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The Church and Organ Donation/Transplantation in Nigeria: An Ethical Exploration

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Abstract

Biotechnology's advancements have enabled the transfer of nearly all human body parts, transforming treatment for previously fatal diseases. However, this progress raises ethical concerns, including consent, commercialization, and the use of foetal organs. Despite these issues, Nigerian churches have not addressed these ethical dilemmas. This research uses qualitative content analysis to explore how church leaders should respond to these concerns, applying deontological and utilitarian ethics. The paper concludes that while organ transplantation offers significant benefits, human life must be respected and not commodified. Nigerian church leaders are urged to address and condemn unethical practices in this field

Keywords: Christian ethics; ethics of organ donation; ethics of organ transplantation; Biomedical ethics

Introduction

The technological and scientific advancements of the 21st century have been crucial in saving lives threatened by various diseases. Biotechnology, in particular, has transformed the diagnosis of kidney disease and the failure or malfunction of vital organs or tissues. Such diagnoses are no longer seen as death sentences but rather as conditions with potential treatment and correction options (Ramsey 2002). Thus, organ donation has now become the only means for survival for patients whose original body organ such as the kidneys, can no longer sustain their system due to a breakdown (Okafor 2016; Emmanuel and Nabena 2020). Hence, sustenance for the sick is now a matter of availability, resources, and a willing donor. Organ donation is the act of giving an organ to assist another individual in need of a transplant (NHS 2020: 2). Regarding the importance of organ donation and transplant, the Danish Council of Ethics (2008) acknowledges that since the first successful kidney transplant in the United States in 1954, many individuals have been waiting for a potential donor to improve their chances of living. For instance, a report on organ sharing in the United States shows that, as at 2011, more than 90,000 persons were waiting for an organ transplant, while 10,000 to 12,000 eligible for organ transplant died due to shortage of donors (Badrolhisam, Idayu, and Zakaria, 2012: 197). Similarly, in Ontario, Canada, one individual succumbs to death every 72 hours while awaiting a life-preserving organ transplant as a result of stringent regulations and an exceedingly low percentage of organ donations (Trillium Gift Life Network, 2021). Due to poor health system in Nigeria, no proper statistics is maintained on donors and those awaiting transplant.

The University of Minnesota's Centre for Bioethics (2018) reports that 106 people join the national organ transplant waiting list daily, and 68 receive transplants, but 17 die waiting each day. To address this organ shortage, campaigns have increased to educate and dispel misconceptions about organ donation (Akinyemi et al., 2020). A new slogan, "share your life, share your decision," replaces "give the gift of life," highlighting both the donor's and recipient's roles to encourage organ donation enrollment (Mongoven, 2003).

In Nigeria, organ donation and transplant are fraught with many issues ranging from cultural, religious, ethical, social, ineffectiveness of existing legal framework, and poor policy implementation (Emmanuel and Nabena 2020). Presently, Nigeria has been termed a kidney exporting country, but lacks the requisite data to monitor such health transactions which is now known as kidney business (Popoola and Yarube 2016). The various church denominations in Nigeria as the custodian of public morality seem to be aloof without a voice in this area. The various blocs of the Christian Association of Nigeria seem to be more interested in every other thing except ethical and moral issues surrounding organ donation and transplantation.

Organ transplantation is considered a significant advancement in the field of bio-medicine. However, it has also prompted scrutiny from those who question the methods used to obtain organs. This has led to ethical concerns, particularly from a religious standpoint, regarding the extent to which medical professionals should intervene to save lives. Some argue that it is unjustifiable to cause harm or encourage someone to sacrifice their life in order to save another person in need of a transplant.

In an attempt to guard against foul play, many countries, both advanced and developing, such as United Kingdom, United States, Canada, Ghana and Nigeria, propose legislation to clarify organ donation and transplant regulations. This study examines ethical concerns and the responses of Christian churches and leaders. It analyses the church's stance and investigates ethical dilemmas in Nigeria's healthcare system regarding organ donation and transplantation.

Given the varying interpretations of the act and rule utilitarianism theory that tend to permit anything for the purpose of deriving peace or pleasure instead of pain, this paper also aims to address the question of the church's and its leaders' roles in the ethical issues surrounding organ donation and transplantation, with a focus on Nigerian Christians.

Research Methodology

This paper adopts the qualitative content analysis method. Content analysis is a qualitative research method that examines text to identify words, topics, or concepts, focusing on understanding the reasons and methods behind human conditions uniquely (Bengtsson 2016; Silverman, 2010). In adopting qualitative content analysis, exploratory and inductive reasoning are applied in the work (Ahmed et al, 2019). Inductive reasoning is necessary because it enables the researchers to draw conclusions based on data before them. Using inductive reasoning entails inferring generalizations from specifics (Hawthorne 2021). One derives a conclusion from observations via inductive reasoning. For predicting the future and creating generalizations, this skill is helpful. Your conclusion might not always be correct, but it needs to make sense in light of the available information (Hawthorne 2021). In content analysis, the researcher arranges the information and presents it objectively and impartially (Catanzaro, 1988; Berg, 2001; Polit and Beck, 2006). Amy Luo states that content analysis is a qualitative method used to detect patterns in recorded speech. It involves systematically collecting data from sources like books, interviews, and social media, then analysing the patterns (Luo 2022).

