Features

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Living Donation and Cosmetic Surgery: A Double Standard in Medical Ethics?

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ABSTRACT

The commitment of transplant physicians to protect the physical and psychological health of potential donors is fundamental to the process of living donor organ transplantation. It is appropriate that strict regulations to govern an individual's decision to donate have been developed. Some may argue that adherence to such regulations creates a doctor-patient relationship that is rooted in paternalism, which is in drastic contrast with a doctor-patient relationship that is rooted in patients' autonomy, characteristic of most other operative interventions.

In this article we analyze the similarities between cosmetic plastic surgery and living donor surgery as examples of surgeries governed by different ethical principles. It is interesting that, while the prevailing ethical approach in living donor surgery is based on paternalism, the ethical principle guiding cosmetic surgery is respect for patients' autonomy. The purpose of this article is not to criticize either practice, but to suggest that, given the similarities between the two procedures, both operative interventions should be guided by the same ethical principle: a respect for patients' autonomy. We further suggest that if living organ donation valued donors' autonomy as much as cosmetic plastic surgery does, we might witness a wider acceptance of and increase in living organ donation.

INTRODUCTION

Living organ donation and cosmetic plastic surgery are both elective procedures, however in both the medical literature and in clinical

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practice, a marked difference exists between how individuals who wish to be living organ donors and individuals who wish to undergo cosmetic plastic surgery are treated. Specifically, the two groups of patients are thought of very differently with respect to their autonomy. A brief review of the literature regarding living organ donation includes many references advocating that physicians play a paternalistic role in the care of potential donors; one author went as far as to suggest "pseudoprotectionism" for the presumably vulnerable donor is necessary.[1] Such attitudes regarding the presumed vulnerability of donors are most likely shaped by the colorful history of organ transplantation. Reports of the People's Republic of China's utilization of organs from executed prisoners, impoverished inhabitants of India selling their organs on the black market, and the drugging and kidnapping of "donors" are examples of the grave injustices associated with organ donation.[2]

While it may seem reasonable for physicians to attempt to protect potential donors, one may question whether adherence to paternalistic efforts minimizes an overall respect for patients' autonomy that is evident in other areas of surgery. For example, in the cosmetic plastic surgery literature, ethical issues about informed consent and the appropriateness of diverse surgical treatments have been raised, but there is little if any discussion of "the protection of patients." Expressions of concern about limiting a cosmetic plastic surgery patient's autonomy in the decision to undergo surgery are virtually non-existent.[3] The body of literature on cosmetic plastic surgery instead focuses upon upholding an individual patient's right to autonomously determine whether he or she would benefit from cosmetic plastic surgery.

Thus, through even a brief review of the literature, it is evident the ethical principle of paternalism outweighs autonomy in the setting of living organ donation, while the reverse is true in the setting of cosmetic plastic surgery. Given this discrepancy, one must question whether living organ donation and cosmetic plastic surgery are different enough to justify that their overall acceptance is governed by markedly different emphases on ethical principles.

In this article we will argue that living organ donation and cosmetic plastic surgery are much more similar than may be commonly perceived. We will suggest that maintaining the same reverence for patients' autonomy for potential organ donors as for potential cosmetic surgery patients is more ethically appropriate than a paternalistic protection of potential organ donors that may limit their right to autonomous medical decision making. To support our claim, we will illustrate the key similarities between living organ donation and cosmetic plastic surgery. We will then discuss the current differences between the pre-operative evaluation processes for each operation and provide an analysis of the different doctor-patient relationship that develops in each setting. Next we will offer a discussion of the likely reasons for continued reliance on paternalism in the setting of living organ donation, and explain why such a rationale is inappropriate. Finally, we will conclude that, given the inherent similarities between the two procedures and a lack of justification for the identified differences, it is ethically appropriate to place an increased emphasis on the autonomy of live donors, as is the case for cosmetic plastic surgery patients.

