

ORIGINAL ARTICLE

The altruistic act of asking

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There are a number of obstacles to increasing the supply of cadaveric organs for transplantation. These include reluctance on the part of relatives to agree to the so called harvesting of organs from their deceased relative, and the unwillingness of some doctors to approach grieving families and ask consent for this harvesting to take place. In this paper I will focus on the altruistic act of asking that the latter entails, and will argue that failure to acknowledge the personal cost of this act to physicians is having an adverse impact on the supply of organs. I will draw analogies with the almost equally neglected altruistic act of undertaking anatomy dissection and all of the related breaking of societal taboos. I will examine the language used in discussions about increasing organ supply and conclude that the terms cadaveric and harvest are unhelpful in gaining public confidence. A process and vocabulary that openly acknowledges and validates the altruistic acts demanded of all the human beings involved—donors, recipients, their respective relatives, and the health professionals who mediate between them—is needed if the supply of organs is to be increased.

When some of us die, certain facts relating to our health status prior to death and the manner of our deaths, will mean that our organs will, in theory at least, be suitable for transplantation. Many of these potential sources of organs for transplantation will not be identified as such by healthcare staff, ever or within a suitable time frame.¹ Some of those suitable to act as organ donors will fail to be identified as a result of lack of familiarity of medical staff with the selection criteria. Targeted educational programmes have been shown to make this less common.¹ Other opportunities for seeking permission for removal of organs for transplantation will be missed by an apparent reluctance of physicians to approach the grieving family of their former patient.¹ And finally, when physicians have identified some of our dead bodies as appropriate sources of organs for transplant, and decided to seek permission from our next of kin, many of those requests will be turned down, even when we've made our wish to be a donor very clear.² Suggested interventions aimed at tackling the current shortage of organs for transplantation by increasing this supply of organs from dead donors, recommend targeting all three stages of this procurement process.^{1, 2a, 3} In this paper I will examine the second of these steps, the act of asking. I will suggest that simply arguing that doctors ought to ask because it is, according to Downie,⁴ in their job description, or because it is, according to Glannon,⁵ their duty, will fail to impact on what doctors actually do. I will argue that the discrepancy between what doctors are told they ought to do, and what they ultimately choose to do, can, at least in part, be explained by an examination of the altruistic nature of the act of asking. As a consequence, until this is acknowledged, attempts to encourage doctors to ask more often will be only partially successful.

I am aware that the use of the word altruistic is not an uncontroversial one.^{4–7} I use the term in this context not to argue for moral brownie points for the doctors who ask, but rather to draw attention to the human being behind the professional role of doctor, and the price we, as a society, pay if we choose to deny the impact of that humanity on how doctors respond in difficult situations. By acknowledging the altruistic nature of asking we can, as a society, provide those who find asking too painful an opportunity to seek support in doing so. Viewing the act of asking, by the doctor, as altruistic casts the doctor in a very different light from the predatory

image of doctors, conjured up by public concern, in too much of a hurry to declare patients brain dead. This public anxiety should be lessened by the longstanding practice whereby members of the team caring for potential recipients—the transplantation team—are prohibited from approaching the grieving relatives of potential donors. Instead, a member of the team who cared for the deceased person in life is expected to make the request. The doctor who does the asking is therefore, necessarily, not the doctor of any of the potential recipients. As such this doctor has no duty of care to those potential recipients, no professional duty to take care that either her actions or inactions do not harm the potential recipients. Nor can she be said to have a moral duty to act beneficently towards these potential recipients over and above that of any other individual. Indeed, at the time of asking, she has been chosen precisely because she has no obligation to those people and is therefore thought less likely to place undue pressure on the relatives to consent. Without wishing to revisit the arguments about the difference in meaning between the terms altruism and supererogation,⁵ I have purposely chosen to avoid the term supererogation in this case precisely because of its association with the metaphor of doctor as hero. Instead I prefer the term altruism in its simplest lay meaning. For the sake of this paper, therefore, an act of altruism should be taken as meaning an action taken in pursuance of the interests of another and not in the interests of the agent. In the situation under consideration the asker is, of course, conveniently placed to ask. She also happens to be a doctor. It might be better if she were not. Sadly, the distinction built so carefully into the system by transplantation societies—between doctors with conflicts of interest and those without these conflicts—is one that is, I fear, currently lost on most members of the public.

