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Ethical Implications of an Amendment to the National Organ Transplant Act of 1984 (NOTA), to Allow Solid Organ Donation Between HIV-Positive Patients

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Abstract: Due to the National Organ Transplant Act of 1984 (NOTA), in the United States it is illegal to perform solid organ donation between HIV-positive patients. If NOTA was amended it would provide organs, such as kidneys, to HIV-positive patients and help to alleviate some of the stress on the current organ transplant waiting list. The arguments not in favor of an amendment include that it is a risky procedure for the HIV-positive patients and for others involved in the procedure, such as surgeons and the surgical team. The response to this argument is that solid organ donation should be legalized and not banned due to the potential risks. The patients and surgical staff that would be participating in organ transplant between HIV-positive patients would knowingly assume certain risks. With the ban on this procedure the autonomy of HIV-patients is not being considered. HIV-positive patients should make the decision on whether or not they want to undergo this potentially lifesaving procedure and it should not be at the discretion of the government.
The United States currently has a ban on the donation of organs between HIV-positive patients in the National Organ Transplant Act of 1984 (NOTA); this ban states that “the Organ Procurement and Transplantation Network shall adopt and use standards of quality for the acquisition and transportation of donated organs, including standards for preventing the acquisition of organs that are infected with the etiologic agent for acquired immune deficiency syndrome”. This ban causes strain on the current donation system and denies HIV-positive patients access to a potential treatment which may extend their lives and increase their quality of life. This treatment is especially necessary, if they are facing diseases, such as liver and renal failure, which are commonly associated with HIV complications. Patients who manage their infections well with drugs are expected to live considerably longer, and doctors say they are as deserving of transplants as anyone else” (Walhberg 2007). “The average life expectancy after an HIV diagnosis was 23 years in 2005, up from 11 years in 1996” according to a study in September 2009 by the Centers for Disease Control and Prevention. Amending NOTA to allow this type of intra disease donation would create more benefits than burdens for HIV-positive individuals and for the already stressed organ donation system.

*Arguments in Favor of Solid Organ Donation Between HIV- Positive Patients*

Individuals with HIV are at a considerable disadvantage when it comes to receiving organs. Roland says that the HIV-associated mortality rate may make the use of a scarce resource seem unjustified and in certain circumstances other organ recipients are given priority, which leaves HIV- positive individuals less likely to receive a healthy persons organs because of the said increased mortality rate of HIV-positive patients. “Restricting access to transplantation because of poor survival rates is no longer justified in the HAART era” (Roland 2003). “During the last
five years evidence shows that in North America and Europe the survival [rate] at three years of an [HIV-positive patient] after an organ transplant is similar to that observed in HIV-negative patients” (GESITRA-SEIMC 2005). There are also “promising case reports of kidney transplantation involving HIV-positive donors and recipients in South Africa that suggest concerns regarding the transplantation of HIV-positive organs into HIV-positive recipients should be reevaluated” (Mgbako, O. 2013). Due to the introduction of HAART, an antiretroviral drug, HIV-positive individuals are living longer, but are in increasing need for organs donations due to the aggressive action of HAART on the liver and kidneys.

Since the symptoms of HIV are better treated now with the introduction of HAART, and are more easily monitored than when NOTA was created in 1984, HIV should not be considered a restrictive transmitted disease towards organ donation, especially when organs with Hepatitis C can be donated between Hepatitis C-positive individuals. With this, “only HIV-positive status is singled out as a mandated exclusion to donation under NOTA. HIV transmission policies are significantly more restrictive than policies addressing other infections that can also be transmitted during the transplantation process” (Cray 2013).

Another motive for the amendment of NOTA is due to the autonomy of HIV-positive individuals. These individuals should be able to decide whether or not they want to accept the risks associated with this type of organ donation and participate. HIV organ donation should not be at the discretion of the government because HIV individuals can make the informed decision on what they are willing to subject their bodies to. This subjection to a high risk procedure would be no different than individuals participating in research studies and clinical trials, such as the ones testing potentially lifesaving cancer treatments. The cancer research participants know the risks associated with the experimental and relatively unknown treatments, but they have the
option to participate. The government recognizes the potential benefits of these studies and they are usually the last hope for some participants, which is also a reason why they are allowed. There are many benefits associated with HIV organ donation, but since it is illegal and there are no studies in the U.S to show the benefits, the U.S government is disregarding the HIV-positive population that is in need of organs.

