8. Unspecified Living Organ Donation
A Challenge to the Duty to 'First Do No Harm'

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1. Introduction

In this chapter, we will discuss ethical issues associated with unspecified living organ donation. We start by providing some background information about the practice, and explaining how it differs from other forms of donation. We then focus in detail on how the medical ethical principle of 'first do no harm' operates within this context, and consider whether unspecified living organ donation falls foul of this principle. In the final section, we explore whether, given the preceding discussion, facilitating unspecified living organ donation is broadly consistent with the aims and values of the medical profession.

2. Background

Most living organ donations occur within the context of existing relationships, normally between family members or close friends (see also chapter 7 in this book). In the early days of transplantation, there was little option but to use family members, as close genetic relatedness was required in order for transplants to be successful. Subsequent developments have, however, reduced the need for this, thereby expanding the pool of potential donors for any recipient. In the majority of living donations, the recipient is specified by the donor: the whole point of the donation is that the organ goes to this specific recipient, who the donor particularly wants to help. In recent years, however, there has been a significant number of *un*specified living donors. These are people who are motivated to help someone in need of the organ[1] they are willing to donate, but they do not choose or specify who this is. For this reason, this type of donation has also been known variously as 'altruistic', 'Samaritan' or 'stranger' donation but can be referred to more precisely as non-directed altruistic or unspecified living donation. We will use the term 'unspecified donation' going forward, as this appears to be the current preferred terminology (Dor et al. 2011). In principle, living donation

1 We refer to 'organ' throughout, but this should be taken to include 'partial organ', as living donors can also donate part of their liver or lung.

– and therefore unspecified donation – could include the survivable donation of any organ: single kidney, liver lobe, lung lobe, uterus and even a testicle or ovary. The latter two options raise particular ethical and legal issues with respect to genetic relatedness and procreation and are still experimental so we will not discuss them further in this chapter. We will also not discuss blood, skin and other tissue donation.

2.1 What Can Be Donated?

The most common living donation is donation of a single kidney. This is perhaps because it is regarded as a relatively low risk procedure and a near normal level of renal function can be achieved for the donor with their single remaining kidney. Additionally, kidney patients make up the majority of transplant waiting lists so demand is high. Although donating a kidney is considered to be low risk in medical terms, the process does involve some negative effects for the donor. The risk of death as a consequence of donating a kidney is approximately 3 in 10.000 (Lentine/Patel 2012), and around three per cent of donors experience major perioperative complications (Lentine et al. 2019). Although it used to be thought that donating a kidney did not increase a donor's risk of developing end stage kidney disease themselves, recent and more nuanced analysis has suggested that donating a kidney is linked to a small but significant increase in risk of developing end stage kidney disease later in life (Mjøen et al. 2014; Muzaale et al. 2014). Although all of these risks are relatively low and broadly considered to be within the realms of acceptability according to the transplant community, they are nonetheless risks that the person would not have faced but for their donation.

Numbers of unspecified donors are much lower than other types of living donor. In the United Kingdom in 2018–2019, there were 62 unspecified kidney donations (compared to 872 specified living donations) (NHS Blood and Transplant 2019: 2). Although kidneys are the most common organ donated via living donation, other organs can potentially be donated. Living liver donation is rarer than kidney donation, and entails the complete removal of one of the liver lobes – usually the smaller, left lobe. Although the liver is a remarkable organ, capable of significant regeneration, living donation of a liver lobe is a much more serious and risky procedure than kidney donation. Risk of donor mortality following liver donation ranges from 1 in 250 to 1 in 500 (Winder/Fontana 2019), and there is a 15–25 per cent risk of complications, which is even higher if the donation is adult-to-adult (approximately 40 per cent) (Dew et al. 2016). Donors can expect significant postoperative pain (Winder/Fontana 2019), and around a third of living liver donors report "lingering physical symptoms" (Dew et al. 2016: 881): despite this, few donors regret donating. Donation of a liver lobe can therefore come at a higher cost than kidney donation, but is still permitted via unspecified donation. Costlier still is the donation of a lung lobe, which occurs only very rarely and requires two donors, one giving the lower right lobe and the other the lower left lobe. No deaths have occurred in recent studies examining the risks of these donations, although risk of complications was fairly high. 19.8 per cent of donors in one study experienced complications (Bowdish et al. 2004), while another study found the risk of serious complications to be around 18 per cent (Yusen et al. 2014). Because lungs are not regenerative organs, lung capacity is permanently lost: one study suggests that the loss may not be as great as anticipated, with donors recovering around 90 per cent of their pre-donation lung function (Chen et al. 2011). We are not aware of any unspecified lung donors. Living

uterus donation forms the backbone of the uterus transplant research programme in Sweden (Brännström 2015; see also chapter 15 in this book). This arguably represents a significant extension of living donation practice, as the main aim of uterus donation is not to extend life or restore health as such, but rather to enable the recipient to experience pregnancy. Here, although the surgery is more complex and takes longer, the risks to the donor are similar to those associated with a radical hysterectomy, which include haemorrhage, infections of the wound site, pelvis and urinary tract, as well as potential for bladder or intestinal injury (Kisu et al. 2013).

