person is acceptable practice to save a human life. Saving life is the highest priority in Jewish law. Jewish religion prohibits the mutilation of a corpse; nevertheless, in organ
transplantation, this prohibition can be overruled by the prescription of the preservation of life
(*pikuakh nefesh*). 628

In Judaism, the primary good deed requires the believers to preserve their health and save
another person. However, the person must not endanger his life to save another according to the
prohibition to injure oneself (*chovel be’atzmo*) even he benefits from it. From this perspective,
some body parts are allowed to be donated, such as blood or skin since there is no critical harm
from the donation act; donating internal organs, on the other hand, is not encouraged because
they are dangerous donations. 629 In Jewish belief, G-d is the only owner of human bodies;
neither the person himself nor his family has control over the deceased body; it is forbidden to
use the deceased body for any purpose (*assur behana’ah*); and a person must be buried with an
intact body or at least as it was at the time of death, mutilation of the dead is a disgrace (*nivul
hamet*). Many Rabbis endorse the practice of autopsy for the exception that it is an autopsy on a
*choleh lefanenu* (a sick person laying there in front of us) to learn about the diseases and save
many others’ lives. Nevertheless, for organ donation, either from the living or deceased, the
Orthodox teaching holds no lenient permission while some legal scholars (*poskim*) are lenient in
certain circumstances. These scholars allow organ donation due to the overriding importance of
saving lives (*pikuach nefesh*). 630

Buddhism also disapproves mutilation of the body but stays skeptical in organ
transplantation. Similar to the other religions, killing is prohibited in Buddhism. The doctrine of
Karma (deeds) upholds the correlation between action and consequence; joys and sorrows are the
result of the person’s own past actions, thus the person’s current actions decide his future life. In
Buddhism teaching, disease is a change of the body from its natural condition to a state resulting
from karma; while karma can be always improve with one’s effort, one cannot predict when the
effect of bad karma will end. Thus, one should take advantage of whatever available means and treatment. 631

In China, the deceased body should be left intact due to the traditional cultural beliefs about the proper disposition of a corpse. The Confucian culture of filial piety requires that a body be returned to the ancestors in an intact state and declares that every part of the body that is given by the parents deserves respect. For thousands of years, people have also believed that keeping the body intact is a way of respecting the dead. These beliefs induce great resistance to organ donation from the public. 632 In an attempt to motivate the public to donate postmortal organs, the Chinese government runs a pilot financial incentive program in several provinces. The Chinese program involves payment to families as appreciation for their good deed. The amount includes funeral expenses, $1600 toward the purchase of grave plot, $3200 allowance for the families, and a possible extra compensation (ranging from $5000 to $10000, or equivalent of 4-8 years’ income) corresponding to the level of financial loss due to the death of their loved ones. It is believed that such high compensation amount accounts for the ethical issues in the pilot program. The amount unintentionally targets the poor since the rural poor people earn about $400 or less per year.633 In fact, the outcome of the pilot indicates that 90% of the donor families fall into this category. Accordingly, the consent to donate is likely under financial influence. It is problematic because the program does not provide sufficient protection for the deceased’s and family’s dignity because the tempted amount of money may induce the family to compromise their cultural values and live among social criticism. In fact, many families have been criticized for selling their loved ones’ organs for money.

There was a great deal of objection to organ donation in Islamic communities for the prohibition of mutilation of the dead. However, in 1982, the Senior Ulama Commision declared
that organ donation after death was permissible (*halal*). According to Islamic teaching, a man is answerable to God for the good or bad use made of his organs during his life-time. If he makes a will donating his organs for saving other lives, he is eligible for reward in the hereafter. 634

In Roman Catholic religion, mutilation is a rather complex issue. For this issue, the agent’s intention is significant. Of course, direct mutilation is absolutely forbidden. For example, castration on purpose of preventing oneself from the danger of sexual sin is a direct act. It violates the sanctity of life by violating God’s creature, violating one meaning of human existence that is co-creator with God, refusing the gift from God, and changing the predestination that is given by God. It also induces loss of quality of life for the man. On the other hand, indirect mutilation, such as removal a decomposed leg to avoid the spread of decomposition to other body parts, is accepted in Catholic morality.635 This act is to preserve a human and prevent him from a worse living condition. Again, the two concepts play crucial roles in judging the act.

In Japan, according to Shintoism religion, a human being is a complete harmony of mind and body. Regardless of hard work by transplant staff and support from the government, organ retrievals from the deceased, therefore, are not a preferred practice in Japan. 636

2. Respect and protection for human dignity in organ donation

Human dignity is the uniqueness of human beings and the individual identity that every person equally posses. Therefore, the perception and acceptance of death should be acknowledged as individualized matters, and it requires effective communication between healthcare professionals and those who are under their care. Thereby, potential donors or their relatives will confidently and willingly decide to donation the post-mortal organs.

The most common obstacle to motivation of organ donation is the integrity of the body after death. It often causes hesitance from the potential donor or the family and it could be the
ultimate deterrent to donation. The model respects and protects human dignity because every individual is treated equally as a human being. The model embraces the notion of human dignity by Kateb, which appeals particularly to the matter of organ donation because it requires fair treatment and protection for every human being, including ones who are disabled or deceased.

The human body and its elements make up a whole person, therefore they cannot have a price tags and cannot be owned by anyone else even after death. Human dignity is respected and protected by fulfilling of the deceased’ wishes; if the deceased wishes to retain his body integrity or to donate his organs to others, all other parties should respect the wish. Personal values and beliefs should prevail over the family or social values.

**Conclusion**

The model for a prospect of sustainable sources of post-mortal organ donation encourages deceased organ donation by assurance of the core value of the donation act- altruism and protection and appreciation for donors as well as healthcare professionals. Most importantly the model targets on obtaining public trust by protecting one’s autonomy and human dignity, thereby creating a sustainable source of donors. The model consists of three essential components: altruism from all involved parties, autonomy, and human dignity in developing policies for cadaveric organ donations at both global and local levels. A policy based on this model gives assurance to obtain and maintain public trust, a significant factor for the success of any public policy.

Policies and practices of organ donation should not shift farther from the core value of a donation act- altruism. Altruism must be from every involved party in organ donation policy, because altruistic acts from every involved party create motivation in public, thereby begetting a promising outlook for stable sources of organ donors.
After the transplantation, a living donor does not gain any physical benefit; still, a donor who acts out of altruism will have at least psychological rewards. On the other hand, a donor who donate for financial purpose will not experience such rewarded feeling because the donation is merely a transaction. Likewise, what benefits the families of the deceased who donate their loved ones’ organ due to financial needs differ from ones who donate out of altruism. Accordingly, when the altruistic donation of organs from the deceased is appreciated by a compensation amount, the donors’ families will benefit at best from the donation while no harm is caused to anyone.

To respect and protect the patients’ autonomy and dignity, the cultural norms and religion of the patients and family should be considered and respected. There are so many definitions of death, such as brain death, cardiac death, and higher brain death. Individualized criteria of death in accordance with the patients’ values and beliefs are necessary.

Trust in modern medicine requires information transparency and patient involvement. Transparency enables patients to make informed decisions and handles patients more power in decision making. Paternalism is no longer suitable in the modern time of medicine because medicine arena no longer belongs to only healthcare practitioners and patients; there are so many other parties involved and controlling the practice of medical field. Therefore, such new relationship that is built on trust and mutual respect between patients and healthcare providers, in fact, benefits and protects both sides; this relationship enables both parties to work together to achieve the best outcomes.

The transparency in every step related to the organ donation gives assurance for the absence of painless oppression. Human dignity is always acknowledged and protected;
furthermore, the moral value of altruism contributes to the enhancement of the dignity for it improves the existential value of the donor and healthcare team members.

To obtain as many potential donated organs as possible, instead of looking for legitimate medical procedures to preserve the organs in operation rooms while awaiting for the families’ permission, policy makers should focus on looking for a way to educate people and change people’s attitudes and behaviors so that they willingly prepare and give their organs when death occurs.

There are two types of motivations: the intrinsic and external motivations. Intrinsic motivations include moral conviction or interest in the task while money or other rewards are examples of external motivations. When people involve in an activity, in this model, these types are balanced. Motivators for organ donation include financial incentives, humanistic or religious duty, positive consideration from others, living on through a receiver, gift of life, and close others. Obstacles for deciding to donate organs include preserving the absolute integrity of the corpus, strict individualism, lack of control over the use of the organs, anonymity of the procedure, and respecting family wishes.641

This model is a new approach for a more long-run outcome in increasing organ donors. It is a model for a prospect of sustainable sources of post-mortal organ donation. It encourages deceased organ donation by assurance of the core value of a donation act-altruism, and the protection and appreciation for donors as well as healthcare professionals. Most importantly, the model targets on obtaining public trust by protecting one’s autonomy and human dignity, thereby creating a sustainable source of donors. It is the model where financial compensation comes with virtues, the donors have control over the financial compensation, the professionals autonomously practice at their best, and the donors’ dignity is protected.
The model seems to be too ideal or even a fantasy for any society, but we live in effort to be most alike an ideal society. Our behaviors should embrace and improve humanity and morality rather than compromise and accept the low moral standards in the society. Either of the three components of the model should not be excluded under any circumstance in order to better society and humanity.
Chapter Seven: Applications of the Proposed Model for Organ Donation in Saudi Arabia and Iran

Introduction

The proposed model is considered into the practice of organ donation in Iran and Saudi Arabia. The two countries share the same Islamic culture; still, each has its own distinguishing religious teaching. In Middle Eastern region, living organ donation is the most common source while the great potential source of the deceased has not been effectively utilized. Several reasons for the failure to utilize the latter include the continued debate about the concept of brain death and lack of social awareness of the significance of organ donation. Moreover, governments and religious leaders have not played active roles in clarification of public perception, such as mutilation, and in promoting the social acceptance for the practice of organ donation. 642

Both Iran and Saudi Arabia are governed by Islamic religion and Islamic law in all perspectives within the society. They all acknowledge the notion of human rights whose foundation is based upon human dignity as in the international framework of human rights.643 In Islamic perspective, human rights are presented as religious duties. Human beings protect their own and other fellow human beings’ rights as their religious duties. They are the right to life, the right to equality, and the right of the weak and oppressed.

Protection of human life is the most significant requirement in Islamic teaching.644 The human body in Islam has its own sanctity in the Prophet’s saying: “Your soul has its rights and your body has its rights.”645 In the Islamic perspective, life is a gift from God to human beings. No human beings can violate others’ life physically or spiritually.646 Deprivation of self or others’ lives and mutilating the bodies of the dead are prohibited in Islam: “If anyone slew a person- unless it be for murder or for spreading mischief in the land- it would be as if he slew the
whole people: and if anyone saved a life, it would be as if he saved the life of the whole people.’ 647

The Qur’an states that all people are descended from one being. 648 This is also one of the principal themes of the Prophet’s Speech: “… The only thing that distinguishes an Arab over a non-Arab is piety.” Even the Prophet was considered equal to other human beings: “Say thou: “I am but a man like you.”” 649 The Qur’an specifies equality among people in a decisive verse: “And We have certainly honored the children of Adam and carried them on the land and sea and provided for them of the good things and preferred them over much of what We have created. With [definite] preference.” 650 With regard of righteousness, justice and other rights, Muslims or non-Muslims are alike. 651

The Qur’an specifies that the weak and oppressed persons are the weak and the invalid among family members (elderly parents and other relatives), the poor, the needy, orphans, the wayfarer, those who ask for help, slaves and prisoners of war. The Qur’an stresses the rights of these people repeatedly that they must receive special attention and no one can violate their rights. 652

Although the two countries recognize all human rights in Islamic perspective, there are some differences in the ideas of prioritizing these rights, which result in the differences in their respective policies of organ transplantation. The basis on which Sunni doctrine (Egypt, Saudi Arabia) is established is the principle of “consensus” and the principle of the common will, that is, the will of the majority. From these principles the following concepts of human rights are derived: 653 rights of the individual of communities. 654 The Shi’a (Iran) and Sunni doctrines are different in the acceptance of the Imamate theory. 655 The Imamate theory was formulated with the establishment of the Ja’fari religious doctrine. In contrast to the Sunni viewpoint, the
Imamate doctrine did not see the position of the Imam as a matter for the community, or nation, to decide on. In Shi’a doctrine, there is Imam Authority.656

In the issue of organ transplantation, the two countries suggest different policies in an attempt to better off the scarcity of donated organs as well as get rid of organ trafficking in the accordance with the religious rules.

