

Ethical Guidelines for the Evaluation of Living Organ Donors

**University Health Network
Bioethics Program**

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INTRODUCTION

Ethical considerations related to the evaluation of living organ donors are complex and continually evolving. Accordingly, the ethical guidelines set out in this document are regularly updated.

A high-quality, ethical living donor transplant program can be described and evaluated on the basis of three elements: structure, process and outcome [1]. Structural elements are the overall qualities of The Program that healthcare practitioners must attend to such as duty to care for patients and the obligation to maintain confidentiality. Process elements focus on interactions between staff, potential donors, transplant candidates, and families, and include, for example, the selection process for seeking and obtaining valid informed consent. Outcome elements relate primarily to medical and psychosocial evaluation and the management of the health status of donors and transplant candidates including follow-up after organ donation/receipt.

1. STRUCTURE

The UHN Multi Organ Transplant Program (henceforth “The Program”) is committed to:

UHN Partners in Care Service Standards

- **Patient Perspective:** Engage patients & families as Partners in Care
- **Approach:** Demonstrate positive intent in all interactions
- **Respect:** Be respectful in interactions with others
- **Transitions:** Work collaboratively with others to ensure seamless care across the patient journey
- **Navigate:** Navigate the environment (way-finding) & care journey
- **Empathy:** Be empathetic in interactions
- **Relationships:** Build & sustain collaborative relationships
- **Service:** Promote a culture of service excellence

Ethical Principles and Values

- Respect for Autonomy
- Beneficence
- Non-maleficence
- Double-equipoise
- Justice
- Diversity
- Trust

These ethical principles and values need to be weighed and balanced against each other.

Respect for Autonomy

Autonomy literally means self-governance. The ethical principle of respect for autonomy recognizes that people are socially situated and their identities are formed within the context of relationships. Moreover, a patient's healthcare decisions are shaped by the interplay of social determinants such as economic position, gender, race, class, and ethnicity. Respect for autonomy is operationalized in healthcare through an informed consent process. To empower potential donors to make an autonomous decision about whether to donate, they must be informed about, and have the ability to understand and appreciate the potential benefits and risks of organ donation in the context of their lives, as well as the alternative courses of action available to them (including the option of not donating). They must also be free from undue pressure or coercion in making a decision about whether or not to donate.

Beneficence

The ethical principle of beneficence requires healthcare practitioners to act in the best interests of their patients. It may require practitioners to refrain from offering or recommending treatments to patients for which the risk of harm may significantly outweigh the potential benefits.

Non-Maleficence

The ethical principle of non-maleficence is a contemporary restatement of the Hippocratic imperative "first, do no harm". Non-maleficence requires that health practitioners endeavor to prevent or reduce the harms associated with the options they offer to their patients.

Balancing Non-Maleficence and Beneficence

Principles are *prima facie*, rather than an absolute requirements, meaning a principle may be overridden by competing ethical principles (for example, the pain associated stitching an open wound may appear to violate the principle of non-maleficence, but is ethically justified by the potential physical benefits of doing so. Hence, the ethical principle of beneficence may outweigh the principle of non-maleficence in this situation). In transplantation, the potential benefit to the recipient is greater than the benefit to the living donor. It is acknowledged that the potential benefit to the donor is primarily psychological in nature, i.e. an increased sense of wellbeing and self-esteem resulting from helping another individual. In balancing the ethical principles of beneficence and non-maleficence, The Program strives to minimize risks, maximize potential benefits, and facilitate autonomous decision-making by maintaining a high standard in the process of seeking and obtaining informed consent from potential donors.

Double Equipoise

Double equipoise in transplantation describes the balance between the transplant candidate's potential survival benefit if they receive a transplant and the probability of donor risks and mortality. The analysis is therefore not restricted to the transplant candidate. Any risk of harm to the donor is not ethically justified if the potential benefits to the candidate are minimal.

Recommended reading: [2]

Justice

Justice requires that patients are treated fairly, equitably, and appropriately. Considerations about justice are also used to help make distributive decisions about the fair allocation of absolutely scarce resources (in this case, solid organs) among patients. Distributive justice also includes priority setting decisions about how to fairly distribute limited institutional resources, such as patient beds, operating rooms, and clinical staff.

