# Organ Donation and Priority Points in Israel: An Ethical Analysis

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Israel's rates of organ donation have been one of the lowest among developed countries. An attempt to change this has led to the introduction of a pioneering new law, the Organ Transplant Act 2008, which came into effect in January 2010 and sets out principles underlying a new policy in relation to the allocation of organs for transplantation. According to this policy, a person can gain priority points by signing a donor card, making a nondirected organ donation during their lifetime, or as a result of a first-degree relative signing a donor card, or consenting to procurement of organs after death. In this opinion piece, we argue that although this approach merits attention for its innovative aspects and its potential benefits, it raises some ethical difficulties. In particular, we discuss some problems of justice and fairness inherent in the system, focusing on inequalities because of the (a) number of relatives one might have, (b) the type of living donation one makes, (c) the potential for strategic behavior, and (d) problems regarding the consent of family members.

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Israel's rates of organ donation have been one of the lowest among developed countries. It has achieved a consistently low rate of cadaveric donations over the last 10 years, reaching 9.8 per million population at its highest to 6.4 per million population at its lowest (*1*). These low rates should be understood on the backdrop of various cultural and religious concerns and beliefs held by some in the Jewish community (*2*). Although organ donation is permitted and encouraged by all denominations of modern Judaism and is even considered a meritorious act (*mitzvah*) by the many influential rabbinical scholars today (*3, 4*), some still hold the erroneous opinion that Judaism objects to the definition of brain death. To fight against this perception, the Israeli donor card allows the donor to stipulate that a clergyman chosen by the family should give approval before retrieving organs. Others hold superstitious beliefs that consent to donation might invoke bad luck (an "evil eye") and bring about premature death. Educational campaigns to counteract such beliefs have been carried out repeatedly, but with limited success. Consent for donation remains disturbingly low. Surveys carried out in Israel have shown that priority points would be the most effective incentive to increase willingness to donate when compared, for example, with direct financial compensation (*5*).

To examine ways of increasing organ donation, the Israeli National Transplant Council established a committee of stakeholders and relevant experts to give recommendations. The committee included transplant physicians and coordinators, lawyers, philosophers, ethicists, and representatives of the main religions. The discussions of the committee resulted in a new law, the Organ Transplant Act 2008, which governs a range of activities in relation to both deceased and living donation that came into effect in January 2010 (*6*). Within the new law, a pioneering priority points system is introduced, intended to motivate individuals to sign donor cards or to consent to donations of the organs of deceased first-degree relatives. The latter is of great importance because the Israeli approach to organ donation is based on an opt-in system in which the consent of first-degree relatives is obtained in practice even when the deceased has signed a donor card (*7*). Although a variety of incentives for organ donation, including the allocation of bonus priority points, have been considered elsewhere (*8–11*), Israel is the first country to implement a system which incorporates these (*12*).

The Israeli Act does not enshrine the details of a priority points system into statute but rather sets them out at

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a policy level (*13, 14*). Section 9(b)4 of the Act authorizes the Steering Committee for the National Transplant Center to "draw up directives in the matter of the allocation of organs" (*6*). When drawing up these directives, the Act stipulates that the Committee must take into account consent to postmortem donation given during a person's lifetime, actual deceased donations of first-degree relatives, and undirected living donations (*6*). It is on the basis of these statutory provisions that the new scheme has been devised based on a tiered system of priority that includes the following: (a) *maximum priority*; (b) *regular priority*; and (c) *second priority* (*13, 14*). Maximum priority is granted to candidates if (a) consent has been given for organ donation from a deceased first-degree relative or (b) they donated a kidney, a liver lobe, or a lung lobe in the course of their life to a nonspecified recipient. Regular priority is granted to candidates who hold a donor card, that is, those who have consented to donate their organs after their death. Second priority is granted to candidates with a first-degree relative who holds a donor card, even if they do not hold a donor card themselves. The rationale behind this principle is that in the past, Israelis who signed a card have systematically consented to donate the organs of a first-degree relative after death, even if the deceased herself did not sign a card. We should note, however, that priority points are given for only one relative and cannot be accumulated if more than one relative has signed a donor card.

Hence, potential donors and their first-degree relatives receive priority points should they need an organ. Those who already hold an organ donor card or who signed up for one before December 31, 2011 will be entitled to their priority points after a waiting period of 1 year and those who signed up after that date will be eligible after a waiting period of 3 years (*15*). In relation to living donation, those who direct their organ to a particular recipient receive no priority, while those who donate to an unspecified recipient receive maximum priority points should they ever need an organ. Points cannot be accumulated if an individual falls under more than one criterion. In such a case, the highest number of points obtained through any one criterion prevails. Thus, the points system acts as a tie breaker in allocating an organ to patients of equal medical need.