I. Islamic bioethics foundation

1. Islamic bioethics in Iran and Saudi Arabia

The practice of Islamic bioethics integrates the two requirements into harmony: adherence to Islamic law (Shari’ah) and consideration of moral standards. Islamic Law is derived from the Holy Qur’an and Sunnah (collection of the actions and decisions of the Prophet Mohammad (saw)). Shari’ah has been a consistent and cohesive entity throughout Islamic history. There are four Sunni schools of jurisprudence, including the Maliki school, developed by Anas Ibn Malik; the Shafe’I school, developed by Mohammad Al-Shafe’I; the Hanifi school, developed by Abou Hani’fa Al-Nu’man; and the Hanbali school, developed by Ahmad Ibn Hanbal. The Hanbali school of thought is the most conservative school, and it is used in some areas of Saudi Arabia. A comparison of the teaching among these schools reveals more agreement and commonality than differences.657 Those developers of the four Sunni schools are the scholars who layout the framework for reasoning in a book called Usul Al Fiqh, or the fundamentals of interpretation and reasoning. This book forms the main source of learning in Islamic law.658

The goals of Shari’ah are numerous since they change with circumstance. The goals of Shari’ah find their origin in the Qur’an and Sunnah and are divided into three categories of essential, complementary, and embellishment. The essential goals are so identified because of
their foundational importance to the preservation of normal order in society and the survival and well-being of individuals. The complementary objectives seek to bring about comfort and repel severity and hardship. The embellishment seeks to attain refinement and perfection in the personal lives of individuals and their interaction in society. Since the goals of Shari’ah are basically concerned with values that take human welfare as their focus, they can be used more effectively to promote human dignity, human rights and welfare. As an instrument and theory of the Shari’ah, the goals of Shari’ah can also be used to address issues of contemporary concern to the Muslims side by side perhaps with the much valued but somewhat technical and over burdened heritage of the science of sources of law. Shari’ah ensures the actions to meet the minimal requirements abiding to the religion (the prohibition and permission) while the moral standards encourage people to make effort to become more perfect (the exception). In other words, Shari’ah maintains people in doing the right things while moral standards encourages people to do things better. The two components are in a harmony relationship in which the law will not be compromised and the morality will not be overshadowed.

Shari’ah covers many sections, including politics, crimes, economics, personal issues, etc. Islamic judges utilize Shari’ah as an official guideline. The Imams are responsible for interpreting Shari’ah. In Shari’ah, law and morality is distinguishable. In Islam, anything that contradicts Shari’ah is prohibited. Accordingly, an ethical dilemma must be argued in the Shari’ah setting.

Bioethics and religion are not separable in Islam. This explain why reference to the Qur’an, hadiths, and the most important interpretations that developed over the centuries still play such an important role in Muslim bioethics. Any opinion regarding ethics should remain anchored to the Sacred Sources to be legitimized; all variations must remain within Islam,
otherwise they risk losing credit, even losing the possibility of being presented in public. The source of Islamic bioethics is the combination of the Qur’an, the Sunnah, and the reasoning. The difference between the bioethical practice in Iran and Saudi Arabia lies on the logic or reasoning when applying the rules. In Saudi Arabia, Sunni Muslims refer to consensus (ijmaa’) and analogy (qiyas). In Iran, Shi’a Muslims do not accept this logic since these logics cannot explain themselves.

The practice of bioethics differs in making decisions for conflicts. In Iran, in addition to the direct reference to the main sources, Grand Ayatollahs- the most qualified jurisprudents of each generation, determine the valid religious practice and provide rules on forbidden, discouraged, neutral, recommended, and obligatory actions; as each Grand Ayatollah develops his own rules, Iranian Islamic bioethics owns its dynamism. Also, consensus is not accepted even among scholars in Iran. On the other hand, in Saudi Arabia, the main sources are the Qur’an and Sunnah, and consensus and analogy will be referred when dealing with conflicts.

The moral status of actions according to Shari’ah specifies the meaning in life and the Hereafter consequences. The first level- obligatory (wajib or fardh) includes the minimum actions required to be considered part of the Islamic community; these actions will be rewarded if performed and be punished if neglected. The recommended status (mandub or mustahabb) are praiseworthy actions that will be rewarded if performed and not be punished if neglected. Permitted status (mubah) covers neutral actions that will be neither rewarded nor punished. Discouraged status (makruh) includes the actions that should be avoided and one will be rewarded for the avoidance but will not be punished if performing it. The last level of status-prohibited (haram) include the actions that are absolutely forbidden.
The most common and the best way to legitimize the new medical treatment is to manifest the similar practice appeared in the Qur’an, related to the Prophet’s life, or mentioned in Islamic law books. For the cases that are not applicable to the above principle, consideration of the issues is based on the element of public benefit, *maslaha*.\(^{665}\) The principle of public benefit abides to the rule that the medical treatment is allowed as long as it presents no contradiction with Islamic law and it benefits the public. This principle is a useful means which facilitates Islamic bioethics confronted with any new emergence of medical treatments in particular and any modern issues in general. Together with the Islamic foundations, *maslaha* accounts for the attribute of flexibility of Islamic bioethics in responding to new matters.\(^{666}\)

Islamic bioethics shares the four Western biomedical principles, yet it emphasizes on beneficence and justice rather than autonomy on the occurrence of issue that conflicts with public good. Four other principles are applied to consider for ethical decision making, including the principles of the public interest, do no harm, necessity, and no hardship. For example, in the confrontation of prohibited action like mutilation of the dead body, necessity can override this prohibition.

*Islamic ethical principles for exceptions: Shari’ah* is the foundation for decision making on the controversial ethical issues, based mostly on the five principles. The first principle states that all issues are judged upon the intended outcomes. Intent is a central concern of Islamic law, and law is a central concern of most Muslim societies. A fuller understanding of Islamic societies, then, would be aided by a fuller understanding of the role of intent in Islamic law. The specific understanding of the nature and function of intent varies even within a single legal text, as the author moves from ritual, to economic, family, and penal law.\(^{667}\) In general, Muslim jurists treat intent as definitive of human actions most of the time, yet when they do not, they have
specific reasons for this. \textsuperscript{668} “Actions are defined by intentions, and to every person what he intends.” This hadith is cited repeatedly in virtually all manuals of Islamic law. It highlights the important role of intent in defining actions and serves as a backdrop for jurists’ formulation of the rules of law.\textsuperscript{669} Medieval Muslim jurists treat intent as a component of nearly every legally relevant action, from purification and prayer, to sales and divorce, to fornication and murder. \textsuperscript{670} In Islamic law, intentions are a constitutive element of human actions, critical to the legal assessment of those actions. Indeed, aside from religious faith itself, intent is arguably the most important subjective or ‘internal’ component of the actions prescribed, proscribed, and evaluated by Muslim legal scholars.\textsuperscript{671} Umar ibn Khattab reported that the Holy Prophet S.A.W. said: “Your actions are judged according to their intentions, and to every man is due what he intended for.”\textsuperscript{672} This refers to those things that are permissible or, sometimes, for those that are not permissible or even prohibited in Islam. \textsuperscript{673} Abdullah ibn Abbas narrated that the Holy Prophet S.A.W. said: “He who makes up his mind to do a good deed is rewarded by Allah for one full measure of it, and if he then proceeds to carry it out, Allah rewards him from 10 to 700 times and even many times more. He who inclines towards an evil deed, but does not carry it out, is also rewarded by Allah for one full measure of good deed. Should he carry it out, he is debited only one evil deed.”\textsuperscript{674}

In Saudi Arabia, abortion within the first forty days is lawful when it generates benefit; from the 40\textsuperscript{th} and 120\textsuperscript{th} days, it is legally allowed if the pregnancy may harm the women’s life or health. After the day 120 of pregnancy, abortion is prohibited unless the pregnancy will cause fatal result to the mother. It is against God and all human mankind if one murders a human being. \textsuperscript{675} However, it is a right act to interrupt pregnancy to save the mother’s life. In Islam, it is clearly stated that prohibited for abortion due to the fear of poverty. \textsuperscript{676} This statement extended
to the situations that abortion is necessary because the pregnancy interferes the woman’s or family’s financial condition or careers, etc. In modern time, however, the roles of the fetus should be considered more. Fetus, also as a creation from God, should be considered his or her later life if it is stillbirth. If the fetus, either normal or abnormal, affects the mother’s health or life, the mother would be a priority to be saved by abortion procedure. On the other hand, in the case that the fetus would suffer from a defect after birth but does not cause harm to the mother, would it be permitted to be aborted to prevent the future burdens for the babies? In both circumstances, abortion is required but the intentions of goodwill aim to different subjects, the mother or the fetus. The acceptance of abortion after ensoulment can be justified by the judgment on the value of the mothers and fetus’ life. In some specific cases, such as fetus with defects, lethal fetus, or the existence of fetus may threaten the mother’s life or health, the value of the mother is greater than the one of the fetus because the mother is still the source of a new life. The confirmation for these cases must be from at least three doctors and consented by the husband and wife or the women’s guardians.677

The second principle states that the necessary may override the impermissible. For Muslims, it is prohibited to consume pork and alcohol. However, when a person is in a life-threatening situation, it is an obligation to consume either of pork or alcohol if there is no alternative to preserve their life. It is the necessity for preserving life that overrides the prohibition.

The third principle emphasizes that the prohibited may be allowed to reduce the hardship. This principle is commonly used to justify the essential use of palliative drugs for patients. Palliative care contains relationships between the patient and his or her family, the patient with specialists, and the family with the specialist. Palliative care refers to care aimed at improving
the quality of life of patients and focuses on the prevention and relief of suffering by means of early identification and careful assessment, as well as on the treatment of problems of a physical, psychological or spiritual nature. Palliative care givers support not only the patient but also the family and relatives.678

The forth principle is similar to the third one but more general. The prohibited matters are changed if they affect a large number of people. In the fifth principle, it is required to remove harm if possible in any circumstances. It is better to remove harm than create only benefits. These principles are common tools to judge on dilemmas in all four Sunni schools (Hanafites, Shafi’ites, Hanbalites, and Malikites). For some scholars, they have been reduced into two principles: the necessary may override the prohibited and harm is always removed.679 Adopting the principles may result in acceptance of exceptions.

**Autonomy:** Among ethical principles in bioethics, the principle of autonomy presents the most significant difference between Muslim society and other societies. In most countries, bioethics is based upon rights which individual right is usually prioritize the public rights or benefit. Islamic bioethics even somewhat rejects the idea of moral autonomy; whereas, the principle of autonomy is essential in other countries.680 From Islamic perspective, the principle of public benefit- *maslaha* is primary to the individual benefit, and that the principle of justice works as collecting the public interest rather than individual interest.681 In addition, the patients’ family remains the decisive subject for the patients’ decisions in relations with the doctors, resulting in a limit to the patients’ autonomy.682

In Islamic society, the principle of autonomy is declined not only because of *maslaha*, but it is also influenced by the cultural background. In such societies, the doctors’ position is so highly respected that patients with little education put all decisions in their doctors’ hands, and
also are afraid of being disrespectful and offensive to the doctors if they doubt or refuse the decisions. Muslim doctors take the oath to protect human life in all stages and under all circumstances because life at all stages is precious. Doctors, as an instrument of God’s mercy, have a duty to rescue the life of every human being, including friend, sinner, and enemy from death, malady, pain, and anxiety. Therefore, cases regarding end-of-life issues were not usually found in the literature. In Saudi Arabia, no case related to end-of-life issues was reported to court. This can be justified by the Muslims’ religious belief of death as a truth that everyone has to face; their trust in the health care provider’s religious beliefs; and trust that his intention is to do best for his people by preserving their life if it is possible. Hence, when death occurs, Muslim people refer that death is due to the progression of the terminal illness, and not that it resulted from something that needs other justification or resolution by a court system. This situation is different, however, if patients or family members discover information suggesting malpractice. In that case, they may petition the courts for a judgment against the physician or hospital.