Diversity

The Program appreciates and acknowledges the diversity of beliefs, perspectives, values, and histories of patients, family members, and staff. The Program strives to maintain a welcoming, respectful and inclusive environment in which a plurality of viewpoints can be safely expressed, represented, and integrated into healthcare discussions and decisions at all levels. A commitment to diversity requires that all staff to be open to learning from others' experiences on an on-going basis.

Trust

Trust is an affective or emotional attitude that depends on a person's good will and motivations toward another person. The provision of healthcare is grounded in trust relationships and the trustworthiness of its professionals and institutions. Patients rely on healthcare professionals motivation, knowledge, skill, and training to competently fulfill their responsibilities.

In some situations, these ethical principles and values may be difficult to balance or optimize. The Program aims to listen carefully to potential donors, family members, and healthcare practitioners in an attempt to support quality decision-making. If there are serious reservations or a lack of agreement about certain decisions, consultation can be sought from the Bioethics Program or other relevant resources within and outside the University Health Network.

2. PROCESS

Maintaining Confidentiality

All information pertaining to the potential donor's workup remains confidential and will not be divulged to anyone outside of the healthcare team, including the transplant candidate. Transplant candidates will not be informed of any potential donor being evaluated.

To achieve confidentiality, transplant candidates will be told in advance that they will not be provided with a specific explanation if a potential donor does not meet the criteria for safe donation or elects to withdraw as a donor. Rather, they will be told that this donation was not suitable. It is acknowledged that this may cause the potential candidate, or others, anxiety around the potential donor's health. The team is available to help the potential donor plan how to convey this information to others. They will also provide counseling, if needed, to the potential donor and candidate, as well as to their families, to help them cope with the outcome.

Payment/Financial Considerations

In accordance with the law, The Program prohibits donors profiting in any material way from his or her organ donation. "Material" is not limited to money or other financial items; it can include other benefits such as employment, commercial goods, educational opportunities, and so on. However, The Program allows for the reimbursement for legitimate costs incurred in the process of donation, such as loss of income, travel, meals, accommodation, and parking. Living donors and living donor candidates may apply for reimbursement of eligible expenses up to a maximum of \$5,500 through Trillium Gift of Life Network's (TGLN) Program for Reimbursing Expenses of Living Organ Donors (PRELOD) [3].

Recommended Reading: [4], [5]

Adequate Time

Donation can be a lengthy process from initial information gathering and provision to evaluations to an actual donation. The potential donor, the transplant candidate and the medical team all need adequate time to ensure high quality discussions and decisions. A "cooling off period" between the donor consent being given and the scheduled donor operation is a useful step so that the potential donor can review their decision to donate. Even in emergency medical cases, potential donors must be fully supported in choosing or declining to donate and undue pressure or coercion should never influence their decision.

Selection

Separate Donor and Transplant Candidate's Healthcare Teams

Conflicts of commitment can be avoided by separate healthcare teams assessing a potential donor and a transplant candidate. At times, surgical team members may be required to be involved in the care of both the potential donor and transplant candidate due to shared expertise within The Program. The potential donor will have a separate advocate and an independent internal medical consult team involved in the assessment process. The potential donor is also interviewed without the transplant candidate present. Other consultations, such as psychiatric and social work consultations are also conducted by separate professionals whenever possible.

Information for Potential Donors, Candidates, and Families

The potential donor should be informed about the process of assessment at the outset, i.e. how The Program is run and the exact steps that will be taken. This information is also shared with the transplant candidate. Parties should be told that as many potential donors as willing and available should be encouraged to submit applications to be screened, but generally only one donor will undergo testing at a time. This is to ensure a safe, thorough work-up; minimize distress for the donor; and minimize the risk of finding health issues that could affect insurability, which donor candidates might prefer to remain unknown. Each potential donor is told which tests will or may be carried out.

Each potential donor is independently informed of the results of their testing.

The Program will not inform each potential donor of how many people are undergoing initial testing for a particular candidate nor will the identity of the potential donors be revealed to them because providing this information might breach donor confidentiality.

