Naava Katlowitz is a 42-year-old Brooklyn mother of 5 children who is waiting for a lung transplant. She recently captured public attention when her family, friends, volunteers, and community organizations joined a nationwide search for a donor to save her life. Mrs. Katlowitz’s lung disease stems from a successful bone marrow transplant she received 27 years ago to treat aplastic anemia. Many well-intended friends and volunteers took up her challenge by publicly appealing on her behalf through a letter writing campaign, which in turn gained media attention.

With the advent of effective chemical immunosuppression, and with the disparity between the availability of, and need for, donor organs, there is a growing practice of live organ donation by family members. Live organ donation has been extended to emotionally-related donors, and more recently, there has been growing interest in directed and non-directed organ donation from living donors, the latter of which has also been referred to as "Good Samaritan," "altruistic stranger,” or “living anonymous” donation. One variation of this practice is a form of organ swapping. Take for example two patients in need of transplants whose relatives are willing to donate organs. In both cases the donor organs are poor matches for the family member recipient. If the donors were better matches for the non-family member recipients, they could designate the organ to go to the non-relative in a “trade.”

Taken a step further, one could imagine a family unable to find another family with whom to swap, running an advertisement or a high visibility appeal looking for a donor—as in Naava’s case. If one can designate and trade organs, is there any problem with letting others know of the need through advertising or special pleading campaigns? Much of the federal system of allocating organs has grown out of struggling with such questions.

In the current allocation system, once a deceased organ donor is identified, an organ procurement organization matches his or her with an organ transplant candidate taken from a ranked list of patients calculated according to its organ allocation policies. Factors affecting ranking may include tissue match, blood type, length of time on the waiting list, immune status and the distance between the potential recipient and the donor. For heart, liver and intestines, the potential recipient's degree of medical urgency is also considered. The organ is offered to the transplant team of the first person on the list. Often, the top transplant candidate will not get the organ for one of several reasons. When a patient is selected, he or she must be available, healthy enough to undergo major surgery, and willing to receive the transplant immediately. If the organ is refused for any reason, the transplant hospital of the next patient on the list is contacted. The process continues until a match is made.

This allocation practice now seems so uncontroversial that it is easy to forget the moral battles...
Educational considerations are not to be construed as policy recommendations.

involved in its development. Conversation about the equity of organ distribution resulted in agreed upon processes. For example, the desire to develop a fair allocation process produced the following practices: it created a level playing field so that all people in need have access, not just those who can gain special access; it made the allocation process “transparent,” for all the public to see, with no hidden decision mechanisms; and it improved a process as it strove to create greater equity. Outside allocating organs, other processes have been identified, such as the opportunity to appeal decisions. The moral discussion around organ distribution also identified substantive criteria such as need, urgency, survivability, effectiveness, and feasibility. Before this system appeared, the practice of allocation tacitly used a “first come, first serve” rationale, which effectively gave preference to those who could first locate and access the organ by getting on several waiting lists. People who had the means to acquire access, whether through wealth or education, got on the lists first leaving those already disadvantaged by income or education worse off.

Does the already agreed upon process reveal any ethical shortcomings with respect to allocation through special advertising for the organ, or designated or non-designated donation? It appears so. First, special pleading or advertising seems to give preference to those who have the means to draw public sympathy and attention, such as friends and volunteers. Second, in the case of non-designated living donation, there exists no governing national policy. Consequently, some institutions that secure a live donor presume that organs recovered in this manner may be applied for the exclusive benefit of the recovering center's patients. However, the goal in pursuing non-directed organ donation from living donors should be to derive maximal benefit and equitable distribution, since it is a unique national (public) resource. When it comes to designated donation, there seems to be less of a problem, as long as other ethical requirements are met, namely, making sure the donor is freely consenting to the procedure and is not being placed at unacceptable risk.

The issue of allocating scarce resources is such a murky moral terrain that most ethics committees are reticent to explore it. Nevertheless, they can begin their exploration by learning about how the processes and criteria that are used in high profile organ allocation cases evolved, and about their benefits and shortcomings.