Regarding Do Not Resuscitate (DNR) orders, for instance, in Saudi Arabia, DNR policies are legally practiced only in the hospital arena and not valid outside the hospitals. In particular, in a fatwa, DNR is legal if three knowledgeable, trustworthy physicians agree that the patient’s condition is hopeless. The family members’ opinion is not included in decision making as they are unqualified to make such decisions; families and guardians cannot decide on the application or removal of resuscitation measures or procedures as they are not considered qualified under the law. Also, a valid DNR form must have signatures of three qualified physicians and only be legally acceptable within the hospital during the patient’s admission.
Withdrawal of life-sustaining treatments is seen as allowing death to take its natural course. Notwithstanding, there is a fine line between having and not having an intention to cause death in such instances. Islamic law permits withdrawal of futile and disproportionate treatment on the basis of the consent of the immediate family members who act on the professional advice of the physician in charge of the case. Some Muslim jurists recognize as legal a competent patient’s informed refusal of treatment or a living will, which allows a person to die under circumstances in which there are no medical reasons to continue treatment. However, even in such rare recognition of the patient’s autonomy in Muslim culture, the law takes into consideration the patient’s long-term treatment relationship with a physician whose opinion, in the final assessment, serves as the grounds for turning off the respirator, for example. In this instance, death is recorded as caused by the person’s underlying disease rather than the intentional act of turning off the respirator; a fact recognized by the Shari’ah.687

*Islamic approach to consent:* When the doctor examines a patient, independently of gender, he should avoid looking at their private parts. The *Shari‘ah* indicates the list of the body parts that need to be protected in order to protect the chastity of both sexes (in particular women) from the looks of others. In men, the anatomical parts from the navel to the knees are to be covered, while in the women all parts except the hands.688 The roles within the Muslim family remain traditionally diversified. In the Qur’an, men and women are equal but, at the same time, different as their natures are different. The prime task of the man is to sustain the family economically; the primary role of the woman is, on the other hand, to raise the children.689 The man (generally elderly) has to take the decisions while the woman bears above all the burden of care.690
According to Muslim jurists, a physician must have permission from a patient or from
 guardian of that patient before any medical procedure can be performed. In many Islamic
countries (Egypt, Pakistan, Turkey, etc.), the desires of patients are often subordinates to those of
the family and/or social group which the patient belongs. In Muslim contexts, internal hierarchy,
social bonds, reverence of doctors who are deemed an instrument of divine compassion are
considered. The decision can easily be delegated to the most authoritative figure in the context in
which it is taken, e.g. father, husband, brother, doctor etc. When the decision-making power of
the family is strong, the interests and desires of the “weak” members may be overlooked. In the
last place, the patient, when seriously ill or without hope, rarely takes autonomous decisions
regarding a possible therapy, in addition, it is general the family that decides who to consult.
Also, all the information necessary for diagnoses and treatment provided by a patient to the
physician is considered a sacred trust. The Qur’an speaks of “those whose contracts and trusts
they vigilant guard.” In Saudi Arabia, the widespread practice amongst doctors not to
recognize any right to consent for treatment or invasive tests that were essential for the health of
female patients. In these cases, the doctors contact the guardian of the patient (generally the
husband or a brother) so that he could sign the informed consent form. In the past, in serious
situations, subsequent death of the mother and of the fetus, the woman had never been asked for
her opinion on the matter which had caused a number of severe consequences. Therefore, in
today rules, a mentally healthy mature woman has the right to accept or refuse the medical
treatment offered to her and does not require the approval of her guardian, her father, or her
brother before giving her consent. The rules of the hospital administration set by the Saudi
Arabian Ministry of Health, according to which written consent to anesthesia or surgery must be
signed by the patient if he/she is mature and mentally healthy, in the presence of two legally
acceptable witnesses who then sign the form in their turn. In the case of minors, unconscious patients, or mentally retarded patients, the form must be signed by the guardian or close relatives in the presence of two witnesses. If these cannot be found, the governor or the police may replace the guardian in the respect of the rule of the Shari’ah. Saudi Arabian society does not seem to judge male mediation as an infringement of women’s rights precisely due to its specific and characteristic family model. It is not stated on the law but it is an implicit social standard. In fact, it appears to be an issue if the women decide on major issues.\textsuperscript{692}

\textit{Human dignity}: In the international principles of bioethics, religious tradition is a key feature in the human rights framework; therefore, we have to take religious tradition into account in order to formulate universal standards for international human rights.\textsuperscript{693} The foundation of human rights is the notion of human dignity which is recognized as the inherent dignity of all members of the human family. It is the intrinsic value of every human being and equal for all humans. Hence, it must be respected and protected among all human beings, regardless of their age, sex, health status, social or ethnic origin, political ideas or religions.\textsuperscript{694} Protecting human dignity means protecting human rights. In some opinions, human rights in the world view and in Islamic view are divergent since the world view centered on man and another centered on God.\textsuperscript{695} However, such perception is proved otherwise in the international document UNESCO Universal Declaration on Bioethics and Human Rights. In the Declaration, religious tradition is a key feature in the human rights framework and it should be respected and included in the framework.\textsuperscript{696} Accordingly, human rights in Islamic rules are on the same track with the world view.

\textit{Altruism}: As the financing in health care has been considerably changing, relationship between physicians and patients has made change, too. In traditional medical ethics, physicians’
duty was to provide the most care at any cost and at best skills and passion to poor people. However, the high cost of health care and the shift of the finance and facilities from physicians to corporations or organizations or even governments have made them unable to provide care at any cost. The decision about treatment for the sick is no longer made by the physicians. They have control only for their professional skills and care but not the facilities and finance. Such change has generated inequalities in health care distribution in which the poor patients have lower quality of care than the rich. Also, it is quite convoluted to contend for the justification of inequalities in such system. However, this trend is excluded in Muslim societies. The tradition of caring and giving charity to the indigent now virtually spread at the social level, not only limit among physicians. Both Muslim physicians and societies understand their duties to commit to treat the indigent according to their long history notion of public welfare and charitable works to the poor and needy. The fear of God and the rewards for goodness in Hereafter endorsed by God play a significant role of maintaining the morality in Islam. Reward in the Hereafter is a motivator of moral behavior. The principle of justice remains meaningful in this matter in Islamic perspective.

In Islamic countries, bioethics is unlikely separable from religion, which, in turn, brings conformity along while many other countries have plural characteristics. Subsequently, it is less obstructive for Islamic countries to reach a consensus solution than other societies where solutions are derived from the multiplicity of ideological positions, which, in turn, create various interpretations for one matter. Contrasting views on one ethical issue are inevitable in most countries.
2. Death in Islamic perspective

In Islamic teaching, from religious perspective, death is a divine act occurring when the soul is separated from the body; death is not the moment when the heart or the brain ceases its activity. In Islam, death marks the transition from one state of existence to the next rather than the end of the existence of an individual. Life on earth is taught as being an examination for human beings, and the afterlife is everlasting. Death is seen as a passage into the eternal life; therefore, death is not to be resisted or fought against but to be accepted as part of the divine plan for every individual.\textsuperscript{701} In a hadith narrated by Abu Hurairah, the Prophet Mohammed (S.A.W) said: “None of you should wish for death, nor should he call for it before it comes to him; because when he dies, his actions are terminated, and certainly the age of a Believer adds nothing but good.” \textsuperscript{702} Death itself is not a punishment but just simply an event that brings a particular stage to an end and starts a period of probation which prepares for the day of resurrection and the final judgment. Death is like an entrance that has no coming back but moving on to the next phase.\textsuperscript{703}

From the medical perspective, cardiac death has been widely accepted for the permanent cessation of heartbeat and respiration. However, the assistance of technology eliminates the necessity of spontaneity for the heart and lungs; a pace maker can make the heart beat, and the ventilator can help the lungs inspire and expire. The observation of such activities places brain death criteria in the middle of debates among doctors, jurists, and others. In Islamic teaching, life must be appreciated and respected, killing an innocent person represents killing all human beings. One must remember death in order to appreciate his life and oblige to optimally benefit from his life. Generally, both cardiac death and brain death are accepted in Islamic law. In
particular, brain death is accepted when the possibility of donating organs after death save people whose lives would not be saved if otherwise. The rejection of brain death occurs when the transplantation leads to the termination of life, justified by the maximum respect for human life.

In 1968, the Council of the Islamic Jurisprudence Academy of the Organization of the Islamic Conference announces the legal rule for the dead as following criteria: a person is confirmed by physicians to have irreversible cardio-respiratory arrest; and a person is confirmed by physicians to have no brain activity, the condition is irreversible, and the brain has entered the state of decomposition. In such cases, intensive care treatment is no longer required and may be weaned off, except for the life-support equipments that keep the heart function artificially. In 1987, the Council allows to take off the life-support equipment from the patients who are confirmed with irreversible brain damage by three expert physicians; however, death pronouncement will not initiated until the respiration and heartbeat cease followed by the switching off the equipment. In 1988, the Council permits the organ transplants from a deceased person to a live person as long as the deceased or their families authorize the procedure and the procedure saves the recipient’s life or restore his body function. Death may be either forms-cardiac or brain death. Overall, in medical settings in Islamic countries, doctors hold great roles in determining whether the patient is dead or alive. In Islamic societies, paternalism remains a common practice in medicine. In fact, patients expect the doctors to make decisions for doctors have superior education and knowledge to the patients and for the fear that questioning their doctors’ decisions could offend their doctors.

For Muslims, life is sacred and death does not happen except by God’s permission. In Islam, healthcare providers must do everything possible to prevent patients from premature death, but it is controversial whether they need to maintain life at any cost or merely to provide
comfort so that death can come as quickly and comfortably as possible. Supporting this point, Muslim jurists of different schools have ruled that when invasive treatment has been intensified to save the life of a patient, life saving equipments cannot be turned off unless the physicians assure about the inevitability of death.\textsuperscript{706}

Death is an inevitable event but the causes leading to death are various. In Islam, death because of suicide is absolutely forbidden. It is clearly stated in the Holy Qur’an: “God gives life, and He makes to die,”\textsuperscript{707} or “A person dies when it written.”\textsuperscript{708} A teaching of a hadith says that a person who commits suicide will be in the Hell forever, where he will suffer the pain of his method of suicide along with all the other punishments: “Who kills himself with a metal weapon will be in the Fire of Hell forever. He will have that weapon in his hand and will be thrusting it into his stomach forever. He who drinks poison and kills himself will sip that poison in the Fire of Hell where he is doomed forever, and he who kills himself by falling from a mountain will continue falling in the Fire of Hell and each of them will live forever in their respective states.”\textsuperscript{709} In Islam, suicide is forbidden for every Muslim, even when his life is of hardship. In the afterlife, the person who committed suicide would realize the baseness of his action and the mistake he made, which could not be corrected or repaired then. In a dreadful or unbearable situation, individuals are advised to pray more for forgiveness and guidance and cannot give up hope for a chance to get out of the misery.\textsuperscript{710} Moreover, people must not destroy themselves for they are not their own masters.