2.2 Legal and Regulatory Context

The practice of living donation is widely considered to be acceptable, and norms such as the requirement of freely given informed consent, screening for physical or psychosocial contraindications, and availability of long-term medical follow-up are well established parts of the ethical and regulatory framework (Ethics Committee of the Transplantation Society 2004: 491; Council of Europe Committee of Ministers 2008). Despite widespread acceptance of living donation, unspecified donation appears to be less well accommodated. Although many European countries (including Spain, Italy, and Austria, for examples) do not place restrictions on the types of relationships between donor/recipient that render living donation permissible, thereby potentially permitting unspecified donation, such donations are performed rarely (Lopp 2013). The United Kingdom and The Netherlands, along with the United States of America, are responsible for the majority of unspecified living donations world-wide (if trade in living-donor organs (legal and illegal) is excluded.[2] In this chapter, we will refer to unspecified donation within the context of the system we understand best, namely that operating in England within the *National Health Service* (NHS). The UK is comprised of several devolved and partly autonomous governments. Legislation, particularly in relation to organ donation and transplantation differs slightly between these regions. Organ donation and transplantation in England is governed by the *Human Tissue Act 2004*. These practices are regulated by the *Human Tissue Authority* with services run by *NHS Blood and Transplant* (NHSBT) and delivered in local NHS Trusts (one or more hospitals under a single administration).

Living organ donation is legal in England if the conditions imposed by the Human Tissue Act are met, otherwise it is an offense (which covers both the removal and use of organs) that is punishable by imprisonment and fines. These legal requirements are that the donor must give written and signed consent (witnessed by one person) and thus must have capacity to consent, and must not receive/solicit any reward. The regulator requires all living donors to be independently counselled prior to donation, by personnel it trains, in order to be satisfied that these conditions have been met, and that the donor has capacity, properly understands the procedure and its associated risks and consequences, and is not being coerced or otherwise pressured into donating. Until fairly recently, the regulator also required unspecified living donors to receive an independent mental health assessment. Although this formal requirement has been dropped, the British Transplantation Society and NHSBT both recommend that psychological testing continues (British Transplantation Society 2018: 43). These

2 Iran is the only country that permits organ sales, and has a centrally organised system to facilitate this.

'screening' processes are in addition to careful medical screening, the aim of which is to ensure that the donor is able to withstand surgery and is at an acceptably low risk of both short and longer term negative outcomes of donation.

Not only is unspecified living donation legal in the UK, one of the goals of NHSBT is to increase the numbers of those donating kidneys in this way (NHSBT 2014: 3). This has been echoed by recommendations from the *Ethical, Legal and Psychosocial Aspects of Transplantation* (ELPAT) group of the European Society of Transplantation (Burnapp et al. 2019). The benefits of unspecified donations go beyond just the number of organs from unspecified donors. Such donations can also be used to commence chains of donations and transplants via paired/pooled donations, and this is now the preferred use for unspecified living kidney donation in the UK. Chains occur when someone needing a transplant has identified someone who would be willing to donate to them, but their chosen donor is not a suitable match for them. If other donor/recipient pairs are in similar positions, it can be possible to organise things so that the donor from Pair one donates to a recipient in Pair two, and the donor in Pair two donates to a recipient in Pair three and so on. Long chains of donors and recipients can be created, but they sometimes require the introduction of a single unspecified donation to kick-start this process. A single unspecified donation can therefore make many more transplants possible. Despite this, those involved in the delivery of transplant services seem to have mixed views about the ethical acceptability of unspecified donation, which clearly remains controversial as far as much of Europe is concerned. We will now explore some of the ethical challenges presented by unspecified living donation and consider why the practice has not been universally embraced.

3. Ethical Challenges Raised by Unspecified Living Donation

3.1 First Do No Harm

It is often said that the first principle of medical ethics is '*primum non nocere*' – first do no harm (see also chapter 7 in this book). Although the precise interpretation of this principle is open to debate, it is clearly reasonable to think that doctors should try to avoid harming their patients. All forms of living donation superficially appear to contravene this principle, since donation entails invasive surgery and the loss of a healthy body part. Obviously, many forms of surgery entail similar harms and the risk of further harm: at the very least, invasive surgery involves the risks associated with anaesthetic, and recovery is likely to entail pain, however well managed, and analgesics also have side-effects. 'First do no harm' is, however, not regarded as an absolute principle, rather it is a *prima facie* obligation that must be weighed against other relevant considerations. Ordinarily, the harms of surgery are thought to be outweighed by the anticipated benefits of surgery when it is performed in response to disease or other abnormality. Removing a tumour, for example, can present complex risks and harms for a patient, but by the end of the surgery the tumour will hopefully have been successfully removed thereby alleviating risks of other harms. The harms of surgery are therefore regarded as unavoidable side-effects that are necessary to achieve the intended benefit for the patient. In normal practice, potential side-effects are balanced against anticipated benefits and provided the benefits outweigh the harms, 'first

do no harm' is not regarded as compromised because it would be more harmful for the patient if no action were taken.

3.2 First Do No Harm and Specified Living Donation

In the case of living donation, a similar approach to justifying the process has been applied, but is made more complex in light of a fundamental but uncomfortable truth: there is no clinical reason to operate on a healthy living person and remove a healthy organ from their body (see also chapter 7 in this book). In order to justify living donation, the outweighing benefits to the donor therefore must be defined somewhat differently, and more broadly, to include benefits that could arguably be considered non-medical (where 'medical' is defined in a fairly narrow sense). In the case of living-related donation, some benefits to the *recipient* (e.g. extended life or quality of life) are thought to also accrue to the donor by virtue of their relationship with the recipient: the donor's life is improved by having their family member or friend return to better health. The closer the relationship, the greater these benefits are thought to be, particularly if the recipient is in peril. In a more formal sense, the interests of the recipient are entangled with the interests of the donor, so furthering the former also serves to further the latter. 'First do no harm' is satisfied if we assume that the donor arguably faces a *greater* harm if the donation does not proceed (e.g. the significant distress caused by bereavement or the shared distress of the intended recipient's highly constrained life). Insisting on a favourable balance of harms and benefits sets some limits on what is acceptable: for instance, no matter the pain resulting from the death of a child, a parent would not be permitted to donate their heart to save that child's life. Equally, and perhaps more realistically, a parent is unlikely to be accepted as a living kidney donor more than once (although some have argued that this should be accepted (Bailey/Huxtable 2016), though a parent has in the past donated both a kidney and a liver lobe. Medical screening of potential donors is used to assess the potential risks/harms, and where more than one person volunteers the least risky donor may be preferred, other things being equal.