THE SIMILARITIES

Despite a societal perception that living donor organ donation and cosmetic plastic surgery are drastically different, we believe that the procedures are more similar than different. First, in both living organ donation and cosmetic plastic surgery, operations are performed on individuals who are physically healthy, and thus, in both cases, surgery has no curative intent. Our intention in making this comparison is not to criticize the practice of cosmetic surgery. Rather, we chose cosmetic surgery as a comparison to living organ donation because, with the exception of cesarean section, vasectomy, and tubal ligation, cosmetic plastic surgery is the only example of a surgical procedure commonly performed on physically healthy individuals. In addition to the lack of curative intent that is associated with both procedures, living organ donation and cosmetic plastic surgery are simi-

lar because they both offer the promise of tremendous personal fulfillment to patients. A living donor will receive a psychological reward: the knowledge that he or she may have saved the life of another person; a cosmetic surgery patient will obtain an enhancement in self-confidence that is associated with a perceived improvement in physical appearance.

Another similarity is that, in order to gain these rewards, both groups of patients must assume the inherit risks associated with surgery. While it may be commonly perceived that the morbidity associated with organ donation drastically outweighs the morbidity associated with cosmetic plastic surgery, this is often not the case. For example, the morbidity of liver donation is 5 to 21 percent, and mortality is associated with less than 1 percent. The morbidity of living kidney donation is as low as 1.3 percent; mortality is as low as 0.03 percent.[4] The risks associated with cosmetic plastic surgery may be as high as or higher than these, depending on the type of procedure.

Cosmetic plastic surgery is not free of complications or mortality. For certain complicated reconstructive procedures, cosmetic surgery patients must remain under general anesthesia for as long as, or longer than, the most complicated living organ donor operation. Many cosmetic surgery procedures are associated with multiple repeated operations, which increases the overall operative risk. Pulmonary embolisms, potentially deadly blood clots, have been reported at an incidence as high as 6 percent in patients undergoing abdominoplasty, a common cosmetic surgical procedure, and mortality from liposuction has been reported to occur in one in every 5,000 procedures. Considering the hundreds of thousands of cosmetic surgery procedures performed every year in the United States, with the underreported morbidity and mortality associated with these surgeries, the perception that cosmetic surgery is not dangerous is inherently flawed.[5]

A perception that patients who consider organ donation are subject to coercion, while patients who consider plastic surgery are not, is likewise flawed. Many in both groups of patients may experience some level of coercion in their decision-making process. Patients who consider organ donation may feel pressured by family members or a healthcare team to donate, and patients who consider cosmetic plastic surgery may be vulnerable to coercion to drastically alter certain physical attributes. For example, an aggressive husband may pressure his wife to undergo liposuction to regain a "youthful figure," or a fashion model may be pressured by a business agent to undergo rhinoplasty or breast augmentation to generate more revenue. It is interesting that there has been a tremendous focus on the potential coercion of living organ donors, while the potential coercion of cosmetic surgery patients has often been overlooked.

THE DIFFERENCES

Despite the clear similarities between living organ donation and cosmetic plastic surgery, the pre-operative evaluation process differs markedly for each operative setting. The first major difference is the attitude of healthcare providers in general toward the two different groups of patients. Potential organ donors are consistently regarded as vulnerable individuals in need of protection from possible injustice and coercion.[6] The principle of *primum non nocere* (first do no harm) is frequently used to justify the paternalistic protection of donors as a primary concern for the healthcare team.[7] The protection of cosmetic plastic surgery patients from potential coercion has not received the same level of attention. It may be reasonable to suggest that an individual seeking cosmetic surgery has more obvious psychological and social motivation than a potential living donor does. And so it seems inappropriate to view potential donors as being in need of paternalistic protection while the autonomy of cosmetic surgery patients is seen to be in need of protection.

The attitude of healthcare providers in general toward potential living donors as a vulnerable population has led to the development of an extensive, highly regulated, pre-operative evaluation process for potential donors that is not utilized for potential cosmetic plastic surgery patients. Regulatory bodies such as the American Society of Transplantation (AST), the

United Network for Organ Sharing (UNOS), and the Center for Medicare and Medicaid Services (CMS) have dedicated a great deal of attention to the safety of donors and have generated strictly defined donor acceptance criteria.[8] There does not seem to be an equivalent pre-operative evaluation process for patients undergoing cosmetic surgery.