Medical/Surgical Suitability

Suitability is assessed by the donor team and an independent medical consultant. Where there are special surgical considerations, the potential donor may be seen by an independent surgeon, who acts as an additional donor advocate.

Psychosocial Suitability

Psychosocial suitability is assessed by a psychiatric nurse or a social worker. Additional psychosocial evaluations from a psychiatrist may be requested. Non-directed donors will be seen by a social worker or nurse and a psychiatrist in two separate interviews, or more if needed. This has the advantage of providing at least two independent assessments of whether the potential donor meets the psychosocial criteria in order to donate. It is optimal for these interviews to be

conducted on separate days because the potential donor may present differently at different times and to different people.

The goal of the psychosocial assessment is to establish that the potential donor is capable of making an informed decision about donation; understands the nature of donation and the likely psychosocial consequences for themselves, their family, and the candidate; and confirm that there are no pre-existing psychosocial issues that may pose an increased risk to the donor. The motivation for donation is examined to confirm that the potential donor is not ambivalent. Expectations are examined to establish that they are realistic. The donor's capacity to cope with a poor outcome and the adequacy of social supports, are evaluated. Substance use issues are also addressed, and clinical support is offered where appropriate. It must be established that there is no co-occurring medical condition that would prevent the donor from making a capable decision regarding donation.

The psychosocial team will ask the potential donor about the attitude of their family about donation in order to ascertain if there is conflict between the potential donor and their family regarding donation and, if so, counseling is offered to resolve such conflict. How donation has been or will be presented to the children of the donor, if applicable, is addressed. The economic impact of donation is explored and the donor is informed of any insurance or financial assistance programs that may be available to them. Optimal timing of the surgery is discussed in terms of reducing economic or social hardship for the donor and/or their family. The plan for surgery is discussed in terms of the potential donor's need for accommodation located near the hospital, accompaniment of family, and any care needs for the potential donor's children, elderly relatives, or pets at the time of, and immediately following, the planned donation.

Recommended Reading: [6] [7]

Informed Consent

Informed consent is a multi-step process of information gathering and sharing that result in donor understanding and acceptance during the assessment process. Sufficient time is needed to ensure adequate disclosure and understanding of donation, and its risks (this includes the physical risks of donation, as well as the psychosocial risks – e.g. the risk that the transplant may have a negative outcome for the candidate, potentially leading to psychosocial distress in the donor) and potential benefits. Sometimes it is possible to obtain informed consent for donation within a brief period of time, although this is not ideal. The informed consent process may also take weeks or months.

Capacity

The donor's ability to understand and appreciate the nature of donation, and its risks and potential benefits, is evaluated by all team members and in particular by the psychiatrist, physician, and social worker. When the potential donor is found to lack the capacity to make a decision about donation, they will be disqualified as

a donor. In circumstances where their capacity is not clear, or if healthcare team cannot reach a consensus about the potential donor's capacity, The Program will undertake a special review to consider the use of a legally authorized substitute decision-maker. In such cases, a UHN Bioethicist will be consulted as appropriate.

Disclosure

The team members must give each potential donor full program-specific information regarding the risks and potential benefits to both himself or herself and the potential recipient during the evaluation process. Members of the donor team, including the coordinator, the donor physician, surgeons and psycho-social team members, are responsible for having these discussions with the potential donors. The authors for the Live Organ Donor Consensus Group outline the following as information to be disclosed to potential living donors [8]:

1. Description of the evaluation, the surgical procedure, and the recovery period.
2. The plan for both short- and long-term follow-up care.
3. Alternative donation procedures, e.g. laparoscopic donor nephrectomy or open flank, including those that are only available at other transplant centres.
4. Possible medical, surgical and psychological complications for the potential donor, including reports of donor deaths and the specific experience with complications following donation in the local program.
5. The medical uncertainties, including estimates of risk and the potential for long term donor complications.
6. Any financial costs that may be borne by the potential donor.
7. The potential impact of donation on the ability of the potential donor to obtain health and life insurance in the future.
8. The potential impact of donation on the lifestyle of the potential donor, and their ability to obtain future employment.
9. Information regarding the specific risks and potential benefits to the potential recipient.
10. Expected outcome of transplantation for the recipient, e.g. results of second and third transplants, effects of co-morbidities, diabetes, arthritis.
11. Alternative treatment options available to the potential recipient (including the option of no treatment).
12. Program-specific statistics of donor and recipient outcomes for the transplant centre.