Although it seems entirely reasonable to think that donors obtain benefit from donating to relatives or friends, quantitative evidence for nonmedical benefits that outweigh known harms and projected risks is somewhat elusive. Maple et al. (2017) found no improvement in psychosocial outcomes post donation, leading them to acknowledge that they were not able to demonstrate measurable benefit (twelve months post-surgery), even though the majority of respondents still felt positively about their donation. Maple et al. conclude, that although there was no measurable benefit, the unchanged outcome scores suggested that respondents were, at least, not harmed; 10.7 per cent are, however reported as regretting the decision. Other research has suggested that quality of life decreased following living kidney donation (Chien et al. 2010), and another study highlights the emotional cost of donation (Smith et al. 2004). Evidence of this nature could suggest that the benefits to donors from living donation are overstated, or alternatively perhaps that the qualitative benefits that are frequently described by donors are just difficult to capture quantitatively using existing survey tools.

It is worth noting that the factoring of psychosocial benefits into risk/benefit calculations has occurred somewhat inconsistently over the history of transplantation.

For instance, Van Pilsum Rasmussen et al. state that "[f]rom its outset, the transplant community has dismissed any potential benefits to the donor in live donor transplantation" (2017: 2567), and altruism (understood broadly as being motivated to act by a selfless desire to help others) has always played a central role in justifying donation practice. There are now, however, increasing moves to expand consideration of richer accounts of benefits (ibid) (and the avoidance of other harms (Allen et al. 2014)). Although precisely specifying and measuring these broader benefits (and avoidance of counterfactual harms) may be challenging, for our purposes here, we need only posit that in some cases where donor and recipient are in a close relationship, the donor is likely to accrue some meaningful benefit from their donation, and that this can outweigh the downsides of donation and thereby justify the process.[3]

3.3 First Do No Harm and Unspecified Living Donation

Unspecified living donation poses a greater challenge to 'first do no harm' because the donor and recipient have no existing relationship through which the recipient benefits may be shared. Given the ordinarily anonymous nature of unspecified donation, no future relationship is anticipated. Even if the harms to the donor are outweighed by the benefits to the recipient, the donor is physically harmed without deriving any obvious physical or recipient-originating benefit themselves. In the early days of unspecified donation, the lack of obvious benefit prompted speculation about the motivations or mental health of those who wanted to become unspecified donors. Given that donating an organ comes at a physical cost involving discomfort, pain and risk, some people thought that a willingness to go through this process for little or no benefit to oneself was more likely to indicate personality disorders or more worrying motivations than a purely altruistic disposition. Research on the motivations of unspecified donors has made clear that these concerns were largely misplaced, however, and that some people do simply want to help others who are in dire need (Clarke et al. 2013).

There are two ways that the issue of 'first do no harm' could be addressed in the context of unspecified donation:

i. Include consideration of other benefits into the calculations of risks/benefit, to produce a favourable balance.
ii. Accept that unspecified donation does cause some harm to the donor, but that this is normally an acceptable level of harm that an autonomous person can voluntarily consent to, and that frustrating a person's autonomous wishes can itself cause harm.

3.4 Including Other Considerations in Risk/Benefit Calculations

In order to justify unspecified donation, the notion of benefit could perhaps be extended to include some kind of specific but abstract moral benefit that accrues to the donor for, at some personal cost, doing a good deed for the recipient. Although it

3 There is further debate about whether donors must themselves receive overall benefit in order to living donation to be justified, or whether it is sufficient for donor and recipient benefit to outweigh harms when combined (Williams 2018: 11).