There is no question that an extensive clinical evaluation of a potential donor is vital to assure prompt recovery and to avoid complications, and the same may be said for cosmetic plastic surgery patients. The view that donors are highly vulnerable individuals has prompted an elaborate system of donor advocate teams, in which each donor is assigned a social worker and a physician whose roles are to "protect and advocate for the donor" during and after the evaluation process. Despite potential threats to cosmetic plastic surgery patients such as societal pressure to achieve an unattainable standard of beauty, or possible pressure from a cosmetic surgeon based on financial gain, such advocacy is not available to help these patients navigate the risk/benefit analysis associated with these elective procedures.

One component of the strictly defined living donor acceptance criteria is an impressively thorough evaluation of the donor's motivation to undergo surgery. The potential donor is typically expected to produce tangible and publicly justifiable support for his or her motivation to donate, and this justification must be deemed valid by evaluating physicians prior to acceptance. Concerns regarding the worthiness of the potential donor's motivation are considered an appropriate reason to deny an opportunity to donate. This seems to place the burden of proof on potential donors to demonstrate that they are making an autonomous decision that is not influenced by pressures from family or others.

When patients elect to undergo cosmetic plastic surgery, however, they are not required to demonstrate that their decision was made in a free and autonomous fashion. The potential impact of coercive family members and other pressures to donate seem obvious, but, as mentioned above, a formal system to evaluate the motivations of cosmetic surgery patients does not exist. Further, the motivation behind cosmetic surgery patients' decision is rarely noted as a reason to refuse them an opportunity to undergo a procedure. This lack of attention to their motivation seems unwarranted.

After stringent analysis of a potential living donor's motivation, a thorough psychosocial evaluation is conducted. The attention paid to this psychosocial evaluation and its weight on acceptance is very different from the often unstructured and relatively minimal pre-operative psychosocial evaluation of potential cosmetic surgery patients. Any suggestion of psychological distress or disorder may make a potential organ donor unacceptable, as the distress or disorder may influence a patient's decision to undergo surgery or may render her or him more likely to experience post-operative psychological distress. This system has resulted in rates of non-acceptance as high as 20 to 36 percent.[9] In addition to limiting the pool of donors, such extensive psychological work-ups might be seen as implying that potential donors are psychologically weak individuals who must be protected from their own decisions or from coercive external forces. This may be seen to imply that living organ donation is a dangerous action, and that anyone willing to participate in it must be deeply questioned regarding psychological fitness.[10]

Conversely, in cosmetic surgery, the presumption is that most individuals considering cosmetic plastic surgery are not in need of special psychological support, and so no minimum standards have been set by the federal government or a surgical society.[11] However, anecdotally, it seems that many patients undergoing cosmetic plastic surgery are afflicted with various psychological disorders, including depression, body dysmorphic disorder, or even gender identity disorder. Such psychological disorders are not frequently used to prevent patients from undergoing cosmetic surgery, as they would be for living organ donation. (Although, in the case of gender identity disorder, a diagnosis may be necessary prior to initiation of any operative intervention.)

In addition to psychological fitness, tremendous importance is placed on a potential organ

donor's social support network and financial means; these issues are no more than superficially addressed with cosmetic plastic surgery patients. The scrutiny given to a potential donor's financial stability is especially interesting, given that the organ recipient's insurance will be charged for all of the donor's medical expenses. There seems to be an assumption in the medical community that potential donors must demonstrate the means to pay for potential adverse effects or tolerate lost wages secondary to time off from work, prior to being allowed to donate. For cosmetic plastic surgery patients, it seems that an individual must merely demonstrate the financial means to pay; there is no need to demonstrate a financial ability to care for possible morbidities that may develop post-operatively.

The differences in the pre-operative process for potential organ donors and potential cosmetic plastic surgery patients that we have described here indicate an overall cultural and societal view of cosmetic surgery such that, short of the financial burden for the individual, access to cosmetic surgery should be relatively unobstructed, benefits should be highlighted, and the desires of the patient are fully respected. Many providers go so far as aggressively marketing cosmetic surgery to potential patients via radio ads, free informational seminars, and billboards.