Organs are generally considered a scarce societal resource. Justice and fairness require that those who are willing to accept an organ would be willing to donate one as well. The new Israeli priority point system rewards those who are willing to donate an organ with an increased chance of receiving one (*5*). In doing so, it is meant to rectify what is perceived as the unfairness of "free-riders"—those who refuse to donate for religious (or other) reasons, but yet are willing to receive an organ when they need one (*5*). However, a few elements of the new system raise ethical concerns. This article describes these concerns and proposes ways to address them to improve the system.

## NUMBER OF FIRST-DEGREE RELATIVES

Israel has a family refusal rate of 50.8% (*16*). Attempting to improve this figure, the new priority points system allows first-degree relatives to gain maximum priority points when they consent to the donation of a deceased relative's organs. However, this provision means that one's chances of obtaining priority points depend on how many first-degree relatives a person has. Moreover, the new system gives second priority to first-degree relatives of a potential donor (an individual who has signed a donor card). This potentially disadvantages those with fewer siblings. If a person has not signed a donor card but has one or more siblings who have done so, they would receive priority points, whereas someone without siblings has no such safety net. As such, the system gives a comparative advantage to those who have (more) siblings, something which is beyond a person's control. This aspect of the allocation system thus involves an element of unfairness.

This unfairness is exacerbated by the fact that the more siblings one has, the greater the likelihood of finding a living donor, as there is more chance that one of the siblings will be a compatible match and a willing volunteer. Therefore, those with larger families may be less likely to need an organ from a deceased donor. Conversely, those with fewer potential living donors are the ones most likely to be in need of a deceased organ, but within the new system they are less likely to gain extra priority points based on the actions of their relatives.

One response to this concern is to say that regardless of the number of relatives a person has "anyone is welcome to sign their own donor card, thereby ensuring themselves priority in organ allocation." (*17*) Although this is undoubtedly true, it misses the ethical nub of the matter. The pertinent point is not whether individuals should benefit from their own good actions, that is, signing their own donor card, but whether they should benefit from the good actions of others where they themselves have not signed a donor card.

## LIVING DONORS

The new Israeli system treats directed living donors differently from those who donate to an unspecified recipient, (*18*) the former being excluded from receiving priority points. This is in stark contrast to some Western countries where the only people who are privileged in the allocation of organs are children and previous living kidney donors. For example, the United Network of Organ Sharing uses a points system for the allocation of kidneys where previous living kidney donors are awarded extra points (*19*).

Directed living donors assume risk during their lifetime to aid another human being. In doing so, they shorten the waiting list by one: they help not only their recipient but everyone else waiting for an organ. Organ transplantation relies ever increasingly on living donors, yet the Israeli system treats previous living donors inequitably. Living donors have already put themselves at risk in donating an organ, a morally good act which benefits both the recipient and wider society. If we are to allocate organs based on previously demonstrated commitment to organ donation, it would seem that a directed living donation is more "deserving" than someone who has taken no steps to complete a donor card, but whose relative has donated after death or signed a donor card. A signed donor card is at best an expression of intent but is neither a morally nor a legally binding contract. Moreover, donation after death cannot be equated with the risk and inconvenience of live donation. Indeed, Lavee et al. acknowledge that this element of the new system is

unfair and state that an appeal is being prepared to reconsider this element because they ''strongly believe all living donors should be granted prioritization in organ allocation''(*5*).

## THE POTENTIAL FOR STRATEGIC BEHAVIOR

Within the context of deceased donation, the incentive of priority points is offered not for the actual organs but for the promise that they will be made available for transplantation after death. This introduces the potential for individuals to engage in strategic behavior. People could join the Israeli register solely to guarantee priority points at a later date, while instructing their families to refuse donation in the event of their death and, thus, expressions of willingness to donate may not translate into actual donations.

The challenge of translating past expressions of support into actual donations is not necessarily new. Countries that operate organ donor registries where individuals have to opt-in also experience this obstacle. The ethical concern arises where those who express this willingness receive something in return; in this case priority points. The problem arises when individuals who never intended to donate after death are given preference over others when competing for scarce organs. It might be reasonable to assume that most people will not engage in this strategic behavior. There is, however, the possibility that a minority might sign up intending to withdraw from the register at a later date. Because Israel is the first country to implement a priority points system, no empirical evidence exists to date and it is thus difficult to tell whether this will happen and to what extent. An assessment will be warranted to track changes in the numbers of organs donated and their causes.