is no longer the preferred terminology, unspecified donation was for a long period of time also known as 'altruistic donation'. Altruism is an elusive concept to pin down with precision philosophically and is used inconsistently in relation to organ donation (Moorlock et al. 2014), but within this context can be understood to broadly mean being motivated by the interests of others to act selflessly. Performing altruistic acts is generally considered to be a good and praiseworthy thing to do, and this seems especially true when that act is potentially life-saving. We normally laud altruistic life-saving acts as heroic, especially when there is a cost to the agent or significant risks involved, and living organ donation would seem to fall into this category. The argument here must go that acting heroically, or more generally altruistically, is either intrinsically beneficial to the agent (it is intrinsically good *for* that agent to do good things), and/or that it results in some psychological 'warm glow' that is instrumentally good for the agent. An obvious issue arises here though: if acting altruistically is considered to be of benefit to an agent, especially if the permissibility or possibility of the action hinges upon the existence of this benefit, then one may wonder whether the action is really correctly characterised as altruistic since the agent stands to foreseeably benefit from it. It is also difficult to see how evidence for this type of benefit can be collected because it is challenging to imagine how it can be isolated and measured or a reliable proxy measure identified. Moreover, it is very difficult to see how abstract 'moral benefit' could be weighed against physical harm. In terms of less abstract benefits, one study found similar post-operative psychosocial measures for specified and unspecified living kidney donors, and that both groups felt good about themselves, though neither reported any increase in their sense of self-esteem, and levels of regret were also similar (Maple et al. 2014). Given that there is actually little evidence to suggest measurable benefit to specified donors, the lack of difference in post-operative psychosocial measures between specified and unspecified donors could merely suggest that measurable benefit for unspecified donors is also questionable. On a theoretical level, moreover, to outweigh the harms incurred, account also needs to be taken of other ways of doing good (deriving similar benefit) that would not generate these harms. In normal medical treatment, if one treatment option offered a more favourable balance of risks and benefits than another, other things being equal, the option with the more favourable balance should be preferred. And just as there may be more than one way to treat a medical condition, there are other ways to be altruistic. Relatively small donations to carefully selected charities can accrue significant benefit to others, which might allow a person to achieve the 'warm glow' of acting altruistically without having to undergo significant surgery. The harms, in this respect, are not unavoidable side-effects of virtuous behaviour in general, but rather just of this virtuous act of kidney donation in particular. It has been suggested elsewhere that excessive altruism should not necessarily be considered virtuous, and that it may be better characterised as intrinsically bad in some situations of organ donation (Saunders 2018). A further issue with reliance on altruism to do work in justifying the acceptability of unspecified donation is that people's motivations for wishing to donate may be multi-faceted and complex. Determining with confidence whether someone is truly motivated by altruism or, for example, narcissism is likely to be extremely difficult, even with the latest approaches to screening of potential donors.

3.5 Adding in Autonomy

Although abstract moral benefit, and the notion of related psychosocial benefit, are sometimes cited as reasons to permit unspecified donation, the real justificatory force increasingly appears to be grounded in respect for autonomy: it has been noted that unspecified donation is very much a 'donor-driven' process (Burnapp et al. 2019), and that if someone comes forward wanting to donate, it could be wrong to stand in their way. Ross states the autonomy argument clearly: "[i]f a competent adult seeks to act altruistically and offers to donate a solid organ unconditionally, and the adult understands the risk and benefits of the procedure, and voluntarily consents to the procurement, then his or her wishes should be respected" (2002: 441). The challenge to 'first do no harm' tends to be met by including donor autonomy in the balance of harms and benefits. According to this justification, the decision as to whether the harms incurred are outweighed by the benefits is one for the donor to make, and blocking an autonomous person's wishes is *itself* harmful, insofar as it prevents them from living their life in the way that they determine to be best for them. Liberal societies generally accept and respect different conceptions of the good life, and donating a kidney does not seem objectionable in this respect. Autonomy is engaged by claiming that placing obstacles in the way of the donor – like adhering too closely to 'first do no harm' – is excessively paternalistic and assumes that the doctor is in a better position than the autonomous donor to judge what is best for that donor. This kind of argument includes within the understanding of 'first do no harm' the harm of frustrating autonomy. The implication of this assumption is that something *prima facie* harmful can be, on balance, good for somebody, by virtue of them wanting it, if this is compared with the counterfactual and allegedly harmful scenario of ignoring their wishes. This is not, however, taken to be true for all actions that a person may conceivably want to take. If someone simply wished to have a kidney removed but had no desire to donate it to anyone, it seems extremely unlikely that any doctor would consider it to be acceptable to remove their kidney (absent any medical indication for doing so). In the case of unspecified organ donation, it is the autonomous wish to do a good thing (hence terminology focussed on altruism as an indicator of their goodness) that makes it an autonomous wish deserving of respect. It also assumes, although this is rarely articulated in the transplant literature, an understanding of respect for autonomy that includes promoting or even maximising opportunities for autonomous action. This is, perhaps, a broader understanding of autonomy than that which underpins the concerns of the *Human Tissue Authority* that the donor has capacity, is fully informed and understands the information. Here respect for the bodily integrity of an autonomous agent is perhaps the driving concern. Moreover, it is clear that the many countries that do not permit unspecified donation either have concerns about the psychological wellbeing and motives of those wishing to donate in this manner (although evidence suggests that these concerns would be incorrect), or do not consider either the 'abstract benefit' or 'autonomy' arguments to be sufficient to permit a healthy person to undergo surgery for another's benefit.

Hilhorst et al. (2011) point out that the determination of acceptable risk is not always left to autonomous individuals: seatbelt legislation, safe speed limits on roads and risks in relation to research are broadly determined by wider society, although these decisions may also be justified with reference to harm to other people. In both

the Netherlands and the UK, a wider social decision was taken to permit unspecified living donation where it was previously unlawful. As we have seen, in the UK, the regulator itself imposes some safeguards in relation to consent and motivation but the process of regulation cuts across whether the harms and benefits can be balanced, and accepts that valid consent to be physically harmed in these circumstances legitimises what would otherwise be wrong-doing. This change was brought about in part as a result of pressure from medical professionals and has not been resisted by the *General Medical Council*. Donors are routinely medically screened using standardised processes, which incorporate mental health assessment even though this is no longer required by the regulator. Standardised screening, and the clearly stated possibility of not being accepted as a donor as a result of screening, denotes a general view that there is a threshold for acceptable risk that must be met prior to any processes that may result in a legal consent being sought and given. Individual clinicians may feel more or less comfortable with this threshold, and this may explain why some clinicians are reluctant to actively promote unspecified living donation (Burnapp et al. 2019), and some are unwilling to participate in some forms of living donation. Although our discussion has focussed primarily on kidney donation, as kidneys are by far the most common unspecified donation, the additional risks and harms posed by the prospect of unspecified living liver donation may explain why this is much less common. Nonetheless, rather than engaging increasingly tenuous justifications in relation to 'first do no harm', its advocates could simply accept that unspecified living donation is a licenced medical procedure where, despite the *complete* absence of medical need, any patient meeting this threshold is legally permitted to consent to be harmed and the doctor performing the intervention is not behaving unlawfully. This suggests that unspecified living donation may occupy a similar legal and ethical space as e.g. cosmetic enhancement, where similar difficulties arise in relation to 'first do no harm', nonmedical reasons and the balance of harm/benefit.