Conversely, an opportunity to engage in living organ donation is so heavily regulated that regulation may act as a deterrent. Throughout the pre-operative evaluation process, the risks of donation are presented multiple times and are often emphasized as a deterrent. Potential donors, along with their donor advocate team, must undergo a complicated, multi-stage consent process and are typically required to undergo a cooling-off period of several days prior to a final decision on whether to proceed with surgery.[12] While the goal may be to protect potential donors from coercion, hasty decisions, and emotionally laden decisions, the fact that no other surgery requires such a consent process may be seen to indicate that organ donation is uniquely likely to psychologically and/or physically maim donors, and that donors may not be capable of independent decision making in such an emotionally charged setting. We by no means are suggesting that the risks of death and severe morbidity in organ donation are not real, or that potential donors should not be properly informed of such risks. However, as suggested by Spital in 1990,[13] such a paternalistic, protective approach to potential organ donors may serve to discourage donors.

From the perspective of a potential donor, it may seem that greater attention is given to the potential negative aspects of donation, while the potential psychological gain is minimized. Thus potential donors may be less able to meaningfully render a decision regarding donation. Multiple authors have investigated the psychological well-being of donors at varying times following donation, and, in almost all cases, donors reported they gained satisfaction and self-esteem from donation. The perceived benefit was often so great that many donors reported that, if it were possible, they would do it again; further, studies regarding the post-operative health of donors report that the overwhelming majority do not suffer any permanent damage to their health.[14] Personal observations from transplant physicians suggest that some donors experience an improvement in their health and quality of life following donation due to increased post-operative efforts to care for themselves by improved nutrition, increased physical activity, and reduced use of alcohol and cigarettes.

These studies suggest that a "doom and gloom" approach for potential living organ donors may not be warranted, and perhaps that a greater emphasis should be placed upon the potential benefits, as is done during the pre-operative process for cosmetic surgery. For example, although the risks of all cosmetic operations are explained, the risks are typically not the focal point of a pre-operative discussion between surgeons and patients. Perhaps this is because the risks of cosmetic surgery are considered more acceptable than those associated with organ donation, because cosmetic surgery may be viewed as less dangerous than organ donation. It is interesting to note that while the pre-operative approval process for donors may

deter some donations, the consent process for cosmetic plastic surgery is more likely to encourage an individual to proceed with surgery. Celebrities and public figures are often glamorized in advertising campaigns for cosmetic surgery, implying that it should be widely accepted by the public. But no such advertising campaigns exist for living organ donation. Perhaps a more balanced approach to the pre-operative evaluation process is warranted for both groups of patients?

THE DOCTOR-PATIENT RELATIONSHIP

One of the most striking differences between living organ donation and cosmetic plastic surgery is the markedly different doctor-patient relationship (DPR) established in each setting. In general, this relationship has undergone a radical shift, from a decision-making paradigm with high reliance upon physicians' paternalism to one with increased respect for patients' autonomy. Once doctors were considered to have decision-making authority because of their superior knowledge. Now, patients have been elevated to an equal position in the decision-making process, and doctors identify various options that are consistent with standards of practice and provide guidance and information to patients, such that patients are then able to decide for themselves what actions will be undertaken. Contemporary American surgery has transitioned to a paradigm based upon a presumption of shared decision making. In this setting, physicians present information detailing the risks and benefits of an intended procedure in a clear and unbiased fashion, so that patients may make informed decisions. By empowering patients to participate in making decisions, the ethical principal of respect for their autonomy is upheld.

If we analyze the nature of the DPR in the cases of living organ donation and cosmetic plastic surgery, we find that there has been no equal paradigm shift for the two groups. Specifically, physicians' paternalism is a dominant principle in living organ donation, while the principal of patients' autonomy prevails in cosmetic surgery. The difference in these approaches appears to be related to the perception that, with regard to living organ donation, a surgeon should play a more dominant role in protecting a patient from any risk or potential coercion related to the procedure. In the setting of cosmetic plastic surgery, a more egalitarian relationship, based upon shared decision making, is appropriate. Different ethical guidelines should not govern the two settings. The principle of patients' autonomy should prevail in the setting of living organ donation, as it does in cosmetic plastic surgery.

DIFFERENT ETHICAL GUIDELINES

Despite the perceived differences between living organ donation and cosmetic surgery, we have argued for several key similarities:

1. Both groups of patients are initially healthy, and neither organ donation nor cosmetic plastic surgery will cure the patients of a disease.
2. Both groups of patients stand to experience psychological benefit from undergoing the operation.
3. Both operations have the potential for catastrophic consequences.
4. Both groups may experience some level of coercion in their decision-making process.

