HARVESTING ORGANS FROM THE MILITARY

by

Michael E. Frisina

The Department of Defense has recently announced in draft a proposal to set up an organ donor program for military medical beneficiaries. The rationale for such a program is that the 9 million people eligible for military medical care provide a large pool of potential donors that could "drastically reduce the waiting time for military members and civilians alike whose lives depend on the transplant of vital organs" (Kimble).

My initial reaction to this proposal was mixed. The circumstances and context surrounding organ donation are extremely complex. The negative psychological and ethical implications of organ retrieval in civilian medicine are well documented (Youngner). On the other hand, there is the potential for doing a great service to those in need of organ transplants (Feinberg). My concern is that the proposed policy considers reducing the number of people on a waiting list for vital organs only, and does not consider the psychological and ethical concerns of those individuals who will be affected by a military organ retrieval program. It is this concern which leads me to conclude that the proposed DoD organ donor policy is flawed conceptually and, in its present form, lacks practical usefulness.

CONCEPTUAL CONCERNS

Perhaps the most disturbing issue surrounding organ-retrieval involves determining the point at which the prospective donor is actually dead. The DoD policy adopts guidelines used by many transplant centers for determining whether a patient can be termed a donor. According to these guidelines, organs can be retrieved only if "a patient has no capability for breathing or blood flow or if the patient is without any brain function (Kimble).

But does this DoD policy adequately define death? The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended different guidelines for determining death than those adopted by the Defense Department. In its report concerning the definition of death, the Commission concluded:

> rules for determining human death should recognize brain-oriented techniques of establishing death because traditional standards often cannot be employed with patients whose respiration and circulation are artificially maintained. (55)

The problem with the definition adopted by the proposed DoD policy is that it does not stipulate whether patients with "no capability for breathing or blood flow" include those whose breathing and blood flow are being maintained artificially. If it does, then the ethical concern is whether the DoD policy will lead to the abandonment of patients who might respond to continued medical treatment, particularly where the brain is still functioning. The ethical concern of stopping treatment prematurely is

unquestionable. Therefore, it is imperative that the policy adopt a conservative definition of death to prevent the possibility of premature cessation of treatment. (For more on defining death see, Douglas Walton. *On Defining Death.* Montreal: McGill-Queens, 1979).

Another disturbing aspect of the DoD policy is the effort to organize a campaign asking every adult eligible for military medical care to donate their organs. This campaign to get organs also requires military physicians to ask family members to donate the organs of loved ones who are brain-dead or near death.

The concern over this wholesale solicitation is twofold. First, it violates the offensive principle. The offensive principle stipulates that whatever causes most people, or normal people, deep revulsion is for that reason a bad thing (Feinberg, 34). Consequently, while a proposal which advocates the dismembering of a corpse may itself not be morally wrong, when that proposal requires members of the medical profession to ask every prospective donor without considering whether that person will experience revulsion by such solicitation, then that proposal is conceptually flawed.

Second, wholesale solicitation raises a concern over individual autonomy and informed consent. In the military, subtle coercion exists to be a "team player." Commanders encourage one hundred percent participation in support of all "voluntary" programs, like blood donations and

contributions to the Combined Federal Campaign. Thus, I have to wonder if unit commanders will be adding a new criterion (organ donor participation) to their monthly briefing charts. With the penchant the military has for statistics, we should be concerned about the organ donation policy becoming another well-intended, yet coercive program.

Additionally, while military physicians express concerns about decisions they make in particular cases, the majority of military physicians practice medicine exclusively from a pragmatic and strongly paternalistic perspective. Since service members must obey lawful directives of superiors, it is likely that given the pragmatic trend existing in military medicine, patients will become means to an end. Individual autonomy will be dismissed as physicians, who literally view sickness as the enemy, counsel patients and family members about the good they can render to their comrades. After all, the motto of the Army Medical Department, "To Conserve the Fighting Strength," suggests that military physicians have a requirement to get organs that might save the lives of soldiers, while military patients or next-of-kin might feel compelled to donate organs for the good of the service. Regardless of the position taken on this issue, we cannot set it aside if we want to ensure informed consent and protect the individual autonomy of military medical beneficiaries.

PRACTICAL CONCERNS

According to a 1982 estimate, out of some 20,000 potential donors--young or middle-aged patients classified as brain dead--only 2500 actually donated their organs (Kolata, G. *Science* 1983; 221:32-33). Though much has been written about this phenomenon, "little attention has been given to the disturbing effects of organ-retrieval surgery on staff members in the intensive care unit and operating room--the health professionals most involved" (Younger, 321).

If the disturbing effects on staff members managing an organ retrieval program are evident in civilian medicine, these effects will not only be evident, but compounded in military medicine by 1) the lack of ethical discussion relating to military health care, and 2) adding another requirement to an already overburdened health care system.

In another paper (that *Military Medicine* will soon publish) I have argued that ethical discussion in military medicine is virtually nonexistent. Given what I have pointed out regarding the pragmatic approach in the military health care system, I have a great concern for the welfare of military physicians who, for the first time, may now have to confront some misgivings about their medical decisions. It is one thing to wonder whether you might have done more for a patient once the respirator has been turned off and the body taken to the morgue. Feelings of regret from having lost a "battle" dissipate as one moves on to another patient

in the war against disease. However, when one becomes involved in the practice of retrieving organs, the battle does not end, one merely shifts emphasis from saving the patient to saving the organs. This shift of emphasis does not come without a price.