Theoretical Framework: Deontological Theory of Ethics

The focus of this work is the deontological theory of ethics. However, Utilitarianism will be applied as opposite of deontological theory. Three (3) types of deontological theory exist namely: agent-centred, patient centred and contractual deontological theory of ethics all of which are derived from the Kantian Deontological theory of ethics. However, patient-centred deontological theory is adopted in this work.

Before discussing patient-centred theory, it is important to give a quick overview of agent-centred theory. According to Alexander and More (2021), under agent-centred theories, we all have rights and obligations that give us agent-relative reasons for acting. Agent-neutral and agent-relative reasons are both objective justifications; neither should be confused with the relativistic justifications of a relativist meta-ethics or the subjective justifications underlying psychological human behaviour theories (Nagel 1986). According to Alexander and More (2021), an agent-relative reason is specific to the individual and may not justify others' actions. Similarly, an agent-relative responsibility refers to an individual's obligation to perform or avoid certain actions, specific to that agent. A second kind of deontological moral theories can be classed as patient-centred, in contrast to the agent-centred variant of deontology that has been addressed. These theories, according to Alexander and More (2021), are rights-based rather than duty-based, and some versions assert that the arguments they offer for moral agents are agent-neutral.

All patient-centred deontological theories can be appropriately characterized as theories based on individual rights, according to Alexander and More (2021). This is particularly relevant to the study, which considers the unconsented removal, donation, and transplantation of human body parts to be morally wrong and should be avoided. This inherent entitlement should not be conflated with other legal classifications, such as the proscription against deliberate or accidental homicide. It is a right not to be used for the user's or another person's gain. Such patient-centred deontological views specifically forbid illegal use of another person's body, labour, or talent.

The patient-centred deontological ethical theory is pertinent in this study. It also has strong linkages to Christian teachings. The word "deontological," which means "bound duty," is derived from the Greek word *deon* (Alexander and Moore 2021). Three distinguishing characteristics or features can be found in the deontological ethical theory. According to Moreland (2009: 4), this viewpoint's main tenet is that obligations should be fulfilled purely out of a sense of obligation. This does not negate the applicability of the penalties for the activities in question. Furthermore, they assert that outcomes help us understand our rights and obligations but do not in itself constitute duty (Mark and Swartz, 2021).

According to Moreland (2009:4), the second characteristic of this theory is that people should be seen as objects of intrinsic moral value, which implies they should never be seen as merely means to an end, (such as global happiness or well-being), which is what the utilitarians advocate. Nevertheless, whether reasonable or unreasonable, deontological ethics presuppose that humans have intrinsic value as ends in themselves. This is highly pertinent to this investigation. No one should be rushed to their death or coerced into organ donation because according to this theory people have intrinsic moral value. Aborting infants for the goal of exploiting their brains to treat others is unethical. The third characteristics of the deontological ethical theory is that a moral rule must be applicable to everyone in the same moral situation, which is a universal categorical imperative (Moreland 2009:4). Moreland (2009) defines moral claims as universal imperatives, like "tell the truth." Moral terms include "keep promises" and "avoid homicide." Deontological ethics highlight the inherent value of life, crucial in organ donation and transplantation (Mark and Swartz 2021).

Utilitarianism Theory of Ethics

The writings of Jeremy Bentham (1748-1832) and John Stuart Mill (1773-1873) introduced and developed utilitarianism, often known as consequentialism, as a contemporary moral theory. A utilitarian perspective on moral dilemmas indicates that no moral shortcoming or act, such as drug misuse, theft, abortion, fornication, adultery, or murder, or rule, such as "keep your word," is fundamentally right or bad. They claim that the rightness or wrongness of every action or rule depends purely on the non-moral good (such as "joy, happiness, knowledge, or satisfaction the individual obtains") created as a result of carrying out that action or adhering to that rule (Moreland 2009: 3).

Utilitarianism aims to enhance life quality by maximizing joy and minimizing pain, rejecting rule-based ethical codes or commands from authority figures or supernatural entities. Utilitarians think that a moral rule is right or justifiable if it helps people (or maybe even animals) in some way (Nathanson, n.d). There are two primary schools of thought within the realm of utilitarianism. Each one is founded on the perspective that it holds towards the results of acts. Both act utilitarianism and rule utilitarianism are included in this category. Rule utilitarianism examines the consequences of various types of actions, while act utilitarianism concentrates on the outcomes of specific actions performed by individuals (Nathanson, n.d).

