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Editorial

From living altruism to systemic resilience in organ transplantation: Towards deceased organ donation programmes

Although the evolution of organ transplantation is often viewed through the lens of surgical innovation, a collective effort of different clinicians forms its basis and success. In renal transplantation, key background work is done by the nephrologists in preparation, optimization and postoperative maintenance. The greatest hurdle remaining is not technical – it is organisational. For clinicians, the frustration of managing terminal organ failure without a graft is a daily reality. For policy makers, the mounting costs of long-term dialysis and palliative care represent a significant financial burden. At the centre of this challenge lies our over-reliance on living donations and the untapped potential of cadaveric donor programmes. In this issue of *Galle Medical Journal,* Weerakkody, Sathananthasarma and Lokuliyana, survey issues related to knowledge and attitudes towards living kidney donation.

Sri Lanka lacks a developed Deceased Donor Programme (DDP), the living donor is the only option available. While living-related transplantation offers excellent outcomes, it is a limited resource that carries inherent risks. Firstly, from an ethical perspective, subjecting a healthy individual to a major procedure (such as a donor nephrectomy) requires a rigorous ethical balance that is difficult to maintain when no other options exist. Secondly, living donations, have a “gap” in care. Living donation is biologically limited. It cannot address the needs of patients requiring heart or lung transplants, effectively creating a “forgotten class” of patients within the healthcare system. Thirdly, there are

economic opportunity costs. Relying on living donors often results in a "limited sporadic" transplant culture - small volumes of high-complexity cases - rather than the high-throughput efficiency required to reduce national waiting lists. In real life situations, one cannot vouch for donor altruism.

The absence of a DDP is rarely a result of public unwillingness; it is more often a failure of infrastructure and legislation. Firstly, policy makers must provide the legal "safe harbour" for clinicians by establishing clear, standardized protocols for Brain Death (DBD) and Circulatory Death (DCD). Without this, the medical community remains paralysed by the fear of legal repercussions. Secondly, a successful programme requires a centralized organ procurement organization (OPO) that operates independently of individual hospitals to ensure equitable distribution based on medical urgency rather than "first-come, first-served" logistics. From a policy perspective, the "cost-per-life-year-gained" for transplantation significantly outperforms long-term haemodialysis in renal replacement. A robust DDP is not just a clinical necessity; it is an economic imperative for sustainable healthcare.

An effective DDP requires a strong legal and ethical framework; an efficient identification and referral system; public awareness and trust; excellent logistics/ infrastructure and an equitable allocation system**.** *e.g.,* a national or regional registry that prioritizes recipients based on objective criteria such as medical urgency (severity of illness), time spent on the waiting list, biological compatibility (blood type and tissue matching) etc.

The transition to an integrated donor model requires a departure from the *status quo*. Clinicians must lead the ethical charge, and policy makers must provide legislative and financial foundation. We in Sri Lanka, can no longer afford to view deceased donation as a secondary option; it must become the cornerstone of our transplant strategy if we are to truly honour the sanctity of life and the principles of distributive justice.

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