To recap, 'first do no harm' is thought to be consistent with specified living donation to the extent that the donor may be regarded as being, overall, more harmed by the failure to proceed, then by proceeding. It is also used to limit the harms by e.g. limiting the number and type of organs that can be donated to a close friend or relative. Likewise, donors are screened and the healthiest donor/the donor most able to withstand surgery may be preferred when more than one donor is available. In the case of unspecified living donation, where there is unlikely to be tangible benefit to the donor, other more abstract benefits have to be considered, or the harm of frustrating autonomy (by deciding for the donor what harms are worth what benefits) is incorporated into the notion of 'first do no harm'. Nonetheless, it remains the case that there are no medical grounds on which the surgical procedure on the donor can be justified, and patient autonomy does not usually extend to insisting on being given an intervention. The question remains, then, of whether unspecified donation is something that the medical profession should facilitate or even promote, or whether a more paternalistic approach may be justified.

4. Considerations beyond First Do No Harm

Moving on from here, and given the potential challenges in terms of 'first do no harm', it is important to consider in more detail whether facilitating unspecified donation is something that the medical profession should be doing, given the values, aims and responsibilities that doctors should have.

4.1 A Reason to Permit Unspecified Donation

Doctors' involvement in the procurement of organs from the living is presumably not primarily motivated by a desire to promote the autonomy of potential donors, but rather an awareness of the need to acquire the resources necessary to extend or improve recipients' lives. The underlying question of whether it is ethical for medical professionals to expose healthy people to the risks of living donation, whether specified or unspecified, cannot be answered in theoretical isolation, and depends upon whether there is a sufficient need for this to occur.

It would be difficult, for example, to justify living donation and its associated risks in a country with a surplus of good quality organs from deceased donors. Although no country is in this situation, the operation of parallel living and deceased donation systems does raise the question of where each donation system should stand relative to the other (see also chapter 9 in this book). We would suggest that, all other things being equal, a source of organs that involves risks to healthy people should not be preferred over a source of organs that involves no risks to healthy people. Of course, all other things are not equal, and factors such as decreased waiting time, increased control over the circumstances of donation/transplantation, and potentially better post-transplant outcomes for the recipient all add something to the case in favour of living donation.

A further claim can also be made then, that living donors should not be used unless serious attempts to maximise rates of deceased donation have been made (Moorlock/Draper 2018). Although the medical risks of living donation are the same regardless of whether a donation is specified or unspecified, it seems reasonable to think that benefits to donors are likely at their thinnest or most minimal in cases of unspecified donation, and so these should be of particular last resort. It is unfortunately the case that people die on a daily basis as a consequence of not receiving a transplant in time, so it is true to say that there is a need for more donors. It is also true to say that significant efforts are being made to increase the number of deceased donors (see England's move to an opt-out donation system, for example), but that this will still not meet demand. Specified living donors go a significant additional way to meeting demand, but there remains a shortfall. There is a need for more donors, and unspecified donors, particularly when used to start chains of living donors, do help to ensure that more lives are extended and/or improved.

4.2 Resource Acquisition and the Roles of Doctors

Given that there is a need, albeit a qualified one, for unspecified living donors, the question still remains of whether it is ethically permissible for doctors to obtain organs from this source. Transplantation itself is regarded as a relatively uncontroversial and

legitimate medical procedure when looked at from the point of view of the *recipient* (for this perspective, see also chapter 13 in this book). It is a procedure performed on a patient, intended to provide clear medical benefit. Arguably one of the main ethical difficulties has been associated with ensuring that the organs used in transplantation have been obtained in an ethical way.

Explantation, the surgical process of donation, is a medical procedure, requiring medical skills, but is not performed for the usual medical reason of trying to make a patient better, as far as the donor is concerned. The donor *becomes* a patient by virtue of donating. Justification is therefore required for using medical skills to make someone a patient, rather than *stopping* them from being a patient. This is not such a concern in the case of deceased donors because they are dead, although an argument could also be made that acting on wishes made during life about what happens after death is part of respect for autonomy. We have seen that some living donors, particularly those in a close relationship with the imperilled recipient – may reasonably be assumed to benefit from the procedure. Since becoming a donor may prevent some harms that may themselves lead to health problems, at a stretch some people have argued that these benefits are potentially health benefits (Freeman/Whiteman 2018). In the case of unspecified living donors this is much less obviously the case and, from the donor perspective, the procedure is being done for purely non-medical reasons. There is a question, therefore, of whether doctors could permissibly, or even should, invoke a paternalistic approach towards unspecified donation.