> When a potential donor is pronounced dead, we do not follow the customary procedures of turning off the machines. . . . Instead, monitoring and intervention continue at maximal levels in order to protect and preserve the organs. . . . It is no wonder that intensive care personnel may feel confused about having to perform cardiopulmonary resuscitation on a patient who has been declared dead, whereas a 'do not resuscitate' order has been written for a living patient in the next bed. (Younger, 321)

This practical problem of keeping organs viable in a cadaver that still looks like a patient extends beyond the intensive care unit. In surgery, the common practice is the removal of unhealthy tissue to preserve healthy tissue. Staff members are often uncertain about how to act after hours of arduous surgery removing organs from a cadaver. While the anesthesiologist turns off the respirator and leaves the operating room, someone else has to close the incision in the cadaver. While some medical staff have been treating the cadaver as if it were alive, others now have to act as if it is really dead. As a result, guilt, resentment, and revulsion are experienced by staff members who participate in the organ retrieval process. Their feelings are real practical concerns that need to be considered especially when staff members fail to acknowledge emotional

distress for fear of being labeled disloyal or weak (Younger, 322).

Additionally, by its very nature, organ retrieval surgery constitutes an emergency. Surgical teams are often assembled from on-call schedules. Placing additional demands on surgical schedules that already are maximizing or exceeding staffing guide requirements, is to ask more of the military medical system then it is currently able to deliver. Manpower requirements will be of particular concern if individuals have strong religious convictions or personal moral reservations against paricipating in organ retrieval surgery. The issue of requiring medical staff to participate in procedures that violate their consciences is beyond the scope of this paper. However, it is a practical concern which needs to be addressed, particularly in a medical system which is suffering from a shortage of qualified physicians and nurses.

Finally, there is the practical concern of the family. Usually, when death occurs, a ritual begins as the family comes to terms with the passing of a loved one. We need to concern ourselves with the psychological effects that occur in a family when this ritual is delayed and made into an ugly experience by the organ retrieval process. The dynamics of this whole situation become complicated when, according to the proposed policy, the physician on-call must still seek the approval of the next-of-kin before removing organs of a dead patient even if that person signed a donor card.

At the time of the patient's death, the desires of the next-of-kin supersede those of the patient. The potential exists for various kinds of family disputes when the next-of-kin exercises the prerogative to supersede the expressed intent of a deceased loved one. Also, this seeking approval at the time of death seems redundant given that the proposed policy already requires physicians to solicit potential donors who are not ill or near death.

CONCLUSION

Sustaining life through organ transplants is a worthy endeavor and every person must be made aware of the need that exists and the good rendered by participating in such programs. However, the conceptual and practical concerns of operating an organ retrieval program are extremely complex.

The complexity of organ retrieval programs begins with the problem of developing an adequate definition of death. The issue of stopping treatment on a patient prematurely, then shifting emphasis to maintaining a cadaver is a real conceptual and practical concern. Not only must we be concerned about making the pronouncement of death too early, we must concern ourselves with the repugnance generated by organ retrieval programs in spite of the good intended from such programs. "Cost-benefit analysis is always least satisfactory when the costs must be measured in one realm and the benefits in another" (Gaylin, 30).

Given the prior history of the use of military personnel in medical testing and experimentation (by this I

mean the experiments conducted with hallucinogenic drugs, proximity to nuclear detonations, and other such experiments) the rights of potential military donors must be protected. Given the coercive nature of the military to support a variety of voluntary programs, adequate safeguards are needed to preserve patient autonomy. Additionally, psychological and spiritual counselling must be included in a donor program to ensure true and proper informed consent.

Along with the conceptual problems resulting from the vagueness and ambiguity of the proposed policy, the military does not currently have the resources to manage an organ retrieval program. The location and staffing of a military medical center or community hospital will greatly affect the ability of that treatment facility to implement an organ retrieval program. Hospitals with a four bed intensive care unit and a smaller surgical staff are likely to be affected to a greater degree than major medical centers where staff scheduling is more flexible and physical resources more adaptable to maintaining cadavers for organ retrieval.

Finally, we must consider the family members, who temporarily lose control of the physical remains of their loved one. It is unlikely that they will have visitation privileges to the breathing cadaver once the pronouncement of death is made. Consequently, they must experience a physical and emotional separation simultaneously until the death ritual can begin.

Given all these considerations, what this paper has attempted to do is illustrate the immense complexity of organ donation and organ retrieval programs. It has been an attempt to get beyond the mere pragmatic cost-benefit analysis of reducing numbers on a waiting list. It has been an attempt to illustrate that the military medical system is not ethically, psychologically, or physically capable of implementing the proposed DoD organ donor policy--a policy that as it stands in its present form is flawed conceptually and lacks practical usefulness.

BIBLIOGRAPHY

Feinberg, Joel. "The Mistreatment of Dead Bodies." The Hastings Center Report (February 1985): 31-37.

Kimble, Vesta. "DoD Wants to Set Up Organ Donor Program," Army Times, 24 August 1987, 3.

Gaylin, Willard. "Harvesting the Dead." Harper's Magazine (September 1974): 23-30.

Kass, Leon R. "Thinking About the Body." The Hastings Center Report (February 1985): 20-30.

May, William F. "Religious Justification for Donating Body Parts." The Hastings Center Report (February 1985): 38-43.

Walton, Douglas N. On Defining Death. Montreal: McGill-Queen, 1979.

Shrader, Douglas. "On Dying More Than One Death." The Hastings Center Report (February 1986): 12-17.

Youngner, Stuart, et al. "Psychological and Ethical Implications of Organ Retrieval." New England Journal of Medicine 313, 5 (1985): 321-324.

ACKNOWLEDGMENTS

I would like to thank Professor Elizabeth Wolgast, LTC John Calabro, and Major Robert Strom for their assistance in proofreading and providing criticism of the conceptual views presented in this paper. All remaining errors are my own.