Understanding

Information regarding the risks and potential benefits to both the potential donor and recipient needs to be presented in a way that is easy for the potential donor to

understand, taking into account their language, ethno-cultural background, and educational level. Such understanding can be facilitated using various strategies, including the use of everyday language and visual material to supplement written material. In cases where the potential donor's primary language is not English, their family members should not be used as interpreters, since they may not be impartial toward the information being discussed. Instead, professional interpreters should be used.

Voluntariness

In order for consent to donation to be ethically valid, it is essential that potential donors offer to donate voluntarily, rather than in response to perceived or actual undue pressure. Pre-transplant psychiatric and social work interviews will include assessment of voluntariness of consent to donate pre-transplant by examining the following:

1. Potential donor's psycho-social situation
2. Potential donor's financial status
3. Whether the potential donor has a relationship with the transplant candidate, and, if so, the nature of that relationship
4. Potential donor's rationale for donation
5. Information on whether the potential donor was asked to donate, and, if so, by whom and under what circumstances
6. Potential donor's appearance of comfort to decline the request
7. Potential donor's comfort in the presence of other family members or people involved in the donation
8. Evidence or suggestion of material reward for donation
9. Potential donor's willingness and motivation to donate
10. Any power imbalances between potential donor and candidate

Procedure for Decision Making on Donor Suitability

Where there is a lack of consensus among team members, the concerns are shared with the potential donor and candidate as appropriate. The following process is undertaken:

1. Consultation with the following professionals:
 - Other professional members of staff when medical or psychosocial aspects of the case need clarification.
 - A UHN Bioethicist when ethical issues are in question.
 - Legal Counsel when legal aspects require clarification.

- Hospital Administration when there are organizational or public relations concerns.
 - Outside resources and consultation, independent of UHN or the University of Toronto, when it appears that the impartiality of involved staff may be questioned.
2. The plan for donation is accepted or refused by the team.
 3. The potential donor is informed of the decision by the donor physician, alone or with another team member. When a potential donor is not accepted, the reasons for the decision are shared with the potential donor and opportunities for addressing the issue(s) are explored. He/she will be offered a referral for a second opinion at this or another institution.
 4. The plan for informing the transplant candidate is discussed with donor.
 5. The candidate is informed of the decision by the potential donor or the potential donor's team members, as agreed to by the potential donor.

Emergency Situations

Transplantation from a deceased donor remains the standard of care for the lung and liver transplant programs. In emergency cases, every attempt is made to balance a living donor's autonomy, i.e. the right to consider a procedure that may save the life of someone who is important to them, with the need to ensure that the potential donor is acting voluntarily and is giving their informed consent. It is recognized that a potential donor will inevitably experience internal pressure in such a situation. In order to minimize external pressure, the usual process is followed with extreme caution:

1. The transplant candidate's family is informed by a member of the medical team of the urgent need of an organ and the option of living donation.
2. If someone offers to donate, a physician explains the risks and potential benefits of the procedure and an outline of the workup process. The potential donor is informed that if they wish to withdraw, complete confidentiality will be maintained around this decision. The potential donor will then be officially classified as an "unsuitable donor".
3. If the potential donor indicates that they wish to proceed and consents to further testing, they are assessed by a member of the psychosocial team to verify that their consent is voluntary. The potential donor's motivation for donation is carefully examined to ensure that perception and expectations of donation are realistic. This includes assessment of both current and past family dynamics, the potential donor family's attitude about donation, the possible repercussions of donation or non-donation, and the potential donor's need for help in handling these.
4. The testing process is then carried out in full.
5. The potential donor is seen without other family members by the donor physician and the donor coordinator. The potential donor is asked again if he or she wishes

to withdraw consent to donate, and is informed again that complete confidentiality will be maintained related to the reasons for this decision and he/she will then be officially classified as a “suitable” or “unsuitable donor”.