Heyd has provided an analysis of what supererogation is that nevertheless fits well with the meaning proposed here for what I have called the altruistic act of asking,⁸ (see box 1). Firstly, as I have already argued, any doctor with a duty of care to a potential recipient is proscribed from approaching relatives for their consent and cannot, therefore, owe any duties (over and above those of any other citizen) to these individuals. Although some commentators have argued for the imposition of a legal obligation on doctors to ask for permission whenever suitability criteria are met, it is important

Box 1

Heyd's criteria for a supererogatory act

An act is supererogatory if and only if:

- It is neither obligatory nor forbidden
- Its omission is not wrong, and does not deserve sanction or criticism
- It is morally good, both by virtue of its (intended) consequences and by virtue of its intrinsic value (being beyond duty)
- It is done voluntarily for the sake of someone's good, and is meritorious

McKay adds a further element

- The act should have a potential cost to the agent. By undertaking the act, the agent risks losing something that he might reasonably be regarded as being entitled to, on some scale of values that includes his own self interests.

for the sake of this argument that legal and moral obligations are not confused. Secondly, omitting to ask does not wrong the potential recipients, since the asker owes them no duty of care over and above that owed by any citizen. Thirdly, asking is morally good given that the intended consequence is helping someone to better health, as well as providing the opportunity for the donor and their relatives to exercise their autonomy in choosing whether to donate. Finally, as no legal duty to ask exists, the act is voluntary and for the sake of someone's good. In addition the act of asking fulfils McKay's additional criteria,⁶ in that the act has a potential cost to the agent. In order to make clearer the nature of that cost, I will describe another altruistic act undertaken by all doctors early in their training. The altruistic act of human dissection.

David Misselbrook, in his book *Thinking about Patients*,⁹ outlines his own "person specification" for the job of a doctor. This person "must be able to break personal and societal taboos by handling and cutting any part of another person's body, sometimes inflicting pain". Furthermore Misselbrook argues that "being a doctor is more than a job", it is instead "a distinctive social role". He describes the acquisition of that role as akin to joining a tribe and the act of dissection as a symbolic initiation into the tribelike corpus of medicine. Dissecting another human being's body is, even by medical standards, recognised as a strange activity for an eighteen year old. The potentially distressing nature of this activity is acknowledged by the profession by a series of "safeguards" built into the initiation process in order to depersonalise the body being dissected. Thus in the anatomy room both teachers and students talk of cadavers not people, the heads of these cadavers are covered until required, and the revelation of even the most anonymised patient details is viewed as risky to the psyche of students. Unfortunately, the failure of this system of safeguards to protect initiates from the emotional consequences of cutting up a fellow human being is evidenced by a rich body of physician generated poetry and prose.¹⁰ A provocative example of this is the poem *Carnal Knowledge* by poet physician Dannie Abse. Written thirty years after his own student days, it reveals a disturbing and mature reflection on an experience his younger self only partially appreciated¹¹ (see box 2).

As the older man looks back, addressing both his younger self and the corpse he dissected as a student, the language is of violation and vandalism, with the title drawing comparisons with the other great taboo, sex. Now whilst I fully acknowledge, and am grateful for, the altruistic act of the person who decides sometime before their death to allow their body to be used for dissection, it is worth clarifying who the main beneficiary of that act is. As a society we have decided to sanction human dissection because when we are ill we all hope to benefit from the increased knowledge and skills those

Box 2

Extracts from *Carnal Knowledge* by Dannie Abse

You, young, whistled again,
entered King's, climbing the stone-murky steps
To the high and brilliant Dissecting Room
where nameless others, naked on the slabs,
reclined in disgraceful silences—twenty
amazing sculptures waiting to be vandalised.