Islamic law explicitly prohibits active euthanasia and physician-assisted death in all circumstances. This position is based upon two principles in Muslim culture. Firstly, as a religious law the \textit{Shari’ah} places more emphasis on the sanctity of human life than a secular system. Suicide is prohibited in the Qur’an, and so there is no right to die. Secondly, illness is
regarded as a test that must be borne with fortitude. In the Qur’an, it states that Allah tests his believers and it is incumbent upon relatives to care for ill people. There is apparently no decision on the legality of withdrawing treatment from a terminally ill patient, but it is unlikely to be accepted as consistent with Muslim attitudes to the sanctity of life and the nature of suffering.711

As Shari’ah does not recognize a patient’s right to die voluntarily because humans cannot actively or passively terminate their lives by any form of intervention. This act is considered as a suicide commitment- the act that is absolutely forbidden for Muslims.712 The majority of fatwas on the subject of euthanasia are remarkably short, simply assimilating it with either suicide or homicide. Such statements are completely in line with the clear statement of the Islamic Code of Medical Ethics, endorsed by the First International Conference on Islamic Medicine, which states: “Mercy killing, like suicide, finds no support except in the atheistic way of thinking that believes that our life on this earth is followed by void. The claim of killing for painful, hopeless illness is also refuted, for there is no human pain that cannot be largely conquered by medication or by suitable neurosurgery.” Nevertheless, fatwas on euthanasia are more complex in their reasoning. Since human life is a trust from God, human beings are required to preserve their life and bodies. Human beings are forbidden from suicide as stated in the Qur’an: “Do not kill yourselves, surely God is merciful to you,” 713 and threatened not to do such things or they would have the worst destinies both in this world and next world. Islamic law orders physicians to be concerned for the sick, and, at the end, to take pains to care for them, and for both patient and doctor to leave the result up to God.714 Another fatwa supports for this idea states: “The termination of human life is caused by Allah. He alone determines when a person should die. He also determines the cause of his or her death. When people interfere with that process which Allah has determined, they actually kill whoever puts [the suffering patient] to death actually
puts himself in the position of Allah, determining when that person should die. This is an assault on Allah’s authority.”

In the modern world, the notions of the “right to die with dignity” and “sparing the patient unbearable pain” are not acceptable. There is no lack of dignity in a person being ill and needing treatment. If he cannot control his own body function, then he should be helped with these. To terminate his life for that reason is inhumane. There is no mercy in such a killing. If people want to be merciful, then they should take good care of such patients. On the other hand, most types of pain can be relieved with appropriate treatment. With the modern advances in medical care, pains which used to be unbearable can easily be reduced or relieved. In case where it cannot be helped, the patient should be reminded that he will be rewarded for his pain. If he bears it with resignation and accepts what Allah has determined for him, then his reward will be the forgiveness of his sins. A believer will always be willing to accept such pain for the prize of earning forgiveness. For Muslims, pain and suffering can have spiritually beneficial effects, and should not necessarily be avoided.

Nevertheless, the wishes of patient not to have his dying prolonged artificially with the presence of hopeless prognosis are well preserved. Such wishes may be declared in accepted standing Do Not Resuscitate (DNR) orders in certain hopeless medical conditions. Withholding or withdrawing life support, however, is still an area of controversy. Its applicability is weighed with benefits and risks and the treatment is for the terminally ill patient. Islamic scholars differ in their views regarding withholding or withdrawing of treatment, in which some of them believe that everything needs to be done for patients, while others believe that unnecessary and futile measures are inappropriate if the patient is going to die. Removal of life support measures from a
clinically dead person is permitted by the Islamic European Council for Fatwa and Research (ECFR).719

Generally, both doctors and scholars of Islamic law would be unlikely to pronounce upon a case where euthanasia is desired. Rather, the decision would be left up to the family. This respect for family prerogative also attests to the conviction that God alone knows what is right and wrong in such cases. The individual conscience is considered a better guide for action, since it is ultimately the individual who will have to answer to God on the Judgment Day. The role of the health care provider in end-of-life cases ought to facilitate Muslim convictions of God’s activity in the world.720

Upon request of euthanasia from the patient, the patient’s intention is considered as intending to commit suicide that is absolutely forbidden in Islam. If the act of euthanasia is proceeded, either active or passive euthanasia, the patient and the doctor (possibly family or relative if involving the decision) would receive warned punishment in the Afterlife as for ones who commit suicide. However, if only the request is made but the act does not happen, there would be no punishment for either involved party.

Most of Muslims wish to die at home, not in a hospital setting, because at the moment of dying, the dying person is seeking for forgiveness and will expect to be visited by friends and relatives, who are encouraged to pray for his or her welfare in the life to come.721

Islam as well as many other faith traditions which subscribe to a belief in the sanctity of life also believe in continuity of existence of the individual after biological death. Such life after death is usually felt to be of greater value than the human condition, and is often believed to be a reward for belief or behavior during human existence.722
In Islamic thought, death is not a taboo but is transition from one state to another state; life on earth is an examination; only the life to come is the eternal. 723

3. Saving a human life in Islamic perspective

God is the only source of life; life is a gift of God, thus we are held accountable for it, but it is not up to us to take it away: “My Lord is He Who gives life and causes death.”724 Man and nature can have a role in the process of giving life and causing death, but only God Who truly and genuinely gives life.725

Human life is a sacred gift from God, thus it is a duty for human beings to defend the sanctity of their life. 726 “Whosoever has spared the life of a soul, it is as though he has spared the life of all people. Whosoever has killed a soul, it is as though he has murdered all of mankind.”727 Saving a person’s life means saving all people. Healing people is a sacred job in which caregivers need to do his best for all stages in a human life and under all circumstances but must know the real healer is God at the same time.

Protection of human life is the most significant requirement in Islamic teaching.728 The human body in Islam has its own sanctity in the Prophet’s saying: “Your soul has its rights and your body has its rights.”729 In the Islamic perspective, life is a gift from God to human beings. It is his right and his religious duties to protect his life and other fellow human beings’ lives physically and spiritually. No human beings can violate others’ life physically or spiritually.730 Deprivation self or others’ live is prohibited in Islam, except for the killing of captives and mutilating the bodies of the dead: “If anyone slew a person- unless it be for murder or for spreading mischief in the land- it would be as if he slew the whole people: and if anyone saved a life, it would be as if he saved the life of the whole people.”731
Islam emphasizes on the equality of all people, regardless of race, ethnicity, gender, or social status. They have been created for the same purpose: serve God. They have same rights to independence, to receive rewarding and punishment from God.\textsuperscript{732}

All the sick have rights to all the opportunities that health care can offer. They should benefit all available support. They all have rights to the protection of human dignity. The explanation is equivalent of the conclusion in Islamic bioethics that under any circumstances will impediments or termination of the care be allowed. All human beings at any moment have great values and must be treated at best and respected fully. Otherwise, the act of, by any means, preventing care provision equivalently means killing acts. Human individuals have obligation to maintain and improve each other or themselves. In the solution to this matter, justice is obtained upon the equality and equity.

In Islam, a human beings is a combination of body and mind, hence human dignity extends to the body and spirit; respect for and protection of human dignity encompass physical and spiritual aspects of a person, either the person is dead or alive.

4. Islamic views on organ transplantation and organ donation

4.1 Organ transplantation

Transplanting solid organs has been considered a promising option only a few decades ago. Advances in understanding the immunologic pathways and improvements in surgical techniques have transformed the hopes for success into realities. Today, transplanting solid organs is a common therapeutic strategy for patients with end-stage organ failure with promising effects for survival and quality of life. Organ donation is a person giving his or her permission while alive for the donation of their organs after death. However, because of a lack of donation, the number of patients on the waiting list is increasing. As deceased donation rates are low in
Middle Eastern region, most donations are done from the relatives of the patients. Previous studies have shown that socioeconomic status, religion, sex, age, and education have played important roles in the volunteering for organ donation. Among these factors, incorrect beliefs about transplant and donation were great obstacles. To increase donation rates, it is impossible to change the economic status, religion, sex, age, and graduated schools. However, it is possible to give correct information about myths about organ donation. The sources of information are media, health workers, and religious figures. These sources could be used for education of organ donation. As in most studies, education is the key factor. After education, rates for organ donation significantly improved. Scientific and religious information about organ donation given by a doctor, with the illustrative techniques, is effective even in a population that has low economic and education levels. Wrong beliefs about religion are not unchangeable. If explained logically, the wrong beliefs can be corrected in most adults. Conversely, new studies performed in larger populations are warranted. Specific factors affecting organ donation like religion, media, education, and economic status should be investigated separately to determine the net effect.733

Organ transplants in Muslim countries first started in the early 1970s and raised controversies on certain matters related to the Until the Resurrection of bodies on the Day of Judgment. Muslim law prescribes burial of the deceased as soon as possible and prohibits cremation and any mutilation of the corpse; the Creator is the sole owner of everything, including of the human body.734 Afterwards, there has been a progressive approval of these operations, even if some opposition remains to the practice in general or limited to some circumstances, especially transplants from the corpse.735 Islamic rule does not dissent from organ donation as long as the procedure respects for the deceased and benefits the recipients.
To justify for the approval of organ transplants, Muslim scholars and jurists adopt the teaching from the Holy Qur’an, that is “If anyone saved a life, it would be as if he saved the life of the whole people.”\textsuperscript{736} The advanced method of organ transplantation is also supported and encouraged on the basis of the hadith collected by Bukhari, “There is no disease that Allah has created, except that He also has created its treatment.”\textsuperscript{737} All acts that make effort to eradicate pathologies and do not conflict with Islamic tradition are permissible and encouraged in Islam. Organ donation is absolutely encouraged for the purpose of saving human life without creating harms to others. The encouragement is justified also by the teaching in the Qur’an: “And spend in the way Allah and cast not yourselves to perdition without your own hands, and do good (to others); surely Allah loves the doers of good;”\textsuperscript{738} and “And what (harm) would it have done them if they had believed in Allah and the last day and spent (benevolently) of what Allah had given them? And Allah knows them.”\textsuperscript{739} The latter can also justify for the contention that human bodies belong to God and human beings should not violate the human bodies. God endows us the body but we are taught to share anything given by God with each other to benefit each other. Accordingly, man can use his organs, in the condition of no harm to himself, for the benefit of the community. Moreover, caring for the ill comes under the responsibility of society and the donation of organs may be considered a social obligation. In general, organ transplantation is approved in Islamic law, yet the four juridical schools claim different explanations. The obligation for human beings to make the best effort to seek treatment in Islamic rule justifies such approval. Besides, according to the Prophet’s teaching that “whoever helps a brother in difficulty, God will help him through his difficulties on the Day of Judgment,”\textsuperscript{740} it is permissible that one may donate his organ to save another’s life but strictly not endanger his own life. For the same teaching, it is allowed to remove the organ of a dead person to be used to save
the life of a sick person. In the case that many patients wait for the organ transplant but the resource is scarce, drawing lots would be employed in order to make a decision for the recipient. This method is created following the solution in which the Prophet drew lots to choose the wife who would accompany him on his journeys. In some cases, it is even allowed to receive organ donation from a non-Muslim if it requires so. When confronting this issue, all involved parties must keep in mind the teaching in the Qur’an that human beings, regardless of any factors, are sacred and their dignity when alive or dead must be protected, and killing a person is equivalent to killing all humankind, and conversely, saving a person means saving all humankind.741 Overall, all human beings must be considered equally. Applying the same teaching, the issue of treatment for end of life follows the rule that no withhold or withdraw of treatment is allowed. Care for any human being at any moment of life, of any quality of life is an obligation.742 For those scholars making judgments about the permissibility of organ transplantation, practical considerations about efficacy, graft survival, surgery risks, toxicity of postoperative medical treatments, and financial costs- questions that might be located within the realms of political economy, public health, epidemiology, medical science, sociology, or pharmacology- are, in fact, formative of Islamic legal-ethical opinions about permissibility.743

On the contrary, there are some opponents of transplants. Such opponents mainly base their views on three principles: the sanctity of the body and of human life; our bodies are given to use in trusteeship; the body is reduced to an object-material end. The opposition may see in the policy that prohibit donation from the deceased in Egypt or the rejection of both living and deceased donors in the view of the popular Egyptian preacher- Al Sha’rawi.744 However, the permissible orientation to organ donations, from both the living and the deceased, is common among Muslim countries. The justification of receiving organs from cadavers is based on the
principle of the “less evil” according to which harming a corpse (violating the deceased to remove an organ) is tolerated to prevent greater harm for a living individual who would die without that organ.

4.2 Organ donation

Organ donation is permissible because it is considered as a perpetual charitable act. Living organ donation is permitted in Islam when the living donor is willing to donate and such donation does not pose any danger to the donor’s life. That makes kidney donation from a live donor justified legally and morally. In this case, the donor saves a life and still lives reasonably. On the other hand, a person cannot donate any organs on which his life is dependent. Cadaveric organ donation is accepted as long as the deceased gave permission before their death or their guardians approves the donation.