6. If the potential donor wishes to proceed and has been approved by the transplant team, i.e. team members confirm that the donor appears to be acting voluntarily and to be adequately informed; the second and final consent is sought and obtained by a physician from the transplant team.

Final Decision for Organ Donation from a Living Donor

For living organ donation to proceed, there must be agreement among the potential donor, candidate, and the medical team. The final decision to perform the living donor transplant rests with the transplant surgeon. There is no obligation on the transplant team to perform a transplant in cases where they believe that the risks to the donor significantly outweigh the potential benefits to the candidate.

When Donation does not Proceed

When a potential donor is deemed unsuitable to donate on medical grounds, arrangements will be made for the appropriate care of the potential donor to address the medical issue if indicated and desired. Potential donors who decide not to proceed with donation or who are ruled out as donors on medical grounds will be offered counseling by a qualified social worker, psychiatrist, or psychiatric nurse from the transplant team.

The goals of the intervention are:

1. To enable the potential donor to work through any unresolved emotions or conflicts that they may have around the decision not to donate.
2. To help the potential donor decide how they want to inform the candidate of the decision not to donate. Staff will help the potential donor to make a plan and to carry it out, if the potential donor so chooses.
3. To help the potential donor deal with the discovery of a serious problem, where applicable.

Incidental Discovery of Misattributed Paternity

The Program conducts human leukocyte antigen (HLA) testing routinely on potential kidney donors and potential candidates to determine their tissue compatibility. When such testing is conducted on a potential donor and candidate, who believe that they are genetically related (e.g. parent and child), the results may suggest that there is no genetic link between them. Therefore, during the evaluation, the team informs the potential donor and candidate that HLA testing may yield results that suggest non-paternity. The potential donor and candidate are informed that further testing in a qualified laboratory through a family doctor would be required to confirm such results. The potential donor and candidate are each given the opportunity to register his or her wish to have or not to have such information disclosed to him or her by the

team. The potential donor and candidate are also informed that psychosocial support and follow-up will be provided to help them come to terms with such information, if applicable [9].

Communication between a Potential Donor and Candidate

While in hospital, staff will aim to maintain confidentiality surrounding the potential donor and candidate's information. The issue of providing the potential donor with information about the potential candidate or *vice versa* may best be addressed prior to admission to the hospital in order to clarify the process to be used and the wishes of the potential donor and candidate. It is acknowledged that the potential donor and candidate are often eager to know that the other is well. However, this may lead to a breach of confidentiality. Nursing staff and/or the social worker will attempt to set up a line of communication between potential donor and recipient when requested and possible. This is especially important when a parent donor is in a different hospital than the recipient child and requires frequent updates regarding the child's condition.

Potential donors and candidates who are known to each other often want to have an opportunity to be together in hospital after the surgery. Staff should be aware of the importance of this and try to facilitate this as soon as it is medically safe to do so and when the two parties indicate that they are ready.

The Program will not facilitate post-surgical contact between an anonymous living donor and transplant recipient. The Program will facilitate anonymous letter writing between the two parties, if desired. Please refer to Standard Operating Procedures Manual LD-012 *Contact between Anonymous Living Organ Donors and their Recipients*.

Documentation

Information regarding the potential donor and candidate is documented and kept in separate charts. The documentation includes written reports by the professionals who have assessed the potential donor, attesting to the potential donor's capacity to make a decision about donation, understanding of the proposed procedure and of its risks and potential benefits for the potential donor and candidate, the disclosure process, and the potential donor's voluntariness and motivation for donation. It should also state clearly if the potential donor is medically and psychologically suitable to donate.

3. OUTCOMES

Success

Evaluation of donor and candidate's experiences and medical outcomes are essential parts of a high-quality and ethical living donor program. The minimum requirements

include an annual review of early and late morbidity, graft function and mortality. It is also desirable to establish a donor registry and to monitor donor and recipient satisfaction rates.

Follow-Up

Donors will be offered medical and psychological care related to the donation process. The length and content of this follow-up will vary according to the organ donated and will reflect best practices as determined by The Program. Follow-up will be provided or arranged by the appropriate member of the transplant team.