It is clear that a desire to increase the numbers of organs available for transplantation is driving doctors' involvement with unspecified living donors: it is a matter of resource acquisition. Absent the need for transplantable organs, there would clearly be no justification for unspecified living donation, regardless of donor autonomy. In this respect the principle 'first do no harm' seems to be being applied across the donation/transplantation procedure as a whole – balancing the harm to the donor against the benefits to the recipient. From a purely utilitarian perspective, this does not pose a problem, particularly if the harms to the donor are indeed minimal. But traditionally 'first do no harm' applies to the individual patient, and not interpersonally or across populations. Moreover, in the case of individual patients, transplant practitioners have traditionally scrupulously avoided allowing the benefits to the recipient to cloud their professional judgement: this is why the person treating the recipient is not supposed to play any part in the screening, consenting or operation on the donor, deceased or living (British Transplantation Society 2018: 31). Nonetheless, it seems clear that it is the potential benefit to recipients of having timely access to good quality grafts that is driving the increase in the number of living donors in general, and unspecified donors in particular. Even those many doctors who do support unspecified donation can conceive of circumstances under which the practice is unacceptable. Donors are carefully screened to minimise risk, which suggests that there is a risk threshold beyond which the practice would not be considered acceptable, regardless of a willing autonomous donor. This seems to be a decision for the profession as a whole, and can be considered to be part of the determination of the circumstances under which the practice is permissible.

We should be cautious too of both placing too much weight on the harm of frustrating potential donor autonomy and tying medical decision-making too closely to utilitarianism. Suppose for hypothetical example, someone was willing to have a kid-

ney removed to raise money for charity, and suppose that they had managed to gain several million pounds in sponsorship money that they proposed to donate to a cause that would directly result in life-saving treatment being given to several young adults. Let's also suppose that although they had two functioning kidneys, a pre-surgical assessment shows that neither kidney was suitable for transplantation. Would it be acceptable for this person to have a kidney removed, even though the kidney removed could not be transplanted into a recipient? The harms experienced would be no greater than for any other donor, and although no single recipient would benefit, several other people would. Presumably, having expended such effort in raising money the potential donor would feel frustrated if the surgery was refused. The onus remains on the medical professionals in those countries that have legalised unspecified donation to justify their support for legalising the practice in such a way that adheres to the legitimate ends of medicine and its values, such as 'first do no harm', without using arguments that could also permit, if applied consistently the facilitation of other – even charitable – surgical procedures that they would be unlikely to consider acceptable. Retaining a perspective on the fact that unspecified donation is performed with the justifiable aim of acquiring a particular life-saving resource that is consistent with the aims of medicine, and that the autonomous consent of the donor is a legitimacy requirement, would appear to be one way of achieving this without centring donor autonomy as the *justification* for the practice.

4.3 Case-by-Case Considerations

Against a backdrop of clear reasoning for the permissibility of living donation as a whole, and agreement on where the limits of acceptability lie, the acceptability of proceeding with particular unspecified donations must then be determined by individual clinicians, albeit guided by the considered views of the profession. If a clinician makes a clinical judgment that the risks of donation for a particular potential donor are above the acceptable levels agreed by the profession, then respect for donor autonomy cannot require the clinician to proceed with the donation. This may be considered paternalistic, but this does not seem problematic in this type of scenario: it has been argued that when offering procedures to patients, physicians have the right to impose their own sense of acceptable risk (Reese et al. 2006).

Assuming that levels of risk for a potential donor do fall within the agreed bounds of acceptability, and that a doctor is therefore willing to proceed with the donation, the final judgment rests with the potential donor. Given that unspecified donation is legal in England, the regulator has chosen to concentrate their efforts on ensuring that sufficiently informed and capacitous consent is gained. A formal mental health assessment is no longer required but it is regarded as good practice. This perhaps addresses the concerns that have been raised about the motivations of unspecified living donors, particularly when compared to specified living donors. The benefits for the latter by virtue of their connection to the recipient appear to provide a motivation that is at least accessible or comprehensible to those who are more sceptical about the motivations of unspecified donors. Even though the law in England does not automatically assume that those with mental health problems lack the capacity to consent or refuse consent to treatment, mental illness may cast doubt on capacity so it is essential to be certain that potential living donors have capacity before they embark on a surgical process

that is, in part, permitted and sometimes even seemingly justified by respect for a capacitous person's autonomous wishes. Guidelines (Lentine et al. 2017) and psychosocial assessment tools (Massey et al. 2018) have been developed to ensure appropriate assessment and screening of potential living donors. There is a difficult balance to be struck between the doctors' adherence to 'first do no harm' and respectful treatment of well-motivated individuals wishing to donate organs to strangers. For example, the screening process should not feel stigmatising and should not create an unnecessarily large obstacle for donors to overcome. Nonetheless, on balance, when it comes to the doctor's duty to the donor, we would err on the side of caution over causing offence or even deterring donation. Unspecified donation should not proceed unless the donor is really sure it is the right decision. A few additional hurdles (as opposed to barriers), including taking time over the assessment, are one way of ensuring that the donor will not later regret their generosity.

5. Conclusions

We have outlined the commonly cited ethical justifications for living donation in general, and have highlighted how unspecified donation poses some particular challenges to these. The particular issue of 'first do no harm' requires careful consideration in this context. It has conventionally been addressed by expanding the notion of 'benefit' within organ donation to include abstract moral benefit derived from doing something good, or to weigh in the harms of frustrating the wishes of an autonomous potential donor. We have then considered issues beyond 'first do no harm', specifically whether there is a sufficient need for unspecified donors and whether the practice is compatible with the roles of doctors. We remain somewhat sceptical about elaborate manoeuvres intended to fit unspecified donation within a traditional risk/benefit model of medical justification. The emphasis on risks/benefits for donors and respect for the autonomy of potential donors risks losing sight of the primary reason for permitting unspecified donation, which is that it helps to meet a significant need that would otherwise remain unmet via deceased or specified donation. We would welcome more transparency and openness around the fact that unspecified donation *does*, from a medical perspective, cause harm to donors. The level of harm is, in most cases, relatively low but it is nonetheless harm that the donor would not experience but for their donation. It is precisely the willingness to undergo this harm, however, that makes unspecified donation a remarkably generous and courageous thing for people to do.