A person may donate his organ to save another life as long as there is no harm to his health, no matter who is the donor or recipient, Muslim or non-Muslim, all have the same chance to donate or receive, respectively. When resources are scarce, drawing lots would be likely to bring fairness in distribution since there is no influential factor, no privilege, or no priority that is able to infringe any individual’s opportunity. Physicians merely provide care for both donor and recipient and treat all with full respect. They do not take part in deciding about the allocation of the resource. It appears to be same for other parties. Obeying the religious foundations and principles brings up justice, equality, and equity just as the content of the ethical principles that all social members are equal in terms of dignity, justice, rights, opportunities, freedom, benefits, and obligations.

Donation between Muslims and non-Muslims: In Islam, it is not required that donors and recipients must hold the same religion. According to the Iranian ayatollah S. Makarem, it is
lawful to donate organs to non-Muslim except when the recipient is at war with Muslims. In a fatwa of 24 June 2002, the authoritative Sunni sheikh Yusuf al Qaradawi declared it was unlawful for the Muslim to donate organs to a non-Muslim that attacks Islam, similarly, it is forbidden to donate organs to an apostate as he is a traitor to his religion and people, which is the reason why he deserves death. In addition, if both a Muslim and a non-Muslim require an organ or blood donation, the Muslim has precedence according to the Qur’anic verse that states: “The Believers, men and women, are protectors one of another.” 745 The Saudi sheikh Al Qattan states, “Muslim Law exhort the members of the Muslim Nation to reinforce its bonds with love and charity so that they become similar to a single body. The donation of an organ of the body to save the life of one of your brothers without causing harm to yourself represents the apex of the unity of the nation and a good example of cooperation between its members.” 746 According to the jurist Abd Allah Al Basam, the body of a Muslim and of a non-Muslim are pure both alive and dead. This makes the organ transplant from non-Muslims to Muslims lawful. 747

Donations from the deceased: Islam prohibited all acts of violence or disrespect on corpses. The corpse must be buried in a correct procedure. As the consequence of these conceptions, in the past decades, the idea has spread that transplants from corpses are prohibited by the Shari’ah. 748 In the Middle East, it is rare to obtain organs from cadavers. Islamic teaching emphasizes the need to maintain the integrity of the body after death, and although some prominent religious leaders make an exception for transplants, others refuse. 749

Advocates for transplants from the deceased base their arguments on the Qur’an 5.32 and the principle of the need to save human life, understood as an operative criterion that is above any other (including the principle of the protection of the corpse), are the duty to respect the body of dead man as if it were that of a living person. The first favorable opinions to transplants
from corpses in the Muslim world were recorded in 1959 when sheikh Hasan Maamoon, Grand mufti of Egypt, approved the transplant of cornea from an unidentified corpse or from a person who had given his consent during his lifetime. In 1989, the Egyptian mufti Al Sharawi was generally opposed to any type of transplant, nevertheless stated that he was in favor of transplants from a corpse as an extreme solution, similar to the premise of the Sahris to feed on a corpse in order to survive. The majority of scholars are in favor of receiving organs from a corpse on condition that the person authorized it during his lifetime or, alternatively, his relatives give their consent; in the event that it is not possible to identify the corpse or there are no heirs, authorization to remove the organ is required from the head of the Muslim community.

Many Muslim scholars who are not in favor of transplants disapprove brain death. The resistance to brain death is reasoned by the point that brain death does not eliminate the heat of life, which indicates the presence of the soul: the heart beats and the kidneys and liver still function. In addition, international literature indicates the possibility of a return of cerebral activity after its interruption. This is the difficult relationship existing on transplants between the Medical Association, the political world, and religious authorities. All Middle Eastern countries except Egypt passed laws allowing deceased organ transplantation and regulate living donations.

On the other side, there are some opponents of postmortal transplants, justified upon the principle that everything belongs to God, including human body. However, this argument was answered by the Grand mufti of Egypt, Tantawi, in a fatwa in 1989, declaring that the entire universe belongs to God; however, allows man to dispose of his body for the purpose of good.
Donations from the living: There are several sources of living donation. The majority of transplants in the Middle East come from living related donors (LRD), that is people genetically related to the recipients (such as parents, brothers and sisters, grandparents), or from living close relatives (emotionally related donor (ERD) such a spouse, in-law, adopted siblings) both because these are operations that are less complex than transplants from a corpse and due to the great difficulty in finding the deceased donors. Organs from living non-related donors (LNRD) are often commercial. Because of the serious ethical problems related to the trade in organs, transplants from LNRD are generally hindered in Muslim countries.755

According to the Islamic Code of Medical Ethics (Kuwait 1981), the donation of an organ has to be the effect of a free and voluntary act that can be performed when the donor does not run any risk for his life whilst the harm suffered is minimal. The majority of jurists seem to be in favor of transferring one of the double organs if the survival of the donor is guaranteed, the damage is not serious and the purpose is humanitarian. Donation must not lead “intentionally” to death or to the disablement of the donor even if it is carried out to save another person.756 A Shi’a jurist opposed to the receiving of “major parts” of the body (e.g. eye, hand, foot) from a living donor but favorable in the case of portions of skin, flesh, etc. In this case, it would even be licit to pay compensation to the donor.757

In some countries specific laws to legislate cadaveric organ donation have been approved such as in Saudi Arabia, Iraq, Kuwait, and Jordan. In Egypt a law regulating corneal donation has existed since 1959, but donation of other organs has not been formally approved as yet. Accordingly, it is generally accepted that selling of body organs is absolutely prohibited by Islam as the body of the human being and its organs are not for sale.
4.3 Organ supplies

The Middle East Society for Organ Transplantation (MESOT) was established in Turkey in 1987 as a nonprofit international scientific society to promote and encourage, and cooperation in the field of organ transplantation between medical centers, societies, and public and private organizations in Middle East countries. The organization includes more than 29 countries, all Arab countries, Iran, Turkey, Pakistan, and countries of central Asia. Living organ donation is the most widely practiced type of donation in the Middle East and includes kidney and partial liver. Donors are predominantly genetically related to recipients; however, genetically unrelated and commercial living organ donations exist. Cadaveric organ donation has great potential in the Middle East because of the rate of accidents. Nevertheless, this source is still not used effectively because of the controversies about the concept of brain death and inadequate awareness of the public of the importance of organ donation and transplantation in many countries.758

The growing reliability of transplants associated with the increasing demand for organs is going in the opposite direction with the scarce availability. This shortage has caused the development of traffic in organs (in particular of kidneys) with high profits for facilitators, private hospitals and unscrupulous doctors.759 The common problems include therapeutic results, high mortality rate, and distinguishing the sale of an organ from compensation received for donation.760 Organ trade also operates in and via the Middle East and elsewhere in the Muslim world. The international trade in human organs, particularly kidneys, has especially flourished in developing countries where organs from nonliving donors are not adequate or available and there are marked disparities in wealth. For example, Persian Gulf countries (Saudi, Kuwait, Baharan, Qatar, UAE, Oman) with transplant programs have no or low number of living donors, and patients from these countries have relied heavily on poor, recruited, living donors as suppliers of
human organs from countries such as India, Pakistan, the Philippines, Eastern Europe, and China.761

Most traffic concerns the kidney since kidneys are subject to disease from a variety of causes, including persistent high blood pressure, adult diabetes, nephritis, and infections.762 As the waiting list to obtain a kidney from a cadaver is very long, in addition to religious and cultural reasons, the best way to get one is from a living donor—usually from a sibling, a spouse, a relative, or a friend. Besides, many people will try to purchase a kidney. Transplantation spreads quickly from developed to less-developed countries. Residents of Saudi Arabia mainly go to India for the organs.763 In India, there are hundreds of clinics that perform kidney transplants.764 Surgeons have also found that patients who receive an organ from a living donor have far better prospects than those who receive an organ from a cadaver.765 India has abundant supply of kidneys because physicians and brokers bring together the desperately poor and the desperately ill. The organs are often from impoverished villagers, slum dwellers, power-loom operators, manual labors, and daughters with small dowries. They are more sellers than donors. The buyers come from Egypt, Kuwait, Oman, and other Gulf States. They readily pay between $2,500 and $4,000 for a kidney and perhaps twice that for the surgery.766 China is at the center of the Pacific route to organ transplantation because it has adopted the tactic of harvesting the organs of executed prisoners. The new law in China since 1984 provided that organs from executed prisoners could be used for transplants if the prisoner agreed, if the family agreed, or if no one came to claim the body. Foreigners do not have to wait days or weeks for an organ to be made available; executions can be timed to meet market needs and the supply is more than adequate.767 Many patients need transplants and they travel to China to get the organs of executed prisoners. Confronted with this unethical matter, surgeons play a much significant role as they
can refuse to operate or involve such cases; otherwise, they have become intimate participants in the execution, instead of protecting life, they are manipulating the consequences of death. Also, in many poor countries in South America, the poor or their children are at risk of being mutilated and murdered for their organs. In Pakistan, due to the low effectiveness of the public operation and absence of transplant legislation, organ transplantation has moved to the private sector. Initially, transplants were from live related donors; however, within a few years, commercial unrelated paid donor transplants took over, where the poor and impoverished of society were exploited to sell kidneys for $1000 to $2000. Initially, the majority of the recipients were local; however, by 2005, most rich buyers came to Pakistan from Europe, the Middle East, and India. These buyers are willing to pay $20,000 to $30,000 for the transplant package, and transplant tourism became an industry in the country. Transplant tourism is the term used for patients who travel abroad for transplantation. The common issues in transplant tourism include how these organs were obtained, the donor’s care after transplantation, and the recipient outcome. The origins of the donors usually could not verify in terms of medical history. According to one survey among 165 patients from Saudi Arabia, the major of transplant tourists obtained their kidneys in Pakistan (49%) followed by the Philippines (28%), Egypt (11%), and the U.S. (3.2%), China and Iran (2% each), and Lebanon, Jordan, and Syria (1% each).

4.4. Ethical issues in organ donation

The majority of scholars have agreed that organ donation is permitted based on the conditions that it will help the recipient with certainty; it does not cause harm to the donor; and the donor donates the organ or tissue voluntarily and without financial compensation.

Organ transplantation is a new method of treatment that can save many human lives and improve the quality of life for many others. Islam encourages a search for a cure and invokes
Muslims not to despair, for there is certainly a cure for every ailment, although we may not know of it now. The donation of organs is an act of charity, benevolence, altruism, and love for humankind. God loves those who love fellow humans and try to mitigate the agony and sorrow of others and relieve their unfortunate. Any action carried out with good intentions and which aims at helping others is respected and indeed encouraged, provided no harm is inflicted. The human body is the property of God; however, man is entrusted with the body as well as other things. He should use it in the way prescribed by God as revealed by His messengers. God on the Day of Judgment will judge any misuse, and transgressors will be punished.

Suicide is equated, in Islam, with homicide. Even cremation of the corpse is not allowed. The only accepted and dignified way is burial of the corpse- which should be performed as soon as possible, but not immediately for medical certainty. Donation of organs should not be considered as acts of transgression against the body. On the contrary, they are acts of charity and benevolence to other fellow humans, which God loves and encourages.

Human organs are not commodities. They should be donated freely in response to an altruistic feeling of brotherhood and love for one’s fellow beings. Because nonliving donation is scarce or nonexistent in the region, few countries in the Middle East can provide transplant organs such as the heart, heart valve, or pancreases. Liver transplants have begun to increase in recent years and mainly consist of partial liver procurements from living donors. A recent study on issues of renal transplantation in Middle Eastern countries identified eleven prominent problems. One of these problems is that paying living, unrelated donors is considered an ‘easy way out’ of the scarcity of problem. Similarities in some of the featured problems of transplants exist amid diverse policies among Islamic countries, but there are key differences as well. For example, Saudi permits procuring organs from the nonliving, while Egypt relies totally on living...
donors. Among countries that permit living donations, a further distinction is in the policies of dealing with living, unrelated donors. Despite a consensus among Islamic jurists as reflected in fatwas that have been issued on paid donations, Iran is the only country worldwide that legalizes commercial kidney donations; the state also recompense donors for kidney donations. This policy is a state attempt to fill the demand for kidneys and standardize the low prices. However, a study on Iranian organ donors reports significant negative consequences for donors’ quality of life and argues that the system has also failed to satisfy the supply. The policy has damaged the ability to advance altruistic and cadaveric donation, has decreased the price of kidneys, and has been unable to eliminate a coexisting black market via a regulated market in organs.