Poor Outcome of Organ Donation

Staff should discuss with the candidate or family whether, how, and when to inform the donor of the failure of the donated organ. If the recipient wishes to inform the donor, support by a member of the transplant team will be offered. The donor will be informed in as supportive a manner as possible, with attention paid to a suitable place, time and way of imparting the information. A member of the transplant team, such as the nurse, social worker or psychiatrist, will be available to provide counseling services as needed. Attention will be paid to the fact that the significance of the donor's gift of an organ is not altered by a poor outcome and that the donor is not responsible for the result of the transplant.

Critical Incident with a Living Organ Donor

UHN and The Program recognize the risk and potential of a critical incident occurring with a living organ donor prior to, during, or shortly after donation as a result of the donation. In the event of such an incident, UHN will provide a responsible, timely, and constructive response. UHN will maximize the safety of other patients, support patients and their families, and maintain confidentiality while preserving transparency, and informing stakeholders. Please refer to UHN Policy 3.20.020 *Critical Incident with a Living Organ Donor*. [10]

Bereavement

In the event that the candidate or donor should die, bereavement counseling will be offered to the surviving person and involved family members. This will be provided by members of the living donor team and the psychosocial team (social worker, psychiatric nurse, psychiatrist, spiritual care, and MOT physician). Based on the donor's wish, a referral can be made to an appropriate service in the community.

4. POTENTIAL OPTIONS FOR LIVING ORGAN DONATION

In an attempt to increase the number of live donor organs available for transplant, numerous options for living organ donation have been described in the literature. This includes new classification systems for donation.

Recommended Reading: [11]

Unspecified Donation

Non-Directed Donation

A non-directed donation occurs when a person donates his or her organ unconditionally to the general pool of recipients on the deceased organ transplant waiting list. The potential donor has neither a genetic nor emotional relationship with the transplant candidate [12]. The potential donor and candidate are mutually anonymous at the time of donation. The donor and candidate are informed about the risks of non-directed donation, such as discovering the others' identity through formats such as social media, including unwanted requests or attention. A potential donor's offer to donate should be motivated by altruism. An altruistic act is generally one in which a person intends to do good or be kind to others. However, the altruism of an act is not necessarily negated if it is performed partly out of self-interest, for example, a desire to discharge a perceived moral duty to help another person.

Recommended Readings: [13],[14], [15], [16]

Specified Donation

Kidney Paired Donation (KPD)

The Living KPD program is a national registry, operated through Canadian Blood Services, that connects incompatible living kidney donor-candidate pairs with other incompatible pairs to make a successful match. The KPD registry can also identify a series of pairs that could exchange donors in a chain-like manner. This process starts with a non-directed donor and ends with a person on the kidney transplant waiting list.

Use of Non-Directed Donors in a Kidney Exchange Program (NDD-LE)

In a list exchange (LE), the intended recipient of an incompatible donor receives priority on the deceased donor waiting list when the incompatible donor donates a kidney to a recipient who is on the deceased donor waiting list. A kidney from a non-directed donor (NDD) is usually donated to a recipient on the deceased donor

waiting list. In the NDD-LE, the NDD donates a kidney to the intended recipient and the incompatible donor donates a kidney to a recipient on the deceased donor waiting list. An NDD-LE increases the number of transplants by one if, and only if, the incompatible pair would not have exercised the LE option without being given the kidney from the NDD. In an NDD-LE, the intended recipient receives a living donor kidney rather than priority for a deceased donor kidney.

Recommended Reading: [17]

Anonymous Directed Donations

An anonymous directed donation occurs when a donor identifies a particular transplant candidate to whom his or her organ is to be given. The potential donor is a stranger who has neither a genetic nor an emotionally relationship with the potential recipient. The Program may accept an offer of donation that is directed to a particular *individual* recipient, such as a person identified in the public as needing an organ. However, the psychosocial team pays special attention to the potential donor's motivations for donation and expectations related to his or her offer [2]. The potential donor is informed about the standard allocation criteria for non-directed organs, and is given the option to donate by such criteria instead [18].

Given that discrimination based on one's membership in a particular group defined by race, ethnicity, sex, gender, or lifestyle contravenes the ethical principle of justice as fairness, as well as human rights, The Program does not accept offers of donation that are directed to or excluding particular *groups* of potential recipients, except those that are directed to children. This is because it is believed that the potential negative impact of end-stage organ disease on the social and physical development of children warrants accepting a person's offer of donation that favors children above other groups. Also, public support of unrelated directed donations to children has been documented in at least one empirical study [19].