If an amendment was made to NATO and the ban on the donation of organs between HIV-positive was lifted, the U.S would be able to utilize the prospective “deceased HIV-infected patients [which] represent a potential of approximately 500–600 donors per year for HIV-infected transplant candidates” (Boyarsky 2011). With this the U.S would be able to “provide organ transplants to every single HIV-infected transplant candidate on the waiting list” (Ending HIV 2011). The current pool of HIV-positive individuals is not being taken advantage of, and this lack of utilization is causing the current organ donation system to be less productive than it could be in saving the lives of many HIV-positive and HIV-negative patients, currently on the waiting list. With the potential benefits of HIV-organ donation, individuals still have doubts about the certainty of the benefits and the well-being of HIV-positive patients.

Arguments Against Solid Organ Donation Between HIV-Positive Patients and Responses to these Arguments

If the ban against the donation of organs between HIV-positive patients was lifted, we do not fully know the impact that HIV-positive organs would have on other HIV-positive recipients. One of the greatest risks is severe post-transplant immunosuppression, which can be caused by “potential interactions between antiretroviral and immunosuppressive agents”, which may accelerate HIV disease progression in the organ recipient (Roland 2003). The immune system
has to be lowered to fight off the risk of the immune system and the body rejecting the new organ. Immunosuppressants are the only methods currently used to keep the body from rejecting the organ. When the immune system is lowered even more than it already is with HIV, there can be severe effects. The body is more susceptible to bacterial infections and viruses when the immune system is temporarily suppressed by these drugs. The suppressed immune system caused by HIV was the reason why HIV was so deadly before the introduction of the antiretroviral drug HAART. When trying to make HIV organ donations safe and effective, the risks of rejection and infection have to be carefully considered. If the risks are too high and the prognosis uncertain, this may justify the current ban of HIV organ donation in NOTA.

A response to this argument that the risks of severe post-transplant immunosuppression may outweigh the potential benefits of the transplant is that yes there is “concern about potential interactions between antiretroviral and immunosuppressive agents, however, experienced centers routinely monitor blood levels of these [immunosuppressive] agents and adjust doses accordingly” (Roland 2003). The pharmacokinetics of the drugs and the extensive monitoring would be the same for HIV-positive transplant recipients as they are for routine transplant recipients who require extreme care. Immunosuppression would be carefully monitored in HIV organ recipients, especially since the potential risk of it is higher in HIV organ recipients.

In addition to immunosuppression, which could lead to serious complications in an HIV positive organ recipient, there is also the uncertainty of the long term outcome of the strains of HIV in the transplanted organ. Some strains might be more virulent or drug resistant than the HIV of the person who is receiving the organ or the two strains could transform into a new strain. “The phenomenon of superinfection with a new strain or with new strains of HIV has only recently been documented, and is under study; this would be of serious concern for patients with
well-controlled HIV infection” (Roland 2003). If a new strain was created due to transplantation, it may be difficult to treat and may cause the organ recipient to relapse back into more serious HIV complications and possibly lose the organ as well.

A response to this argument is that HIV-positive donors and recipients would have to be more thoroughly screened “to eliminate unsuitable donors and the recipients who would not appropriately gain from transplantation” due to markers for the potential risk of superinfection. “Furthermore, recognition of special risks for infectious complications of transplantation will help to guide preventive, diagnostic, and therapeutic steps in the control of infectious complications in individual patients” (Schaffner 2001). In the end “the acceptability of risks for infectious complications after transplantation depends also on the urgency of transplantation of a vital organ” (Schaffner 2001). There are always risks involved in surgeries and even in routine organ donations. Patients who receive organ transplants assume these risks.

Another objection to HIV organ donation is that if these types of transplants were to become more prominent it could increase the chances of organs being mislabeled and possibly being transplanted into an HIV-negative patient. This could cause transmission of this disease from the organ to the HIV-negative patient, which could alter the organ recipient’s life forever and have serious consequences. If this were to potentially happen and be detected in a time sensitive manner, an aggressive round of antiretroviral drugs would have to be administered immediately in order to reduce the risk of the organ transmitting the disease to the recipient. The organ would also have to be removed in most cases. Not only is the recipient at a risk of infection, but it would also cause serious emotion distress to the recipient.

A response to this argument is that there is always risk in any surgery and this risk of contamination or mislabeling a organ can potentially happen readily in routine organ
transplantations. The reason why this does not happen is because the procedure to ensure the quality of organ transplantation is strict and the organs must pass through extensive examinations and hospitals before it can be transplanted. Overall the “transplant-related HIV infection risks” associated with HIV organ donation and transplantation are “low” (Organ Tissue Transplants).