Organ trafficking is gaining worldwide attention as indicators suggest that the market in organs is a global phenomenon that continues to expand. Consequently, an increasing trend of commercial donors via international brokers has appeared. The organ trafficking also caused difficulty in protecting health and financial issue, especially for the donors due to a lack of donor follow-up and general welfare concern; and a subsequent undermining of deceased and altruistic donorship.

II. Application for organ donation in Iran

1. Current organ donation status in Iran

Iran embraces both living and cadaveric organ donation in the organ transplantation practice. However, living organ donors considerably prevail cadaveric organ donors due to its regulated paid living unrelated donation policy. The living unrelated donor gets paid from the government and recipient; the amount paid by the government is regulated while the one by the recipient is privately negotiable between the donor and recipient; living related or cadaveric donors receives no reimbursement as the donating act is considered pure altruism.
The first kidney transplantation in the Middle East took place in Iran in 1968, but a real program has only been in force since the mid-1980s. Initially, the most resource of donated kidneys is from living non-related donors followed by the living related donors and emotional related donors, such as spouses or friends. The number of patients in dialysis is constantly increasing and their treatment is paid for by the State. Although receiving cadaveric organs is hindered by resistances of a cultural, social, and religious nature; several transplants from a corpse have been performed since brain death is accepted in Iran. In 1989, the ayatollah Khomeini made a pronouncement on the removal of organs from a brain-dead body allowing the life of someone else to be saved; it is not forbidden, but it needs permission of the owner of these organs. In 2000, the Parliament definitely recognized brain death and cadaveric organ transplantation, as well as the Guardian Council- a body controlled by Shi’ite religious authorities and more conservative- approved cadaveric organ transplants in the condition that transplant operators do not have to pay the compensation. The announcement of brain death is established by means of clinical criteria, apnea and electroencephalogram. The first heart transplant was in 1993 as was the first liver transplant. There were nine multi-organ transplants performed from corpses with the consent of the relatives in 1992-1993. By the end of 2006, there are 21,359 kidneys transplants, of which 5.2% is from deceased donors. There are 28 transplant facilities, mainly located in Shiraz and Tehran university hospitals. Transplanted organs and tissues include cornea, bone marrow, skin, heart, kidney, liver, lung, cardiac valves, bone, ligament, and cartilage.

In 1997, a new law was approved in order to increase the number of organs available. Kidney donors should receive, after the operation, 10 million rials (about $600) from the Charity Foundation for Special Diseases (CFSD) financed by the government. However, along with this
official compensation, there is often a personal and uncontrollable economic negotiation between the donor and the recipient. In addition, the costs for pre-operation tests on the donor are the result of negotiation. Even donation between relatives is often accompanied by a payment of money. Precisely, due to the ethical problems raised by the living non-related donor (LNRD), which are too often associated with commercialization and prohibited by other Muslim countries, the advocates of transplants from corpses are on the rise.

The largest number of foreigners who underwent transplant in Iran consists of Afghan refugees, who were allowed to receive kidney transplants from Afghan donors; they were not allowed to volunteer as donors to Iranians. Before the prohibition, despite scrutiny to avoid transplant tourism, there were reports of foreign nationals receiving kidney transplants from Iranian paid donors. In order to prevent transplant tourism, the Iranian model adopts the following regulations: no transplantation between foreigners, including refugees and Iranians is permitted, but transplantation between foreigners who hold the same nationalities is allowed.

In Iran, despite its potential of cadaveric organ sources, the cadaveric organ donation does not receive as much support as the living program. The reason for this lagging status is not the religious reason because Islamic law endorses both criteria of death and permits organ donation and transplantation from the deceased to the living. In fact, organ donation after brain death has received support from many religious leaders, such as Ayatollah Khomeini, Ayatollah Khamene’i, Ayatollah Fazel Lankarani, Ayatollah Makarem Shirazi, and Ayatollah Noori Hamedani. However, the public is not widely willing disregarding the approval of the religious authority for this practice. A study indicates that the deceased’s families find it hard to accept the brain dead pronouncement because they are not satisfied with the treatment system.
and medical staff for not adequately and timely informing them about the brain death status. The families worry about their loved ones who might not be dead.  

On the other hand, when a person or his family decides to donate organs after death, the donation act must be purely altruistic; therefore, there is no appreciation gift or any type of compensation from the government like how it works for living non related organ donors. This is the main reason that the deceased organ donation is lagging behind. Consequently, deceased donation is of less public interest, making its rates very low in Iran. Religious leaders and government can improve the cadaveric donation by interacting more with the public to express their approval and support as well as to educate citizens about this matter.  

The resistance to the donation from the deceased accounts for the high rate of transplants from living non-related donors. The government provides only the expenses for medical services, while the incentive that is usually negotiable was covered by the recipients. Usually, the donors are not emotionally or financially satisfied. Most of the donors claim that the things they have lost much outweigh the things they receive. They do not free them from debt and poverty as they expected from the donating transactions. Their lives change in every aspect. Most of them suffer psychological complications. Many even receive rejection from their families and friends. The donors prefer the government to regulate and cover the financial incentives.  

Confronted with the commercial exchanges, there is an attempt to respect some rules, for example, the donor and the recipient could be asked to declare in writing that no commercial transaction has taken place and, in the case the contrary is discovered, the surgeons can refuse to perform the operation. In fact, the situation appears contradictory. Out of 32 donors interviewed in a study, only one admitted having donated a kidney out of altruism, for the others there was
always a commercial dimension. Poverty is often considered the main cause of living-non-related- donor donation and organ trafficking in the country.\textsuperscript{792} 

Many have raised questions about the stated positive outcome resulting from the financial incentive program for living organ donors in Iran.\textsuperscript{793} Some report that there is no longer a waiting list of end-stage-renal patients while some assure the existence of such patients as well as underground organ brokering.\textsuperscript{794} Moreover, patients who are waiting for hearts, livers, and lungs are much less of concern than ones awaiting for kidneys because cadaveric program is overlooked by the government and public.

\textbf{2. Ethical justification for the application of the model in Iran}

Although religious leaders- Ayatollahs, have granted approval of both cardiac and brain dead criteria as well as postmortal organ donation, the potential, ample source of deceased organ donors are neglectedly utilized. Throughout the country, in 2006, deceased donor kidney transplants account for 5\% to 10\% of the total annual kidney transplants, much declined compared with the review of 10-year data from Shiraz shows that 38\% were from deceased donors. Also, only 15\% of kidney transplants are from living related donors.\textsuperscript{795} There are several reasons for such failure. First, better financial attraction by the policy for living unrelated organ donation has diverted public concern about becoming organ donors after death. Second, many families of the deceased find it hard to accept brain death because of the insufficient support from healthcare staff when the incident occurs; they fear for the misdiagnosis for their loved ones. Third, also most importantly, potential donors or their families feel underappreciated and less important than the living unrelated donors because the government do not grant any reimbursements or support for their donation.
On the other hand, living organ donation does not bring benefits to the donors as they expect. The first kidney transplant in Iran was performed in Shiraz in 1967. To accommodate the large number of patients with no living related donor, and owing to the lack of legislation for deceased donor kidney transplant, Iran instituted a government-funded compensated living unrelated kidney donation program in 1988. End stage of renal disease (ESRD) patients without living related donors will be on the waiting list for deceased donors for 6 months, then be referred to the charitable organization Dialysis and Transplant Patients Association (DATPA).796 On the other hand, potential donors also register with the DATPA and undergo evaluation in the foundation’s clinics. The kidney transplant candidates and their living non-related donors (LNRD) are referred by DATPA to the kidney transplant teams. DATPA receives no incentives for identifying or for referring the donor-patient pair to kidney transplantation (KT) teams. KT teams belong to university hospitals and all expenses are paid by the government. The LNRD receive a fixed award from the government (apprx. $1200) and 1 year of health insurance. The donor and recipient meet at DATPA before donation to negotiate the amount of supplemental “rewarding gift” (U$2300-U$4500). 797 The LNRD program has succeeded in increasing the number of KT's. Iran has one of the largest numbers of living donor transplantations. Despite the success, the system has definite flaws and limitations. The negative effect of this policy of paid donation has been proved in a recent study. About 40% of donors consider financial factors as the sole motives for donation. Most of the donors are facing financial hardship a few months before the decision of donation.798 Many of them admit that the reimbursement does not deserve the loss of their organs. Besides, black organ markets remain due to unregulated transactions between donors and sellers; making profits from the donated organs has become the goal of the donation. In fact, the compensation for organ donation has created more burdens to the
recipients. The recipient bears the major burden of payment rather than benefit from the donors because the paid rate of the organs have been competitive among recipients in order to receive the organ as soon as possible. 799

Under this circumstance, Iran would face the decrease in number of organ donors, which will worsen the current organ shortage in all needed organs: kidneys, lungs, livers, and hearts.

Applying the proposed model in making policy for organ donation in Iran potentially eliminates the current ethical issues and creates sustainable sources of donated organs by gaining back the public trust. According to the model, the sources of donated organs need to switch from living to deceased donors; the switching pace depends on the public response to educational campaigns and infrastructural establishment for deceased organ transplantation. In primary care settings, doctors are required to provide education about cardiac and brain death criteria as well as options to donate organs after death; afterwards, a valid consent should be obtained. Further information about procedures pertaining to organ transplantation will be provided to the patients if they are interested in organ donation. Regarding financial reimbursement, the government is the only body that decides the fixed amount, no additional amount is legally allowed. Yet, the paying party depends on the circumstances; it could be the individual who can afford, charity organization, etc, as long as the amount abides with the law.

The current policy for living unrelated donors violates the right of the weak and oppressed. Paying for donation leads to coercion and exploitation of the poor, and, in the end, produces more harm than good. Many have argued that payment helps the poor, and we should all have sovereignty over our bodies and, thus, should be allowed to donate for remuneration.800 This argument, however, is not relevant to the religious teaching which is the foundation of the national rules on most perspectives. The policy somewhat diverts the poor (the donors) and the
ill (the recipients) from the religious standards for sharing the thing (the organs) given by God, out of altruism, to help each other in the condition of no harm or severe harm to the donors.

Utilization of deceased donors not only correlates with religious teaching about the good deeds of donation but it also eliminates many existing ethical and social issues, such as adverse side effects of post-transplantation (physical and psychological impairments) and organ trades. Moreover, the monetary amount for appreciation that comes exclusively from the government also contributes to eliminate the exploitation, organ trafficking, and organ black market.

Since both physicians and religious leaders have approved brain death, it is likely to make the deceased organ donors become the only source for organ transplantation. Yet, it is necessary to establish an educational system via media campaigns, religious scholars, healthcare workers, and leaders of the society about organ donation and brain death criteria in order to raise public awareness and public trust in organ donation and brain death diagnosis.

From a healthcare professional perspective, this policy should not be a challenge since it does not cause the healthcare providers to compromise their professional and moral practice. They do not need to confront the conflict of interest, especially in public healthcare facilities because of the universal healthcare. Healthcare providers do not experience conflict of conscience because the healthcare system operates on Islamic laws and bioethics, which are shared between the healthcare staff and patients. The model ensures their practice in accordance with their stated religious duties.

In fact, with the existing financial-involved system, Iran would face less difficulty in an administrative aspect. Moreover, the policy would not encounter resistance toward financial involvement from the public. The public is familiar with the concept of compensation; in fact, it
is in favor of deceased organ donation for its meaning of appreciation for the deceased donors, which has been neglected in the current policy.

In Iran, a policy is likely to succeed if it is endorsed by the religious leaders—Ayatollahs, who determine the valid religious practice. When an issue is endorsed by the current Ayatollah, the public will accept the teaching from the Ayatollah and the issue will no longer be in extensive debates. It is an advantage of the Iranian religious system that public policy makers should deliberately consider. Religious leaders have an important role in creating awareness and disseminating information about organ donation.

