Whereas, Ethical guidelines for transplantation are set forth by our AMA, the World Medical Association and the World Health Organization; the medical profession has the responsibility to protect the rights and interests of patients who need and seek transplant surgery, as well as to protect the rights and interests of organ donors whose organs may have been procured in an unethical manner; and

Whereas, China is second only to the United States as the country that performs the largest number of transplants and thus has a particular responsibility to act ethically and transparently regarding organ transplants; and

Whereas, Systematic, state-sanctioned organ harvesting from executed prisoners and prisoners of conscience in China has occurred with the knowledge of the Chinese government; and there are also reports about forced organ harvesting from Uighurs, House Christians, Tibetans and Falun Gong practitioners; and

Whereas, The U.S. Congress passed House Resolution 343 in 2016, calling for an end to forced organ harvesting from Falun Gong prisoners of conscience in China; and the European Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to forced organ harvesting from Falun Gong prisoners of conscience in China; and

Whereas, Doctors Against Forced Organ Harvesting (DAFOH), a medical NGO that was nominated twice for a Nobel Peace Prize, collected over 3 million signatures for a petition to the U.N. High Commissioner for Human Rights, calling for an end to forced organ harvesting in China; and

Whereas, Chinese transplant numbers have increased dramatically and transplant tourism has become a lucrative source of income in China, leading to a rapid expansion of the transplant infrastructure in China; and China has declared the Hainan Islands to be a special economic zone for medical tourism; therefore be it

RESOLVED, That our American Medical Association reaffirm Ethical Opinion E-6.1.1, “Transplantation of Organs from Living Donors,”, and believes that transplant surgeons, especially those who come to the United States for training in transplant surgery, must agree to these guidelines, and that American medical and hospital institutions not be complicit in any ethical violations or conflicts of interest (New HOD Policy); and be it further
RESOLVED, That our AMA representatives to the World Medical Association request an independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation into the Chinese practices of organ transplantation including (but not limited to): the source of the organs as well as the guidelines followed; and to report back on these issues as well as the status of Prisoners of Conscience as sources of transplantable organs (Directive to Take Action); and be it further

RESOLVED, That our AMA call upon the U.S. Government to protect the large number of transplant tourists by implementing legislation to regulate the evolving, ethical challenges by initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not meet the same transparency and ethical standards practiced in the U.S. (such as the public listing of annual transplant numbers by every transplant center to permit scrutiny). (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/27/18

RELEVANT AMA POLICY

E-6.1.1 Transplantation of Organs from Living Donors

Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:
(a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donors well-being.
(b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
(c) Carefully evaluate prospective donors to identify serious risks to the individuals life or health, including psychosocial factors that would disqualify the individual from donating; address the individuals specific needs; and explore the individuals motivations to donate.
(d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
(e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
(f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
(g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
(i) the minor agrees to the donation;
(ii) the minor’s legal guardians consent to the donation;
(iii) the intended recipient is someone to whom the minor has an emotional connection.
(h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
(i) Inform the prospective donor:
(i) about the donation procedure and possible risks and complications for the donor;
(ii) about the possible risks and complications for the transplant recipient;
(iii) about the nature of the commitment the donor is making and the implications for other parties;
(iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the
organ or collect tissue, whether the context is paired, domino, or chain donation; and
(v) that if the donor withdraws, the health care team will report simply that the individual was not a
suitable candidate for donation.
(j) Obtain the prospective donor’s separate consent for donation and for the specific intervention(s) to
remove the organ or collect tissue.
(k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors
should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care
associated with the donation only.
(l) Permit living donors to designate a recipient, whether related to the donor or not.
(m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be
expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
(n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain
in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation
to a stranger include:
   (i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired
donation ("organ swap," as when donor-recipient pairs Y and Z with incompatible blood types are
recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
   (ii) domino paired donation;
   (iii) nonsimultaneous extended altruistic donation ("chain donation").
(o) When the living donor does not designate a recipient, allocate organs according to the algorithm that
governs the distribution of deceased donor organs.
(p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel
donation arrangements that involve many patients and in which donation-transplant cycles may be
extended over time (as in domino or chain donation).
(q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs
of psychological distress during screening and after the transplant is complete.
(r) Support the development and maintenance of a national database of living donor outcomes to support
better understanding of associated harms and benefits and enhance the safety of living donation.

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