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November 14, 2011

John R. Lake, M.D.
President
Board of Directors
OPTN/UNOS
700 N. 4th St.
Richmond, VA 23218

Re: Proposed changes to the DCD Model Elements

Dear Dr. Lake:

We write on behalf of the over 16,000 members of the Christian Medical Association (CMA).

While appreciating the worthy goal of increasing the supply of donated organs available for transplant, CMA has the following concerns about proposed changes to guidelines on organ donation after death:

1. The proposed Requirements remove the important stipulation separating patient care from donation solicitations.

Whereas previously the hospital's primary healthcare team and the legal next of kin must have decided to withdraw ventilated support or other life-sustaining treatment before the patient is evaluated as a DCD candidate, under the proposed policy a patient may be evaluated as a DCD candidate *prior* to a decision by family members and caregivers, which ought to be free from external pressure. Gone is the crucial wall separating patient care from donation solicitations. Such undue influence on difficult decisions at a heart-wrenching time is ethically unacceptable.

2. Removal of the requirement of "irreversibility" of cardiopulmonary cessation exposes patients to potential exploitation.

The proposed policy states that, "Pronouncement of death can only be made after a sufficient time period has passed, as defined by hospital policy." The revised wording, which authorizes shorter time periods, abolishes a vital safeguard that previously required waiting at least several minutes "to determine that circulation will not recur spontaneously (auto-resuscitation)." CMA is concerned that relaxing the definition of death would considerably increase the risk that procedures to remove vital organs would be performed on some patients lacking unambiguous signs that death has occurred. CMA is also concerned about the impact that publicized abuses of the new policy could have on the public's trust in transplant medicine and their willingness to volunteer as future organ donors.

3. The proposed Requirements broaden donor criteria to include patients without cognitive neurological injury.

The proposed policy broadens donor eligibility to include patients with upper spinal cord injury or irreversible disease of the pulmonary or musculoskeletal systems who may be cognitively unimpaired. As physicians, we are greatly concerned that patients with chronic illnesses such as spinal cord injury or amyotrophic lateral sclerosis (ALS) would be vulnerable to real or perceived pressure to decline further treatment in order to donate their organs, especially since the Requirements would permit evaluation of their eligibility for organ donation in advance of a decision whether to withdraw ventilatory or other life-sustaining support.

In this regard, we maintain that the proposed policy change conflicts with the 1978 Amendments to the Rehabilitation Act, under which the U.S. Department of Health and Human Services “may not, directly or through contractual or other arrangements, utilize criteria or methods of administration the purpose or effect of which would [s]ubject qualified individuals with handicaps to discrimination on the basis of handicap[.]”

4. The unintended consequences of the proposed Requirements would be antithetical to the ethical practice of medicine.

By loosening previous stricter guidelines, by eliminating vital safeguards and by failing to clarify key criteria, the proposed Requirements signal that hospitals and healthcare professionals can now relax ethical concerns and safeguards in favor of pursuing a utilitarian "higher good" of obtaining a greater number of organs for transplant. We believe that such a change in emphasis, however subtle, would erode the ethical practice of medicine by promoting a culture of utilitarianism or casualness regarding life and death decisions.

As physicians, we believe that the patient must always be treated with the dignity and respect due a human being. Regulations that would base the definition of death on intent, e.g., for the purpose of organ donation, represent a dangerous shift from treating patients as persons who are ends in themselves to treating them, or withholding care from them, as a means to someone else's ends. If physicians conscientiously opposed to such policies were forced to retire from the practice of critical care medicine rather than participate in them, society would lose many dedicated, skilled and compassionate caregivers.

Therefore, we urge the OPTN/UNOS Board to vote against the proposed Requirements and retain the current Model Elements.

Thank you for your consideration of our views.

Sincerely,



David Stevens, MD, MA (Ethics)
CEO, Christian Medical Association



Jonathan Imbody
Vice President for Government Relations, Christian Medical Association



William P. Cheshire, Jr., MD, MA (Ethics)
Chair, Ethics Committee, Christian Medical Association