Presumably the transplant community's adherence to rigorous paternalism in the care of potential donors may be due to concern for donors' motivation, questions regarding donors' perceived vulnerability to external coercion, and concern regarding the impact of secondary gain for transplant surgeons and transplant centers. We will argue that these issues do not justify the transplant community's strict adherence to paternalism and relative dismissal of autonomy for potential donors.

For example, it is not clear to us how concern regarding donors' motivation justifies a relationship characterized by paternalism. This may be the only surgical procedure for which physicians question patients to the point of convincing them to not undergo a procedure. Some may argue that physicians should commend potential donors for seeking out a procedure that

may have tremendous impact upon the life of another, while only secondarily enhancing their own life. Physicians should be more willing to accept that, for some, the psychological benefits associated with organ donation may outweigh the risks. Overall, since the act of donation is, *per se,* an act of good, the relationship paradigm should shift to increased respect for donors' autonomy. A more balanced approach to the pre-operative evaluation process for donors would address both potential morbidity and mortality, as well as the potential life-enhancing outcomes.

Physicians' concerns regarding donors' vulnerability to coercion may contribute to continued paternalism. The idea that donors are more vulnerable to coercion is not substantiated by published data or by the anecdotal experience of many transplant physicians. This is not to suggest that potential donors for related organ recipients do not feel inner pressure to donate; rather, while there may be some inner pressure to donate, for the most part in Western culture, tremendous familial coercive pressure on donors is rare. In the majority of cases, potential donors make the decision to donate independently, and only in a handful of cases do donors change a decision based on the checks and balances built into the pre-operative evaluation process. If potential donors were as vulnerable to coercion as typically believed, one would expect that the transplant community would witness more ambivalence regarding donation and a greater number of donors changing their decisions prior to surgery. The consistency in donors' decisions over time suggests that the need to paternalistically usher potential donors through an extensive evaluation process is most likely unnecessary. Rather, reliance on a DPR that is rooted in respect for the decisions of autonomous donors seems more appropriate.

Finally, concerns that transplant physicians may inappropriately focus on secondary gain rather than on donors' health may promote reliance on a paternalistic DPR. Specifically, the transplant community worries that the pressure for career advancement, potential for external recognition, and concern for financial gain may prompt some transplant surgeons to aggressively direct potential donors to undergo surgery without due regard for the overall health of donors. While such pressures undoubtedly exist, there is no evidence that these factors are unique to, or especially pronounced in, transplant surgeons. Cosmetic plastic surgeons face similar pressures for career advancement, external recognition, and financial gain in their own practices, yet they are able to maintain a relationship with patients that favors respect for patients' autonomy over paternalism. Thus, continued paternalism toward potential organ donors is not justified by a fear of inappropriate focus on secondary gain among transplant surgeons.

CONCLUSION

A desire to protect potential donors has generated an intense ethical debate and the development of strict rules and regulations to govern the process of living organ donation. The end result has been an adherence to a paternalistic approach toward potential donors, with an emphasis on the potentially negative aspects of donation, rather than on the lifesaving benefits and psychological rewards of donation. While the rationale for the current utilization of different ethical standards regarding potential organ donors and potential cosmetic plastic surgery patients is understandable, we hope that our analysis of the similarities between these two patient groups has demonstrated that they should be treated more similarly; specifically, that the ethical principle that governs the practice of living organ donation should be the same as for cosmetic plastic surgery: a respect for patients' autonomy. Given the lack of evidence that a legitimate basis exists for holding these different surgical procedures to different ethical standards, the principle of respect for autonomy should not be given different emphasis in these situations.

Respect for donors' autonomy should be the driving ethical principle behind the pre-operative living organ donor evaluation process. To facilitate this, a discussion of the risks and benefits of organ donation must be evenly tempered

and stress the life-threatening as well as the life-enhancing aspects of living donation. The ultimate goal of the transplant community should be to create a culture of donation that is built upon providing truthful and balanced information. Given the increased reliance upon living donor organs to provide access to transplantation to the many patients on organ waiting lists, a change to increased respect for donors' autonomy may generate a universal increase in organ donation. This would increase access to this lifesaving intervention and allow more potential donors to reap the psychological benefits associated with organ donation.

NOTES

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