References

Allen, Matthew B./Abt, Peter L./Reese, Peter P. (2014): "What are the Harms of Refusing to Allow Living Kidney Donation? An Expanded View of Risks and Benefits." In: American Journal of Transplantation 14/3, pp. 531–537.

Bailey, Phillippa/Huxtable, Richard (2016): "When Opportunity Knocks Twice: Dual Living Kidney Donation, Autonomy and the Public Interest." In: Bioethics 30/2, pp. 119–128.

Bowdish, Michael E./Barr, Mark L./Schenkel, Felicia A./Woo, Marlyn S./Bremner, Ross M./Horn, Monica V./Baker, Craig J./ Barbers, Richard G./Wells, Winfield J./Starnes, Vaughn A. (2004): "A Decade of Living Lobar Lung Transplantation: Perioperative Complications after 253 Donor Lobectomies." In: American Journal of Transplantation 4/8, pp. 1283–1288.

Brännström, Mats (2015): "The Swedish Uterus Transplantation Project: the Story Behind the Swedish Uterus Transplantation Project." In: Acta Obstetricia et Gynecologica Scandinavica 94/7, pp. 675–679.

British Transplantation Society (2018): "Guidelines for Living Donor Kidney Transplantation". Available at: https://bts.org.uk/wp-content/uploads/2018/07/FINAL_LDKT-guidelines_June-2018.pdf (accessed April 01, 2021)

Burnapp, Lisa/Van Assche, Kristof/Lennerling, Annette/Slaats, Dorthe/Van Dellen, David/Mamode, Nizam/Citterio, Franco/Zuidema, Willij/Weimar, Willem/Dor, Frank J. M. F. (2019): "Raising Awareness of Unspecified Living Kidney Donation: an ELPAT* view." In: Clinical Kidney Journal 13/2, pp. 159–165.

Chien, Ching-Hui/Wang, Hsu-Han/Chiang,Yang-Jen/Chu, Shenghsien/Liu Hsueh-Erh/Liu, Kuanlin (2010): "Quality of Life after Laparoscopic Donor Nephrectomy." In: Transplantation Proceedings 42/3, pp. 696–698.

Chen, Fengshi/Fujinaga, Takuji/Shoji, Tsuyoshi/Sonobe, Makoto/Sato, Toshihiko/Sakai, Hiroaki/ Bando, Toru/Date, Hiroshi (2012): "Outcomes and Pulmonary Function in Living Lobar Lung Transplant Donors." In: Transplant International 25/2, pp. 153–157.

Clarke, Alexis/Mitchell, Anne/Abraham, Charles (2014): "Understanding Donation Experiences of Unspecified (Altruistic) Kidney Donors." In: British Journal of Health Psychology 19/2, pp. 393–408.

Council of Europe Committee of Ministers (2008): "Resolution CM/Res(2008)6 on Transplantation of Kidneys from Living Donors Who Are Not Genetically Related to the Recipient."

Dew, Mary Amanda/Butt, Zeeshan/Humar, Abhinav/DiMartini, Andrea F (2017): "Long-Term Medical and Psychosocial Outcomes in Living Liver Donors." In: American Journal of Transplantation 17/4, pp. 880–892.

Dor, Frank J. M. F./Massey, Emma K/Frunza, Mihaela/Johnson, Rachel/Lennerling, Annette/Loven, Charlotte/Mamode, Nizam/Pascalev, Assya/Sterckx, Sigrid/Van Assche, Kirstof/Zuideme, Willij C./Weimar, Willem (2011): "New Classification of ELPAT for Living Organ Donation." In: Transplantation 91/9, pp. 935–938.

Ethics Committee of the Transplantation Society (2004): "The Consensus Statement of the Amsterdam Forum on the Care of the Live Kidney Donor." In: Transplantation 78/4, pp. 491–492.

Freeman, Michael A/Wightman, Aaron G (2018): "Did Parents Have it Right all Along? Parents, Risk, and Living Kidney Donation: Revisiting the Arguments for and against Parental Living Donation of Kidneys." In: Pediatric Transplantation 22/3, pp. 1–6.

Hilhorst, Medard/Wijsbek, Henri/Erdman, Ruud/Metselaar, Herold/van Dijk, Gert/Zuidema, Willij/Weimar, Willem (2011): "Can We Turn Down Autonomous Wishes to Donate Anonymously?" In: Transplant International 24/12, pp. 1164–1169.

Kisu, Iori/Mihara, Makoto/Bannom, Kouji/Umene, Kiyoko/Araki, Jun/Hara, Hisako/Suganuma, Nobuhiko/Aoki, Daisuke (2013): "Risks for Donors in Uterus Transplantation." In: Reproductive Sciences 20/12, pp. 1406–1415.

Lentine, Krista L./Patel, Anita (2012): "Risks and Outcomes of Living Donation." In: Advances in Chronic Kidney Disease 19/4, pp. 220–228.