Similar concerns may be raised regarding people in certain potentially adverse health states. A person with chronic hepatitis C, knowing that they are at increased risk of liver failure, could join the organ donor register to secure a higher place on the waiting list should the need arise. Although it is possible that their other organs could be transplanted after death to another person with hepatitis C (of the same viral genotype), due to the much reduced pool of possible recipients, it is an unlikely scenario. Thus, this would not result necessarily in any extra organs for transplantation. This seems to disadvantage others with similar medical needs, who had not taken strategic advantage of the system.

It may be argued that the way around this problem is to exclude those groups who are unlikely to ever contribute to the organ pool through a system of medical testing and certification of good health. However, such an approach presents pragmatic and ethical difficulties. First, besides the cost of testing and certification, it might further deter people from joining the register due to the time and effort involved. Second, such a suggestion seems to present its own problem: people most likely to need a transplant due to a foreseeable health state would be the ones systematically disadvantaged because they would not have access to waiting list prioritization enjoyed by those who are in good health. Thus, whether those individuals in adverse health states were permitted to participate in the system or not, there would seem to be ethical issues that need to be addressed (*20*).

## CONSENT

Finally, we wish to draw attention to a potential problem regarding consent. The transplant community has valued voluntariness in organ donation as an expression of respect for the autonomy of individuals. Offering incentives, such as priority points, does not necessarily vitiate voluntariness. Instead, they could simply be seen as providing extra factors to consider when deciding about organ donation. However, incentives to donate one's own organs are different from incentives to donate the organs of others. Therefore, the case where a person signs up to become an organ donor is to be contrasted with the situation where an individual's wishes were unrecorded and the family is asked to make the decision after death. In Israel, there has never been a known case in which family members consented to organ procurement against the known wishes of the deceased (Lavee J., personal communication, 2012). Prevailing cultural norms have hitherto underpinned the acceptance of individuals' wishes regarding the use of their organs postmortem as a part of their will and such wishes are not violated by family members. Yet by offering extra priority points to first-degree relatives of deceased donors, the new Israeli system gives families an incentive to donate a loved one's organs even if the deceased's wishes for donation are unknown or against donation. Consequently, giving the family extra motivation to donate raises questions regarding the primacy of individual autonomy in deceased donation.

## CONCLUSION

Israel's new Organ Transplantation Act has enabled a unique system to be introduced to motivate individuals to donate their organs. Commendably, it goes some way to addressing the challenge posed by those who are willing to accept an organ but not willing to donate. Indeed, in 2011 Israel saw an unprecedented increase in consent for donations (from 49% to 55%, with a record number of 70,000 individuals signing donor cards) and in actual transplantations (an increase of 68%) (*21, 22*). Although the new system may not provide a comprehensive solution to the organ shortage in Israel, these data show that the campaign surrounding its introduction has already been successful in improving the situation. Some cultural barriers to donation that currently exist in Israeli society will still have to be addressed by additional campaigns and by an ongoing effort to educate the public, in particular by engaging religious authorities and guaranteeing their support and endorsement and by enhancing public trust in the healthcare system (*7*).

Nonetheless, the law and the consequent organ donation policy raise some challenging ethical questions. Our own discussion indicates at least two possible changes which could be made. First, because those who make a living donation to a specified person take on risk for the benefit of another during their lifetime, they ought to be brought within the purview of the scheme. This would reverse the current injustice by appropriately recognizing their contribution. We would suggest that living donors ought to be given greater priority than those who sign a donor card which is at best only an expression of willingness, something which might not come to pass. Second, it is not clear to us why a person should benefit from the actions of their relatives rather

**TABLE 1.** Improving the points system

| Action | Points allocated – current system | Points allocated – improved system |
|---|---|---|
| Signs donor card | Y | Y |
| Relative signs donor card | Y | N |
| Donate deceased relatives organs | Y | Controversial |
| Live donation – recipient not specified | Y | Y |
| Live donation – recipient specified (eg to child, spouse, etc.) | N | Y |

than their own good deeds. Therefore, we would propose that the allocation of priority points be restricted and ought not to include first-degree relatives (Table 1). Such changes would go some way in addressing the justice issues inherent in the new system which undermine its ethical integrity.

The principles underlying the priority points system as set out in the law resulted from the deliberations of a committee of experts (including ethics experts) that examined the relevant issues. However, when the recommendations of the committee were brought before the Labor, Welfare and Health Committee of the *Knesset* (the Israeli Parliament) that was responsible for preparing the law for a final vote, not all of them were accepted. For example, the original recommendations of the expert committee were to grant priority points only to holders of donor cards and not to their first-degree relatives and to grant priority points to all live donors whether or not the recipients are identified. It is therefore possible that acceptance of expert opinion by the legislators could have prevented some of the ethical problems currently present within the points system.

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