6.2.1.1 Organ Transplantation Allocation Decisions

When making organ transplantation allocation decisions, physicians have a responsibility to provide equitable and just access to health care, including only utilizing organ allocation protocols that are based on ethically sound and clinically relevant criteria.

When making allocation decisions for organ transplantation, physicians should not consider non-medical factors, such as socioeconomic and/or immigration status, except to the extent that they are clinically relevant.

Given the lifesaving potential of organ transplants, as a profession, physicians should:

(a) Make efforts to increase the supply of organs for transplantation.

(b) Strive to reduce and overcome non-clinical barriers to transplantation access.

(c) Advocate for health care entities to provide greater and more equitable access to organ transplants for all who could benefit

AMA Principles of Medical Ethics: I,III,V

Background report(s):

CEJA Report 08-A-25 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 08-A-25

Subject:	Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation
Presented by:	Jeremy A. Lazarus, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

Policy H-370.954 was adopted at A-23 and asks that the Council on Ethical and Judicial Affairs (CEJA) consider amending Opinion 6.2.1, "Organ Transplantation from Deceased Donors," to address concerns regarding immigration status and access to donated organs.

BACKGROUND

Resolution 003-A-23 noted the profound disparities that exist in the United States between undocumented immigrants versus documented immigrants and citizens access to organ transplantation. For example, United Network of Organ Sharing (UNOS) data reveals that only 0.4 percent of liver transplants in the U.S. went to undocumented immigrants, while undocumented immigrants accounted for up to 3 percent of the total deceased liver organ donors in the U.S. [1].

AMA's ethical criteria for organ allocation were set out in a 1993 CEJA report on organ transplantation [2}. Ethical criteria for scarce resource allocation include the likelihood of benefit, change in quality of life, duration of benefit, urgency of need, and the amount of resources required for successful treatment. These criteria must be weighed in a complex analysis that takes into account all these criteria together.

Likelihood of benefit is aimed to "maximize the number of lives saved as well as the length and quality of life" [2]. Change in quality of life is a criterion that one maximizes benefit "if treatment is provided to those who will have the greatest improvement in quality of life", however defining what constitutes "quality of life" is difficult as it will "depend greatly on patients' individual, subjective values" [2]. Duration of benefit can be thought of as the length of time a patient can benefit from a treatment, which often will involve a calculus of life expectancy to be part of analysis; however, life expectancy is not always a determinative factor when making allocation decisions [2]. Urgency of need "prioritizes patients according to how long they can survive without treatment" [2]. The amount of resources gives higher priority to "patients who will need less of a scarce resource" in order to maximize the number of lives saved [2]. Resources in this context does not mean a patient's finances, but rather scarce medical resources like an organ, e.g. a patient who requires two organ transplants may be lower priority than someone who only needs one [2].

ETHICAL ISSUE

To what extent may non-medical factors such as immigration and/or socioeconomic status be considered in organ transplantation allocation decisions.

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* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

REVIEW OF RELEVANT LITERATURE

The ethical problem regarding "fairness" has been well documented, as undocumented immigrants "are able to, and do donate their organs, but they are effectively barred from receiving transplants" [3] or, after receiving transplants, may not have the proper resources down the line to receive continued therapies like immunosuppressive medications [4]. The Organ Procurement and Transplantation Network (OPTN) declares that "residency status cannot factor into decisions on whether to allocate an organ to a specific patient" [5]. The OPTN policy states: "A candidate's citizenship or residency status in the United States must not be considered when allocating deceased donor organs to candidates for transplantation. Allocation of deceased donor organs must not be influenced positively or negatively by political influence, national origin, ethnicity, race, sex, religion, or financial status" [6]. While OPTN's policy strives to achieve equity, the practical reality is that financial and socioeconomic considerations are indirectly weighed, as insurance coverage is usually needed for pre-and post-opt care.

Despite the perception that immigration status may affect health status, "unauthorized immigrants who receive liver transplants in the United States have comparable three-year survival rates to the U.S. citizens", indicating that survival outcomes are not drastically different for undocumented immigrants and that "concern for worse survival should not be used as a reason to deny access to liver transplant" [7]. Additionally, a cardiothoracic transplant study in the U.S. found that citizenship status was not relevant in determining transplant outcomes, noting that "citizenship status does not appear to be an independent determinate of early post-transplant outcomes", reinforcing that immigration status by itself is not a medically relevant characteristic in determining likely success of organ transplantation [8].

Lack of insurance is often the largest obstacle for undocumented immigrants seeking organ donation. Many undocumented immigrants who would otherwise be good candidates for an organ transplant do not have insurance to cover the surgical procedure or the long-term after care, and as a result are removed or not allowed on transplant wait lists [9]. Other practices, such as hospitals asking patients for Social Security numbers while making transplant eligibility assessment—though there is "no legal requirement to do"—also exclude undocumented immigrants from transplant eligibility, further contributing to disparities [10].

ETHICAL ANALYSIS

Numerous factors are involved in the allocation of organs and scarce resources and are all aimed at maximizing the "good", i.e. "number of lives saved, number of years of life saved, and improvement in quality of life" [2]. Opinion 11.1.3, "Allocating Limited Health Care Resources" addresses these criteria. The 1995 CEJA opinion on organ transplantation states that both social worth and ability to pay are not ethically justified criteria to make decisions on how to allocate scarce resources. Additionally, the ethical concerns raised by Res 003 are valid, in that immigrant status itself is being used as an indicator of financial status or socioeconomic status. However, the key aspects associated with the disparities of immigration status, "social worth" and "ability to pay", are both already addressed by H-370.982.

Not all undocumented immigrants have lower economic status. Some immigrants (undocumented or otherwise) may have strong financial means, e.g. wealthy foreign immigrants who travel the U.S. for medical care. Hence, specifically calling out "immigration status" or "undocumented status" is not ideal, as the term is not precise and does not always imply an individual without proper insurance or financial means or a person with lower socioeconomic status.

As previously discussed, it is impossible to truly separate medically relevant and non-medically relevant criteria in the context of organ donation. The *Code's* broader approach to generally avoid lists of specific examples of non-clinical characteristics allows physicians to make their own analysis about what is and is

not clinically relevant in specific cases. There is clearly an apparent disparity between those who donate organs and those who receive them and we continue to have disparities in outcomes due to socioeconomic status. While finances and ability to pay are by themselves not medically relevant and in an ideal sense, should not be ethically considered, they often must be considered in the context of organ transplantation eligibility because they can affect the patient's ability to obtain the necessary resources or participate adequately in regiments to ensure the long-term viability of the transplant thus, becoming medically relevant; however, when these non-medical factors are not clinically relevant should not be considered. The result is an ethical tension that is effectively paradoxical. Leaving the paradox outside of the policy allows for more fluidity in interpretation of the *Code* in any context.

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends the following:

1. That a new Code of Medical Ethics opinion be adopted as follows:

   When making organ transplantation allocation decisions, physicians have a responsibility to provide equitable and just access to health care, including only utilizing organ allocation protocols that are based on ethically sound and clinically relevant criteria.

   When making allocation decisions for organ transplantation, physicians should not consider non-medical factors, such as socioeconomic and/or immigration status, except to the extent that they are clinically relevant.

   Given the lifesaving potential of organ transplants, as a profession, physicians should:

   (a) Make efforts to increase the supply of organs for transplantation.

   (b) Strive to reduce and overcome non-clinical barriers to transplantation access.

   (c) Advocate for health care entities to provide greater and more equitable access to organ transplants for all who could benefit.

2. That Policy H-370.954 be rescinded as having been accomplished by this report and the remainder of this report be filed.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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