Recommended Reading: [20]

5. ADDITIONAL ISSUES

Living Donation from Non-Residents or Non-Citizens of Canada

Living donation from a non-resident or non-citizen occurs when a donor who is not a legal Canadian resident or citizen donates an organ to a local candidate. The team assesses each potential non-resident or non-citizen donor using the standard robust evaluation, but pays particular attention to the potential donor's motivations and expectations, as well as any evidence or suggestion of material exchange. The team considers thoroughly the unique set of circumstances surrounding each potential living donation for a non-resident or non-citizen, weighs the various ethical and practical considerations, and exercises its best judgment in deciding whether to accept

or reject the donor's offer. The potential donor is informed, among other standard details, that:

1. Material exchange for organs is illegal in Canada.
2. There must be proof of a medical team in the potential donor's jurisdiction of origin who is able to assist with follow-up post-surgical care and for monitoring purposes in case of complications.
2. Reimbursement for transplant related expenses is acceptable, which the donor may apply for through TGLN's reimbursement program (see "Payment/Financial Considerations").
3. Non-transplant related medical coverage while in Canada is strongly advised.

The Program does not accept offers of donation from people who reside in Canada and do not have legal standing in Canada.

Recommended Reading: [21]

Public Solicitations for Organs

The Program accepts public solicitations for organ donors initiated by transplant candidates or their representatives. A potential donor may answer a transplant candidate's need for an organ that is advertised in the public through, for example, print or online social media, community groups such as faith congregations, or spoken communication. The team assesses the potential donor using the standard robust evaluation, and pays special attention to the potential donor's motivations for and expectations of donation, as well as any evidence or suggestion of material exchange [12]. When the potential donor's relationship with the candidate is based solely or primarily on the solicitation, the team informs the potential donor about the risks associated with his or her lack of knowledge about the potential recipient (e.g. the potential recipient's story may be exaggerated or false). The Program will pay extra attention to these issues in the case of a potential anonymous-directed donor found through public solicitations. See Section 3 above: "Anonymous Directed Donations".

The Program aims to commit the human and resource infrastructure necessary to manage a surge in donation applications resulting from public solicitations. Such infrastructure includes a surge and communication plan. The decision-making process around the plan should be made transparent to all program staff. All program staff should have the opportunity to contribute to the content and revision of the plan.

Recommended Readings: [22],[23],[24],[25],[26],[27] [28],

Publicity

The Program does not refuse categorically offers of donation that are motivated by a desire for public recognition. However, the potential donor's desire to gain publicity is usually regarded as a high risk factor for donation [26]. Therefore the team proceeds carefully and uses its best judgment in deciding whether to accept or reject

offers of donation that is motivated by publicity. The team may decide not to accept a potential donor's offer if publicity is his or her primary or sole reason for wanting to donate, or if the purpose for the publicity is considered inappropriate (e.g. to enhance one's political profile).

Living Donors' Families or Close Others

The potential donor is strongly advised to inform his or her family or close others about his or her intention to donate. When possible, and if the donor provides consent, the attitudes of the family or close others about donation are explored through two separate interviews, one with and one without the family present. If there is conflict between the potential donor's decision and the wishes of the family or close others, counseling is offered and strongly encouraged to help resolve such conflict. Ultimately, the potential donor's autonomous decision takes precedence over the wishes of the family or close others, unless the consequences of accepting an offer against the wishes of the family or close others are believed to place the potential donor at higher risk of emotional distress or inadequate social support.

Recommended Reading: [29]

Repeat Living Donation

When a previous donor makes a subsequent offer of donation, the team assesses the potential donor (again) using the standard robust evaluation. The team pays special attention to the donor's motivations, for example, whether the donor's offer is based on an excessive desire for attention.

6. RESEARCH

The principles embodied in this document are consistent with those of the Tri-Council Policy Statement 2 on the Ethical Conduct of Research Involving Humans and are intended to support research into the care of living organ donors.

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