An objection to the argument that the government should not have authority on whether or not HIV organ donation should be allowed, but rather at the discretion of the HIV positive donors and recipients, is that the U.S government needs to regulate medical practices and procedures in order to ensure the safety of the people in the U.S and to uphold certain ethical principles it has adopted through the U.S Department of Health and Human Services, such as “respect for persons, beneficence, and justice” found in the Belmont Report. In the case of HIV organ donation, the U.S government does not believe that it is in the best interest of the U.S to make HIV organ donation a legal medical practice as of now.

A response to the concern that the U.S government is indeed taking the necessary steps to protect individuals in the U.S by banning HIV organ donation, is that the U.S is not protecting the health and safety of HIV-positive individuals to the same degree as HIV-negative individuals because the U.S government is allowing HIV-positive patients to die as they wait for an organ. “HIV-infected patients [would] be transplanted faster”, if NOTA were to be amended to allow HIV organ donation (Margaret 2005). This would be extremely beneficial because “some [HIV-positive] patients can wait as long as 7-10 years for their transplants and many die waiting” (Margaret 2005). By the U.S government not allowing this donation, it is not taking into account the health, safety, and distress of HIV-positive individuals in need of organs.
By removing the ban on HIV organ donation, not only does this have an effect on the donor, the recipient and potentially additional waiting list candidates, but “another concern is that HIV-positive patients might transmit the virus to members of the surgical transplantation team” (Halpern 2002). Surgeons and surgical staff would be at risk of possibly contracting the disease during HIV organ transplantation surgery. Since there is a high demand for HIV organs, these surgeries would be prevalent and the surgeons would have a greater risk of contracting the disease especially dealing with infected organs and body fluids. If a surgeon or staff member were to contract the disease through a cut or prick with a needle, they would have to go through an aggressive round of antiretroviral drugs. There is always risk associated with performing routine surgeries especially when it is not known if the patient is HIV-positive or not, but when dealing with an increase of HIV related surgeries, this risk is increased.

A response to this concern “that HIV-positive patients might transmit the virus to members of the surgical transplantation team” is that “many argue that physicians are obligated to accept such small risks because of their unique responsibilities and privileges” (Halpern 2002). Physicians assumed these risks when they decided to become physicians and perform surgeries. Surgeons are expected and even required to provide care for HIV-positive individuals. “Several major medical associations, including the American College of Surgeons, contend that individual physicians have a duty to provide care to HIV-positive patients. There may also be a legal duty to provide treatment because HIV-positive persons are covered under the Americans with Disabilities Act” (Halpern 2002). In addition according to Halpern, if an individual on the surgical transplantation team potentially gets exposed to HIV in a way such as “getting cut or stuck with a needle that was used to draw blood from a person who may have HIV infection, or getting blood or other body fluids that may have lots of HIV in their eyes or mouth”, “various
post-exposure regimens provide effective prophylaxis against infection” (Organ Tissue Transplants, Halpern 2002).

In conclusion, the ban which NOTA currently has on the organ donation between HIV positive patients needs to be lifted because there would be significant benefits to HIV- positive and other benefits to HIV- negative individuals. The benefits that HIV- positive patients would receive are among those that would allow them to receive a life-saving operation and even an extension of their life. Overall the benefits for HIV- positive patients outweigh the potential risks discussed, and with this studies performed in other regions such as South Africa, that allow organ donation between HIV- positive patients, have shown promising evidence that these transplantations would be beneficial to HIV- positive individuals. As for the benefits of HIV-negative patients, they include opening up space on the organ donation waiting list and a faster rate of transplantation. The contribution that I am making to potentially help with pushing for an amendment to NOTA is that I consider the importance of the autonomy of HIV- positive patients, which has not been analyzed before. By making solid organ transplant between illegal, the government is denying the right to life for some HIV-positive patients. The procedure may be risky, but it could be lifesaving and it should be up to the HIV-positive patients to make that decision. There are other risky operations and procedures currently performed today and in each one, patients assume certain risks. The next step in making organ donation between HIV-organ donation legal, is to start clinical trials and track the results and health of the participants after surgery. Based on the results, a decision can be made on whether to make the procedure legal. With this there are an increasing number of patients who are in need of organ transplantations and the demand for organs is only getting larger with less than sufficient numbers of organs available, thus the need for an amendment to NOTA is not an act of desperation or selfishness on
behalf of HIV-positive patients, but rather it makes sense to allow a procedure that is promising and can potentially save thousands of lives, both HIV-positive and HIV-negative.
Bibliography:


