RESOLUTION 11-21

Title: Updates to Organ Donation and Transplant Policies

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Original Author: Richard Burney, MD

Referred To: Reference Committee D

House Action: **APPROVED**

Whereas, living donation provides expanded access to kidney and liver transplants to appropriate candidates, preventing waitlist death and in turn increasing organ availability of other candidates to deceased donor transplants, and

Whereas, living donors often face considerable financial hardships to facilitate donation, including time off employment and travel expenses, which are not able to be directly reimbursed by law, and

Whereas, the Gift of Life Michigan is the state's only federally designated organ and tissue recovery program, and

Whereas, the Gift of Life Michigan recovers organs from HIV-positive donors, in accordance with the federal HIV Organ Policy Equity Act, or HOPE Act, and

Whereas, in Michigan, policy that was created decades ago during the AIDS crisis prohibits blood and other anatomical gifts from HIV-positive donors to be given to recipients, even those who are HIV-positive, and

Whereas, proposed legislation in Michigan would remove this outdated restriction on organs and as a result, those organs could go to HIV-positive patients, instead of being allocated out-of-state, and

Whereas, transplant programs that do not have waiting recipients who are HIV-positive also will benefit, because more available organs relieves pressure on the waiting list in-state and nationwide; therefore be it

RESOLVED: That MSMS amend MSMS policy, "Payment for Organs," by addition to read as follows:

> MSMS opposes payment in any form to the donor, the donor's family members, or the donor's agents for organs used for transplant. **Payment does not mean provisions for donation-related expenses incurred by a living organ donor including, but not limited to medical expenses related to the donation or expenses incurred after the donation as a consequence of donation**; and be it further

RESOLVED: That MSMS actively advocate for and endorse legislation in Michigan that would enable organ transplants from HIV-positive donors to HIV-positive recipients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: There is current legislation (sponsor Rep. Felicia Brabec) pending in the Michigan legislature related to organ donation and transplant policies. This is a joint advocacy opportunity supported by the Gift of Life Michigan.

Relevant MSMS Policy:

Payment for Organs
MSMS opposes payment in any form to the donor, the donor's family members, or the donor's agents for organs used for transplant. (Res5-93A)

Relieve Burden for Living Organ Donors
MSMS supports efforts to remove financial barriers to living organ donation, such as the provision of paid leave for organ donation. (Res61-17)

Relevant AMA Policy:

6.1.1 Transplantation of Organs from Living Donors
Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.
Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.
Physicians who participate in donation of nonvital organs and tissues by a living individual should:
(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donor's well-being.
(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.
(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
(i) the minor agrees to the donation;
(ii) the minor's legal guardians consent to the donation;
(iii) the intended recipient is someone to whom the minor has an emotional connection.
(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
(i) Inform the prospective donor:

(i) about the donation procedure and possible risks and complications for the donor;
(ii) about the possible risks and complications for the transplant recipient;
(iii) about the nature of the commitment the donor is making and the implications for other parties;
(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
(v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.
(j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.
(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.
(l) Permit living donors to designate a recipient, whether related to the donor or not.
(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:
(i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
(ii) domino paired donation;
(iii) nonsimultaneous extended altruistic donation ("chain donation").
(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.
(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).
(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.
(r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.
AMA Principles of Medical Ethics: I,V,VII,VIII

6.2.2 Directed Donation of Organs for Transplantation

Efforts to increase the supply of organs available for transplant can serve the interests of individual patients and the public and are in keeping with physicians' obligations to promote the welfare of their patients and to support access to care. Although public solicitations for directed donation—that is, for donation to a specific patient—may benefit individual patients, such solicitations have the potential to adversely affect the equitable distribution of organs among patients in need, the efficacy of the transplant system, and trust in the overall system.

Donation of needed organs to specified recipients has long been permitted in organ transplantation. However, solicitation of organs from potential donors who have no pre-existing relationship with the intended recipient remains controversial. Directed donation policies that produce a net gain of organs for transplantation and do not unreasonably disadvantage other transplant candidates are ethically acceptable.

Physicians who participate in soliciting directed donation of organs for transplantation on behalf of their patients should:

(a) Support ongoing collection of empirical data to monitor the effects of solicitation of directed donations on the availability of organs for transplantation.
(b) Support the development of evidence-based policies for solicitation of directed donation.

(c) Ensure that solicitations do not include potentially coercive inducements. Donors should receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.
(d) Ensure that prospective donors are fully evaluated for medical and psychosocial suitability by health care professionals who are not part of the transplant team, regardless of any relationship, or lack of relationship, between prospective donor and transplant candidate.
(e) Refuse to participate in any transplant that he or she believes to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.
AMA Principles of Medical Ethics: VII,VIII,IX

Removing Financial Barriers to Living Organ Donation H-370.965
1. Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (a) provisions for expenses involved in the donation incurred by the organ donor; (b) providing access to health care coverage of any medical expense related to the donation; (c) provisions for expenses incurred after the donation as a consequence of donation; (d) prohibiting employment discrimination on the basis of living donor status; (e) prohibiting the use of living donor status as the sole basis for denying or limiting health, life, and disability and long-term care insurance coverage; and (f) provisions to encourage paid leave for organ donation.
2. Our AMA supports legislation expanding paid leave for organ donation.
3. Our AMA advocates that live organ donation surgery be classified as a serious health condition under the Family and Medical Leave Act.

Sources:

1. https://www.kidneynews.org/kidney-news/cover-story/kidney-donation-costs-too-high-for-potential-donors-with-low-income#:~:text=For%20donors%2C%20however%2C%20the%20reported,month%27s%20salary%20for%20most%20donors
2. https://www.giftoflifemichigan.org/about-us
3. https://optn.transplant.hrsa.gov/learn/professional-education/hope-act/