You corpse ...

I dug deep into your stale formaldehyde
unaware of Pope Boniface's decree
but, as instructed, violated you—

You, anonymous. Who were you Mister?

A mere coloured plate in some Anatomy Book;
your right hand, too, dissected, never belonged
it seemed to someone once so shockingly alive
(Surprise, surprise, that they had relatives
those lifeless-size, innominate creatures).

caring for us have acquired in the dissecting room. It is therefore society that is the direct beneficiary of the altruistic act of donation of one's body for dissection, not medical students or doctors. Instead of being beneficiaries of the act (other than in their role as future recipients of medical care), I would argue that students act altruistically by agreeing to undertake dissection with all the necessary breaking of personal and societal taboos this involves. Whilst the individual students are indebted to the donors for making possible their personal decision to play a particular role in society, the reason why people donate is not directed at students as such. Society has had a long time to think about and come to uneasy terms with how it feels about human dissection.¹² A once forbidden activity is now sanctioned by society for a limited range of medical ends. Encouragingly, the lay public does appear able to express some empathy with those undertaking this task on their behalf. Comments such as "I couldn't dissect a human body" and "I don't know how you do that" will be familiar to doctors and students alike. At some level, the altruistic act of dissecting seems to be appreciated by non medics if only in the sense that we are grateful when others do the jobs we'd rather avoid.

Interestingly, this is a point easily lost on medical students whose unease at dissection is often soothed away by well meaning reassurances from their teachers, who explain that the student is enabling the last wishes of the donor to be respected. That is clearly helpful, reassuring to know. Just like it's a comfort to know that when you ask grieving parents for permission to use their dead child's organs that someone else will live, that other parents will suffer less. A comfort to both the bereaved parents and the asker. But it doesn't get rid of the unease of dissecting or of asking. It feels profoundly uncomfortable doing either, and by failing to acknowledge this we risk leaving individuals unsupported and, importantly for patients, unable to ask. Of course, students have little choice when it comes to dissecting. Dissect or don't become a doctor. A significant number do drop out, arguably some of the most sensitive who might, properly supported, have made compassionate and able doctors. Most do stay because of their overriding desire to be a doctor and in that sense—that it is obligatory for those wishing to become doctors—dissection fails Heyd's criteria. It falls instead within what Downie calls the job description. But if we want doctors to respond to the challenges of Alder Hey and Bristol,¹³ to see things differently, to see an organ the way much of the public sees it—as personal and important—then we might just need to acknowledge that the job description asks a lot of its eighteen year old initiates and their older colleagues. Just as patients want doctors to understand how illness impacts on them as human beings, so doctors need the public to appreciate the price their job extracts from them. Not heroes, just ordinary, vulnerable human beings doing a sometimes dirty job.

Dissection and the act of asking have a lot in common. Firstly, in the same way that dissection was once thought to be immoral and an offence to God, so transplantation was once denounced as unnatural and wrong. Just as the benefits of dissection became accepted within society, so the transplantation of organs has acquired respectability. Put simply, most of us hope that if one day we, or a loved one, require a transplant, someone will have been willing to make this possible. But unlike dissection, there is no public acknowledgment of the demanding role the asking doctor is expected to undertake. This is a taboo so far back in the closet that it doesn't even get talked about, and given the human suffering of both recipients and donor families, drawing attention to their own pain might well strike many doctors as self indulgent. An interesting recent phenomenon is public appeals by parents of children in urgent need of transplants. Direct appeals in the second person are rare, instead mothers talk in the third person of hoping a donor will come forward or be found. Presumably there is an understandable concern that a direct appeal to grieving parents, along the lines of "If your child has died, would you please consider donating their heart so that my child can live" could be harmful to any one in this position who nevertheless felt unable to agree. Yet making such an approach is precisely what we ask doctors to do. One minute they are caring for the person, placing that person's needs as their overriding priority, the next they are asked to act as a well meaning broker for body parts. The potential cost to the asker is great enough for many to opt out of asking. Rather than condemnation for this human weakness support and understanding is required.