Lentine, Krista L./Kasiske, Bertram L./Levey, Andrew S./Adams, Patricia L./Alberú, Josefina/Bakr, Mohamed A./Gallon, Lorenzo/Garvey, Catherine A./Guleria, Sandeep/Li Philip Kam-Tao/Segev, Dorry (2017): "KDIGO Clinical Practice Guideline on the Evaluation and Care of Living Kidney Donors." In: Transplantation 101/8, pp. S1–S109

Lentine, Krista L./Lam, Ngan N./Segev, Dorry L. (2019): "Risks of Living Kidney Donation: Current State of Knowledge on Outcomes Important to Donors." In: Clinical Journal of the American Society of Nephrology 14/4, pp. 597–608.

Lopp, Leonie (2013): Regulations Regarding Living Organ Donation in Europe: Possibilities of Harmonisation, Berlin: Springer.

Maple, Hannah/Chilcot, Joseph/Burnapp, Lisa/Gibbs, Paul/Santhouse, Alastair/Norton, Sam/ Weinman, John/Mamode, Nizam (2014): "Motivations, Outcomes, and Characteristics of Unspecified (Nondirected Altruistic) Kidney Donors in the United Kingdom." In: Transplantation 98/11, pp. 1182–1189.

Maple, Hannah/Chilcot, Joseph/Weinman, John/Mamode, Nizam (2017): "Psychosocial Wellbeing after Living Kidney Donation – a Longitudinal, Prospective Study." In: Transplant International 30/10, pp. 987–1001.

Massey, Emma K./Timmerman, Lotte/Ismail, Sohal Y./Duerinckx, Nathalie/Lopes, Alice/ Maple, Hannah/Mega, Inês/Papachristou, Christina/Dobbels, Fabienne/ELPAT Psychosocial Care for Living Donors and Recipients Working Group (2018): "The ELPAT Living Organ Donor Psychosocial Assessment Tool (EPAT): from 'What' to 'How' of Psychosocial Screening – a Pilot Study." In: Transplant International 31/1, pp. 56–70.

Mjøen, Geir/Hallan, Stein/Hartmann, Anders/Foss, Aksel/Midtvedt, Karsten/Øyen, Ole/Reisæter, Anna/Pfeffer, Per/Jenssen, Trond/Leivestad, Torbjorn/Line Pal-Dag/Øvrehus, Magnus/Dale, Dag Olav/Pihlstrom, Hege/Holme, Ingar/Dekker, Freido/Holdaas, Hallvard (2014): "Long-Term Risks for Kidney Donors." In: Kidney International 86/1, pp. 162–167.

Moorlock, Greg/Ives, Jonathan/Draper, Heather (2014): "Altruism in Organ Donation: an Unnecessary Requirement?" In: Journal of Medical Ethics 40/2, pp. 134–138.

Moorlock, Greg/Draper, Heather (2018): "Empathy, Social Media, and Directed Altruistic Living Organ Donation." In: Bioethics 32/5, pp. 289–297.

Muzaale, Abimereki D./Massie, Allan B./Wang, Mei-Cheng/Montgomery, Robert A./McBride, Maureen A./Wainright, Jennifer L./Segev, Dorry L. (2014): "Risk of End-Stage Renal Disease Following Live Kidney Donation." In: Journal of the American Medical Association 311/6, pp. 579–586.

NHS Blood and Transplant (2019): "Annual Report on Living Donor Kidney Transplantation". Available at: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/16883/annual-report-on-living-donor-kidney-transplantation-2018_19.pdf (accessed June 28, 2020)

NHS Blood and Transplant (2014): "Living Donor Kidney Transplantation 2020: A UK Strategy Available at: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/1434/ldkt_2020_strategy.pdf (accessed June 28, 2020)

Reese, Peter P./Caplan, Arthur L./Kesselheim, Aaron S./Bloom, Roy D. (2006): "Creating a Medical, Ethical and Legal Framework for Complex Living Kidney Donors." In: Clinical Journal of American Society of Nephrology 1, pp. 1148–1153.

Ross, Lainie F. (2002): "Solid Organ Donation between Strangers." In: The Journal of Law, Medicine & Ethics 30/3, pp. 440–445.

Saunders, Ben (2018): "How Altruistic Organ Donation May Be (Intrinsically) Bad." In: Journal of Medical Ethics 44/10, pp. 681–684.

Smith, Graeme C./Trauer, Thomas/Kerr, Peter G./Chadban, Steven J. (2004): "Prospective Psychosocial Monitoring of Living Kidney Donors Using the Short Form-36 Health Survey: Results at 12 Months." In: Transplantation 78/9, pp. 1384–1389.

Van Pilsum Rasmussen, Sarah E./Henderson, Macey L./Kahn, Jeffrey/Segev, Dorry (2017): "Considering Tangible Benefit for Interdependent Donors: Extending a Risk–Benefit Framework in Donor Selection." In: American Journal of Transplantation 17/10, pp. 2567–2571.

Williams, Nicola J. (2018): "On Harm Thresholds and Living Organ Donation: Must the Living Donor Benefit, on Balance, from his Donation?" In: Medicine, Health Care and Philosophy 21/1, pp. 11–22.

Winder, Gerald Scott/Fontana, Robert J. (2019): "Outcomes in Living Liver Donor 'Heroes' After the Spotlight Fades." In: Liver Transplantation 25/5, pp. 685–687.

Yusen, R D./Hong, B. A./Messersmith, E. E./Gillespie, B. W./Lopez, B. M./Brown, K. L./Odim, J./Merion, R. M./Barr, M. L. and RELIVE Study Group (2014): "Morbidity and Mortality of Live Lung Donation: Results from the RELIVE Study." In: American Journal of Transplantation 14/8, pp. 1846–1852.