Some obstacles should be overcome when applying the proposed model, such as more discussion to establish regulations in the private medical facilities, and improvement of primary care utilization.

III. Application for organ donation in Saudi Arabia

1. Current organ donation status in Saudi Arabia

In Saudi Arabia, transplants were approved by the Committee of the Senior Ulama on Aug 25, 1982. In addition, the majority approved transplantation from a corpse and from a living donor for the benefits of Muslims. In 1988, it is emphasized that the transplant of parts of the body that are renewed spontaneously (e.g. blood, skin) from one person to another as well as from a corpse is legal with the authorization of the donor, or, after his death, the consent of the close relatives. Despite the prohibition of paying compensation for the vital organs, there remains the possibility for the recipient to pay costs in order to obtain the vital organ or to pay compensation to the donor.

Accepted organ donation sources include living donors (both related and unrelated) and cadaveric donors (both cardiac and brain death). Among brain dead donors, the major causes
include non-traumatic cerebrovascular accident (CVA) and traumatic injuries due to motor vehicle accidents. 70 percent of the total donors are males. 803

According to the 2014 annual report of the Saudi Center for Organ Transplantation, among 570 potential deceased donors who are approached by the transplant team, 110 cases give consent to donate organs. Of these consented cases, 100 percent agree to donate livers and kidneys, 97 percent to donate heart, 60 percent to donate corneas, and 28 percent to donate bones. 804

The first kidney transplant from a living donor was performed in 1979 and the first deceased kidney transplant was in 1986 at Prince Sultan Military Medical Center. Since the first cases to the year of 2014, there have been 6,316 living kidneys transplant and 2,694 deceased kidney transplant operations. The first liver transplant was performed in 1990; up to 2014, there are 738 living and 790 deceased liver transplants. The first heart transplant took place in 1986 at Prince Sultan Military Hospital; from which to 2014, a total of 208 whole hearts and 602 hearts for valves are transplanted. From the first lung transplant in 1991 at King Fahd Hospital to 2014, a total 144 lung transplant operations are performed. 805

Despite the good intentions, the availability of organs from corpses remains low due to the scarce inclination of relatives to donate the organs of their deceased relatives to strangers. At the same time, there is greater willingness to be living-related donors (LRD) instead of signing a Donor Card authorizing transplantation from the corpse and this has the principal aim of protecting the relatives, in the name of the great value that the family maintains in the Saudi context. 806

There is a tendency in Saudi Arabia to refuse transplants from living non-related donors. In 1997, out of 171 kidney transplants from living donors, 161 were from LRD while the
remaining 10 were from the spouses (LNRD). Between 1998 and 1999, all 348 kidney
transplants from living donors were between blood relatives (LRD). In 2014, of the total 514
living donate kidneys, 91% kidneys are from related donors; and among 1596 donate livers from
1999 to 2014, 49% from the deceased, 46% from related living donors, and 4% from nonrelated
living donors. Such trend of organ donation has caused a severe imbalance between the
number of people in need of organs and the available donated organs. In turn, it renders the
phenomenon of organ tourism. Saudi citizens who need organs for their health condition have to
tavel to other countries in attempts to receive matching organs. The common destinations
include India, some European countries, United States, and China. In addition to the high cost for
the organs, transplant operation, and traveling, the recipients may also involve organ trafficking
without awareness. Infection is also a critical problem in organ tourism. Organ trafficking and
organ tourism create severe violation of human rights to both donors and recipients. Therefore, it
is of urgency to combat such phenomena. The awareness of such consequences needs to be
raised among recipients and their family members. Follow-up care for donors is necessary so that
their quality of life is not affected by their benevolence.

For living donors, donors receive lifetime follow-up care due to organ donation,
reimbursement for the absence from work due to surgery, other reimbursement, King Abdul Aziz
Medal, and discount for Saudi Airlines. In the cases that people want to donate their organs after
their death, explicit authorization for transplant is required, with the signature of a donor card. If
there is no signature of the donor, the consent of relatives is necessary. The importance of the
family in Saudi society means its consent is required to remove an organ from the deceased. Donation from a living individual requires free and informed consent by the donor. In Saudi
Arabia, most people are in favor of postmortual organ donation. What people are concerned about
organ donation include a good reputation, confidentiality, and body organ after death. The emotion and reputation of family as well as socially desirable behavior have strong impact on the decisions to donate organs after death. In several studies on public attitudes toward different types of consent, it is indicated that Saudi citizens prefer mandated choice to presumed consent. In their justification, organ donation is an altruistic act and presumed consent is not sufficient to represent their willingness or unwillingness to donate organs after death. 810

The disjointed condition between Islamic Jurisprudent scholars and medical experts has significantly adverse impact on the public attitude toward organ donation in Saudi Arabia.

2. Ethical justification for the application of the model in Saudi Arabia

In Saudi Arabia, every kind of donation is permissible, yet, the public expresses strong favor for cadaveric organ donation. The religious rules that the human being should always maintain his dignity even in disease and misfortune have been strictly followed in Saudi; the human body should be venerated likewise. Mutilation of humans or animals is not allowed; however, performing post-mortems or donating organs from a cadaver are not tantamount to mutilation of the corpse or an act of disrespect. The harm done, if any, by removing any organ from a corpse should be weighed against the benefit obtained, and the new life given to the recipient.811

Cadaveric organ transplantation is approved but there are not a lot of donations from the deceased. The reason of the refusal for deceased donation usually comes from the family members, who, in turn, often lack the cognition of the importance of organ donation and do not receive sufficient information of the approval by scholars for the cadaveric transplantation.

The policy that accept all kinds of organ donations with regard of the altruistic intention, the free will of the donors, and the harmless consequences to the donors seems to be an effective
model to guarantee all human rights, for donors and recipients, for Muslims and non-Muslims. However, the cooperation among Saudi Muslim scholars, governments, and medical teams may be not consistent and collaborative enough to provide sufficient information about the organ transplantation and donations to their citizens.

Similar to the case in Iran, a total shift to cadaveric organ donation would attract more public attention to organ donation as well as eliminate the issue of transplant tourism resulting from extremely low number of organ donors. Moreover, the application of the proposed model is more manageable in Saudi Arabia for its practice in accordance with the principle of public interest and the rule of consensus. Again, good cooperation between medical practitioners and Islamic jurists and theologians would better the public response to the policy.

The biggest obstacle that Saudi Arabia would face when implementing the new policy is to establish the financial system for the organ donors.

**Conclusion**

The applications of the proposed model in Iran and Saudi Arabia illustrate that the model could be effectively applied in different cultural and healthcare system backgrounds. In Islamic countries, bioethics is unlikely separable from religion, which, in turn, brings conformity along while many other countries have plural characteristics. Subsequently, it is less obstructive for Islamic countries to reach a consensus solution than other societies where solutions are derived from multiple ideological positions, which, in turn, create various interpretations for one matters.812

Although both countries utilize the source of living organ donors, the reasons that the public engages to the donation and the extension to agreement are much distinctive. In Iran, living organ donors prevail in organ transplantation practice since the donors are drawn to the
financial attraction by the government and freedom of naming the prices for their donated organs; whereas, the government expresses no support for the postmortal organ source. On the other hand, in Saudi Arabia, living related donors are the most common source; the public hesitate to become either living or deceased donors due to the absence of endorsement and encouragement from religious leaders in regard to organ donation. Using living donors raises more controversies than the deceased ones. The most important point is that no harm, caused by oneself or others, would happen to the donors; otherwise, the act would be considered as homicide or suicide, both of which are considered among the most detestable crimes in Islam. The donation of an organ whose loss would usually cause no harm, or a minimal increased risk to the health or life of the donor, is acceptable if the benefit to the recipient is greater than the harm. The harm done by the disease, which can kill a human life, is not to be compared with the harm incurred by donation.

Both countries should move toward the source of deceased organ donors as soon as possible in order to eliminate current ethical issues, gain and maintain public trust, as well as become self-efficient as recommended by WHO on the matter of organ donation.

Improvement in communication and incorporation among healthcare professionals, religious leaders, and the public would warrant the effectiveness in applying the proposed model in the two countries.

The patient or family must clearly understand the medical situation. Persistent requests based on deeply held religious beliefs should most often be honored. Such requests should be justified based upon thorough and compassionate discussion of religious beliefs. The two factors of religion and medicine should be integrated in responding to the request, so that the patients’
best interest, including their belief about the meaning of life and death becomes the center of the ultimate decision.814

For Muslim patients, in addition to the scientific aspect, physicians must take religious norms into consideration for the medical judgment, thereby determining the appropriateness or inappropriateness of the treatment. Religious values are more intrinsic than the other shared values because they deal with the very meaning of life.

When all parties get involved in joint decision making, problems in communication would be eliminated; as a result, competent care would be provided for the patient. Joint decision making is a helpful means for patients, family, and healthcare providers reach agreement on the method of relieving suffering and/or improving the quality of life for the patient.815

It is noteworthy that even though the source of normative life is based upon Shariah, the justification of an action requires another factor for the moral deliberation, that is particular human conditions which affect the way a person justifies an action as moral. In view of the normative Islamic tradition for standards of conduct and character, Muslim scholars must have recognized the importance of decisions derived from specific human conditions as an equally valid source for social ethics in Islam as the scriptural sources such as the Qur’an and the sunnah, which prescribe many rules of law and morality for the community.816
Chapter Eight: Summary and Suggestions

The dissertation discusses the current practice of organ donation and transplantation around the world. Comparing and contrasting the utilizations of living and deceased organ donors as well as the current and proposed policies bring forth the benefits of post-mortal organ donation and the suggestion of a model consisting of the three components- altruism, human dignity, and autonomy. The proposed model aims at obtaining and maintaining public trust so that a sustainable source of organ donation is achieved. In the model, altruism should come from all the involved parties, yet by distinguishing acts corresponding to each party’s ability. It is the original perception of donation: a voluntary act as one’s ability at will. The donor donates his/her organs upon death, healthcare team members donate their skills and care, the hospital administration donates skills and effort to find a match between the donor organs and the people in need. As every involved side is willing to work at will and/or free of charge, the cost of a transplantation case would significantly decrease. The ultimate fee would not be a concern for the party who covers all the transplantation procedure, either the organ recipients, organizations, the government, or the insurance companies.

I. The skeptical outlook of the current policies for organ donation

Organ scarcity and shortage remain unavoidable due to the growth of people who are waiting for transplantation. The demands for organ transplants have increased because transplants is worth having; for instance, kidney transplantation brings patients with end-stage-renal disease chances to improve quality of life, be free from dialysis, be able to return to work, and improve strength and energy. In addition to the improved post-transplant outcomes, advances in pharmacy, technology, medical knowledge and skills, aging populations, and rising morbidities have caused shortfall in supply for organ transplantation. 817
To deal with organ shortage, several policies have been introduced throughout the world. Some policies have failed to improve the shortage condition, such as required request policies. Some other policies have brought positive effects to the organ shortage by the increasing number of donated organs, yet they do not guarantee a sustainable future for organ donation, such as presumed consent or regulated organ market. The operation of such policies have raised many ethical implications from its manipulating or placing coercion on the public, imposing consent on ones who lack means to access to the policy information; and exploiting financially, emotionally, or altruistically. They violate human dignity, deprive individual autonomy, and infringe human rights. The subsequent public resistance to these policies is inevitable.

II. Postmortal organ donors as a sustainable source of donated organs

Living organ donors are a less recommended source because this creates numerous ethical problems. The exploitation of living donors, who are either financially vulnerable or emotionally vulnerable, is much likely and complicated. Medical consequences to the health of living organ donors include risks due to surgery, effects of nephrectomy on glomerular filtration rate, risk of mortality, chronic kidney disease, proteinuria, and hypertension. After nephrectomy, the remaining kidney increases the renal plasma flow to adapt its new function. Harmful outcomes for the living kidney donors are limited and worsen with the age of the donors. For this point, many people conclude that living organ donation is safe. The concerns of surgical risk and poor health after donation are the significant factors influencing the willingness to donate live organs. The mortality and morbidity risks for living donors do exist even at a very low probability.