The language used in this debate, indeed in the practice of obtaining organs for transplant also merits attention. This special edition is devoted to cadaveric organ transplantation. In clinical practice we talk of harvesting those organs. Any doctor asking for permission to use the organs of someone who has died would do well to avoid using the words cadaver and harvest in conversation with the relatives. Yet health care professionals continue to use their own parallel language. In this case its use is avoided with patients, not so much because it is difficult to understand but because it is offensive. Presumably these terms are used as part of the depersonalising of a disturbing aspect of medical practice that is meant to protect doctors psychologically. We talk of cadavers, cover heads, conceal all personalising details. Organs are harvested from cadavers, a helpful psychological ruse perhaps when giving life means someone else must have died. Maybe it helps doctors to cope, but I suggest it can also act as a barrier to the human to human communication so important if the act of asking is to take place and take place well. If we leave doctors unsupported to deal with situations like this, that the rest of

us find too distressing to even talk about, then we should not be surprised if they employ well trusted and effective depersonalising tactics or even avoid this particular task.

This example reflects a more wide ranging state of confusion—amongst both doctors and the lay public—about exactly what we want from doctors. If it is merely a job for which society writes the description, then presumably individuals can choose whether they wish to take on the job. If this is so, however, then as employers we shouldn't be surprised if some of the duties—to do the things the rest of us prefer not to do—are either avoided altogether or most easily undertaken by employees who have found their own way to acquire a certain distance from the human suffering involved. If we want doctors to do more than a job, to be there at a human level for those they care for, with all the potential for personal cost to the doctors that entails, then we as a society will have to acknowledge and support them in that task. Asking, with compassion, is an altruistic act. It's about people not cadavers, about caring for those in pain, about sharing that pain, about facilitating an altruistic gift from one individual to another.

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REFERENCES

- 1 Singer P. Cadaveric organ donation in Israel: the facts and perspectives. *Ann Transplant* 1999;4:5–10.
- 2 Wendler D, Dickert N. The consent process for organ procurement: how does it work? How can it be improved? *JAMA* 2001;285:329–33.
- 2a Erin CA, Harris J. A monopolistic market. In: Robinson I (ed). *The social consequences of life and death under high technology medicine*. Manchester: Manchester University Press, 1994:134–57.
- 3 Spital A, Erin CA. Conscription of cadaveric organs for transplantation: let's at least talk about it. *Am J Kidney Dis* 2002;39:611–15.
- 4 Downie RS. Supererogation and altruism: a comment. *J Med Ethics* 2002;28: 75–6.
- 5 Glannon W, Ross LF. Are doctors altruistic? *J Med Ethics* 2002;28:68–9.
- 6 McKay AC. Supererogation and the profession of medicine. *J Med Ethics* 2002;28:70–3.
- 7 McLean SAM. Commentary on Glannon and Ross, and McKay. *J Med Ethics* 2002;28:74.
- 8 Heyd D. *Supererogation*. New York: Cambridge University press, 1982.
- 9 Misselbrook D. *Thinking about patients*. Newbury: Petroc Press 2001: 51–4.
- 10 www.endeavour.med.nyu and follow the links to lit-med/ (accessed 4 August 2002).
- 11 Abse D. *Carnal knowledge. New and collected poems*. London: Hutchinson, 2003.
- 12 Richardson R. *Death, dissection and the destitute*. Chicago: Phoenix Press, 2001.
- 13 Bristol inquiry—learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Infirmary 1984–1995. London: The Stationery Office, 2001. (Cmnd 5207); *The Royal Liverpool Children's inquiry report*. London: The Stationery Office, 2001 (HC 12).