After the procurement, living donors may experience some changes in their health conditions, but these effects would be easily resolved with changes of lifestyles and medical
assistance. The suggestions for lifestyle adjustment and attending medical care after donating organs are feasible in certain cases, such as when the living donors’ living standards are well or better, when the income or job will not be affected by these changes, when they have appropriate healthcare access, and when no one depends financially on the donors. Such cases often occur when the donors are living related donors. As a matter of fact, in the organ market operation, most of the cases are often unrelated donors who give their organs for their financial needs. The transaction is only a temporary correction for their financial hardship. The money from their organs would not be large enough for these donors to work less or have breaks from work, to support their dependants for life, or to have access to healthcare in readiness.

Why are healthcare professionals involved in transplantation between living people? Healthcare professionals who involve in transplantation between living people justify their practice by saying that they advocate for their own patients who are the ill and they are not organ and moral police who investigate the origins of the donated organs and the donors’ motivations; besides the outcomes of the living transplantation are better than of the deceased. This justification shows nothing but a practice without medical ethics, except for the benefit of the organ recipients. The human dignity of the donors is neglected as they are not treated and cared as equally as the recipients are. Loss of trust in healthcare providers likely occurs. With respect to the post-transplant outcomes, it is pointed out that the delayed screening and procurement are the causes of the poor outcomes. Better communication and patient education campaigns provide patients the importance of timely procurement to avoid or shorten the warm ischemic time, ensuring the viability of the donate organs. Also, the sooner the valid consent to donate is obtained, the more appropriate and systemic pre-transplant screening is. Moreover, the gratitude
compensation in the future would encourage the donors to maintain their health and lifestyle so that their beneficiary would receive the granted amount after the organ procurement.

_Altruism:_ Living organ donors bring up controversies and distract the discussion from the necessity to raise public awareness of their significant role as potential postmortal organ sources. In living organ donation, possible skepticism about the legitimacy of altruism is not uncommon, either with or without financial involvement. On the other hand, the potential deceased donors are given the chance to act out of altruism and even to extend their altruism to more parties.

_Autonomy:_ Living donors may choose to donate but the coercion or manipulation of the donated acts present in so many forms, either by individuals, government, or community, that it is improbable to recognize or prevent. Whereas, before the future donors give consent to donate organs after death, they have received adequate information pertaining to organ donation as well as a sufficient amount of time to make deliberate decisions by themselves or with loved ones if necessary. They can access and learn about the most confusing matters- the criteria of death and the procedure to pronounce death, which are also the biggest obstacles that prevent potential donors or families from conceding to donate. The decisions to donate here are a thorough process with discussion and professional assistance, rather than a merely quick Q-A questionnaire and a signature.

_Human dignity:_ Living organ donation brings forth concerns about human dignity at every level of arguments- individual, social, and humanity levels. On the contrary, the source of deceased donors holds out arguments that can be resolved by communication among involved and concerned parties.
III. An approach to gain and maintain public trust

Organ shortage and organ donation should be recognized and approached as a public health issue. To effectively introduce the policies that are based on the proposed model to the public, it is important to have a relevant approach to the public. To approach ethical issues in public health, several well-known approaches have been widely discussed so that policy makers can choose the best-fit one for particular public and issues. They are utilitarianism, liberalism, paternalism and communitarianism. Utilitarianism asserts that decisions should be judged by their consequences, in particular by population benefits. Liberalism focuses on rights and opportunities for individuals. Paternalism enforces individuals to give up their preference to achieve benefits for the community. Communitarianism involves appropriate social orders and the virtues that will maintain such an order in a particular community. 824

In the particular case of organ donation, the goal of public health is to maximize public welfare, lessen and eliminate inequalities, reduce and remove harms, and allay the tension between individual liberty and community benefit.825 Any theory attempting to weigh and balance the population and individual interests would be the best theory that can be applied in moral justifications in public health.826 Human rights and ethics scholars endorse public health strategies that aim to balance individual and community rights, maintaining that public health interventions that protect human rights also achieve population health.827

Utilitarianism: Utilitarianism emphasizes the greatest good for the greatest number. The utilitarian approach is not adequate in organ donation for its morally unjustified preferences among individuals. 828 Utilitarianism is an impartial method because it disregards differences and preferences. Any means would be approved as long as it creates the maximal social welfare, even if individual rights have to be sacrificed for the social benefits.
In organ donation, nonetheless, the utilitarian approach provides no protection for individual rights, risking the wellbeing of the vulnerable and minority (e.g. the poor, people with mental impairments, patients in coma, patients in persistent vegetative state, anencephalic newborns, or other disabled people) to benefit the major public. 829 Another situation is for posthumous people who consented to donate their organs or tissues but the healthcare practitioners have to act according to the family’s wishes that are against the donors’ wishes. For the public interest, or from the utilitarianism perspective, it is ethical not to obtain consent. This argument is justified for the organ conscription. However, the contention is unjustified because public interest should not be fulfilled at cost of public trust, autonomy, and human dignity. 830

Utilitarianism-based policies of organ donation should be against, because they aim at the reduction in death tolls of awaiting organ recipients rather than avoidance of harm to the donors. 831 Such policies include using living organ donors or presumed consent. Applying the approach of utilitarianism creates more vulnerable parties who are considered to benefit the others. The approach does not eliminate the dilemma between individual rights and public benefits and augments the inequalities. 832

Libertarianism: The libertarian approach grants the highest freedom and rights to individuals. As long as the person does not intrude others’ rights, he can practice full autonomy without concern of his community. Individual freedom guarantees just distribution of burdens and benefits in the society. 833

Advocates for this approach argue that the community is composed of individuals, so overall individual benefits will compose the social benefits. However, the operation of this approach diverges the community as it places individual roles and benefits in the center of the issues. Besides, more conflicts will be subsequent results as every person aims to achieve
different benefits. In general, libertarianism is not a good choice to apply in public health ethics because it prioritizes the individual benefits, which is on an opposite path to the goal of bringing benefits to the communities.\textsuperscript{834}

In the scenario of organ donation, libertarianism justifies and supports the existence of organ markets and the idea of commodification of organs. As a result, it does not provide any solution to the organ shortage and donation; it turns society into one that is disordered; it turns the organ donation system to be monetary-oriented rather than altruistic-based; it creates social injustice; and it causes serious ethical problems that violates human dignity.\textsuperscript{835} Moreover, it places individuals out of the community, creating unbalance between individuals and public.

\textit{Paternalism:} The paternalistic approach applies coercion on individuals in order to modify their individualistic mind and behavior providing that they prioritize individual rights over protecting the third parties. Coercion can be in the legal form or moral form. \textsuperscript{836}

A prevalent application of paternalism in public health promotion is that when the government, within their rights, has made policies or laws to minimize the detrimental impact by population behavior modifications. \textsuperscript{837} In this way, there should not be any controversies around individual freedom issues but the target of protecting communal health is of assurance. There are some examples of justified practices of paternalism in public health. For instance, instead of removing snacks vending machines at schools, the United Kingdom government has banned unhealthy foods; or, to prevent people from adverse effects, such as diseases and economic burden, caused by smoking, governments have taxed up cigarettes.\textsuperscript{838} By this way, people would voluntarily choose to give up their preference, besides, the government assures the respect for individual freedom, autonomy and right to self-determination. \textsuperscript{839} Another example is when the public experiences a pandemic. It is an emergent situation that requires the authority to take
immediate actions to protect the public by overriding any individual rights and values that could endanger the public.

The issues of organ shortage and donation should avoid this approach. The issues require time to gain and maintain public trust that is the foremost factor for the success of organ donation policies. The coercion in paternalism for organ donation policies, in fact, will cause long-term adverse effects on the public welfare.

Above all, paternalism is a sensitive theory to be used in a policy making process. It is more likely to encounter objections than liberalism and utilitarianism. Probably, there is a political involvement that leads to an ethical dilemma: whether the policies are indeed in the interests of the third parties or are merely excuses for power fulfillment among legislators. Although the policies aiming to modify social behaviors may be justified in some particular issues, they may create unfairness when extendedly applied. When application is extent to intervene individual lifestyle that is more likely to cause harm to them (voluntary self-destruction) rather than to other people.

Communitarianism: Among all, communitarianism seems to be the most equitable to public health ethics practice. The theory has centered on the communal health protection and promotion without interference with individual freedom because it conforms to the social and cultural traditions that impact on behaviors and thoughts of individuals within the community. To avoid the complexity of adapting liberalism that requires the mutual presences of utilitarianism and government, as well as the possibility of paternalistic involvement, communitarian theory seems to be the best theory within public health.

Communitarianism includes a wider set of substantive philosophical positions than liberalism and utilitarianism, since there are many different views about what constitutes
individual and social virtues. A basic question in communitarianism is who decides what is virtuous.

There is an important distinction between relativistic and universalistic communitarianism. From relativistic communitarianism perspective, every community defines its own norms. Relativism contends that there are different norms among communities whilst universalistic communitarianism assumes that there is a single norm for every society. Relativists argue for respecting each society’s particular cultural traditions. Universalistic communitarians, by contrast, believe in a single true form of good society and its associated virtues. This approach appears in public health as the belief that certain behaviors, such as not smoking in public should be promoted in all societies, regardless of local cultural norms. Such policies can be justified by their health consequences or as a matter of rights. For example, when can people with certain religious beliefs limit their children’s access to life-saving medical care for religious reasons?

Public health professionals who want to use communitarian ideas must resolve the definition and justification of their vision of the good community. Ethical analysis can help this process by highlighting what is assumes and implied in various communitarian positions, and their relation to utilitarian and liberal perspectives. The ethical judgments will depend upon culture and history. Government should not coerce people or restrict their freedom unnecessarily and to provide the conditions under which people can live healthy lives.

In organ donation, the specifications make the communitarian approach appropriate for both secular and religious perspectives, for both cultural pluralism or non-pluralism societies. The campaigns to call for public awareness of organ donation can be customized according to the communal norms or virtues by applying social and cultural traditions of particular community while maintaining the individual roles of the community members.
Expansion of the organ donor pool requires the incorporation of educational initiatives, public policies, and clinical protocols. Transparency, education, and communication will overcome the barriers of the cultural differences, especially in the era of cultural pluralism in medical settings. Understanding cultural expectations can predict and acknowledge other people’s preferences and perceptions.

Principles and moral standards serve as tools in assisting healthcare professionals in analyzing the ethical dilemmas in particular issues in death and dying, organ transplants, and consent. For example, beneficence, non-maleficence, justice, respect for autonomy, fidelity, veracity, and avoidance of killing in medical practice.

The proposed model could be applied in different backgrounds, in either sacred or secular contexts. Ethical viewpoints of sacred and secular ethics present differences, which, in turn, often lead to contradictory positions in bioethics, such as the brain death matter.

Distributive justice plays an important role in organ donation. Unfair systems could cause public reluctance to participate in the public issue. A just health care system is the system that succeeds in protecting everyone’s health. In order to obtain justice, it is required for setting such limits in a fair procedure with public accountability, a healthcare system provides everyone accessibility to healthcare upon their needs, not depending upon their financial status. The inevitability of limited resources does not justify the unfairness of the system. In fact, unfair distribution is caused by the inefficiency of the system; thus, we should seek for and work on any resolution that makes the system work efficiently. 840

Founding a just health care provision in confrontation with such economic changes should be the new roles of physicians, patients, and other parties. In addition to the traditional duties of professional competence, compassion, and honesty, physicians have new duties,
including economic advocacy, economic disclosure, and a scrutiny of the economic structures and institutions with which they affiliate. On the other hand, patients must have responsibilities for their choices for medical decisions, lifestyle, and health care coverage. Physicians, with obligations to individual patient and to the society, are able to help the patients to actively make their own decisions over medical treatments. The significant assisting roles of physicians who may apply their professional competence, knowledge, and morality to help their patients to make sufficiently informed decisions. Though physicians must seriously dedicate themselves to their patients, physicians do not need to make unreasonable personal sacrifices.
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