Act and rule utilitarians both aim to maximize overall outcomes but differ in methods (MacAskill et al., 2022). Act utilitarians focus on choosing actions that maximize utility in each situation. Rule utilitarians prioritize ethical laws, arguing that actions are morally permissible if they follow rules that maximize overall value. They believe a moral code is excellent if it aligns with superior moral principles or none at all, emphasizing the importance of ethical

standards in guiding actions to achieve greater happiness (Nathanson, n.d.).

Act utilitarianism holds that disobeying a rule is justified if doing so will lead to some larger benefit, while Rule utilitarianism holds that if a rule cannot lead to some greater good, disobeying it will not (MacAskill et al., 2022).

Act utilitarians apply the utilitarian principle to assess individual actions, whereas rule utilitarians apply the utilitarian principle to assess rules and thereafter evaluate individual actions based on their adherence or violation of those norms, with the aim of maximising utility. Act utilitarians assess individual actions based on whether they conform or violate standards that, if accepted, would lead to the highest level of overall well-being. Rule utilitarians evaluate individual activities based on their conformity to established rules. The key distinction between act utilitarianism and rule utilitarianism lies in this aspect.

To summarise the utilitarian viewpoint, Moreland (2009: 3), argues that morality is determined by the positive outcomes and effectiveness of actions and regulations, and moral responsibility is based on practicality rather than inherent nature. Morality serves as a tool, not as a goal in and of itself. A significant flaw of this theory is that it justifies immoral behaviour as appropriate if it gives joy, happiness, knowledge, or any form of satisfaction, even if it harms the individual or others. This theory is included in the work to show the opposing views of those who abhor deontology. It is applied here to show that some argue that organ donation, no matter the illegality or immorality involved, provided the result is good should be accepted.

Data/Context

The Concept of Organ Transplantation, Donation and Ethics

Transplantation refers to the relocation of an organ or tissue from one part of the body to another, or from a donor to a recipient (*Oxford Concise Medical Dictionary*, 2002, 265). Success in transplantation depends on the degree of compatibility between the donor and the graft, the organ or tissue for replacement. Thomson (1977) explains that the process of organ transplantation is "an extension of the same principle as blood transfusion ..." (249). Transplanted organs and tissues include kidneys, lungs, liver, heart, and brain from an aborted baby and other body parts. Biotechnologists agree that the process of transplantation, though like the extension of the same principle of blood transfusion as Thomson (1977) says, is still a very difficult procedure because of the natural rejection processes in the recipient of the graft- the tissue or organ. This is why special treatment is given to the recipient to suppress his immune system so that person's body will not reject the graft. Thomson et al (1992) calls this treatment "immune suppressant drugs" (Thomson 1992: 1).

This issue of organ transplantation has given rise to so many practices in biomedicine such as harvesting of body tissues, abortion, and foetal neural transplantation, the sale of body parts for transplantation and so many other issues.

(a) Harvesting of body tissues: Due to the scarcity of donors of body parts, it is now possible to use the body parts of those in post mortem examination. This means that they go all out to get body parts or tissues. There is the practice of harvesting body parts of one who died for treatment of another. Thomson (1977) explains that cadaver post-mortem donor only involves such body parts as kidney, bone marrow, and has remained one of the leading means of getting body tissues (249).

i) Foetal neural transplantation: This is a type of harvesting of body tissue, especially the brain of a foetus. Biotechnologists are now harvesting parts of human embryos either for research or the treatment of other people. One common example of such practice is the harvesting of the brain from an aborted baby to treat people with brain diseases such as Parkinson's, Alzheimer's and Huntington's, and Type I (Juvenile) Diabetes Mellitus. Kordower *et al* explain that over 100 Parkinson's patients have been implanted with human foetal midbrain tissue, which now reveals that such grafts can survive for a long period in the human brain, and "restore innervations to the basal ganglia in patients with Parkinson's disease" (ctd. in Campbell *et al*, 1977: 93).

ii) Sale of Body Parts for Transplantation: Some individuals have turned transplantation into a lucrative industry in which they seek for human organs to sell to those who are seeking them. It has led to serial killings in some nations so that body parts can be taken and sold for profit. In Nigeria, for example, there are currently reports of murders and mutilations. Consider the situation in Osogbo, Osun State, in which a man was apprehended with human body parts (Bamigbola 2022). Daniel (2022) also described an instance of a missing woman whose mutilated remains were discovered. In certain instances, it may be for ritualistic purposes, while in others, the components are removed for transplanting. Muhammed (2020) describes how the organ harvesting industry is currently thriving in Lagos, particularly during the Covid-19 Pandemic. He reveals that in the Abule Egba neighbourhood of Lagos State, Nigeria's Katangua market, many second-hand clothing vendors have sold their kidneys as "life givers" to a powerful Indian-based mafia. In the United States, Henry Reid, the director of the Willed Body Programme at the University of California, was arrested in March 2004 for the illegal sale of body parts (Farrell 2006: 3). Michael Mastromarino, who headed BioMedical centre, Joseph Nicelli, who controlled funeral homes, Chris Aldorasi and Lee Cruceta, were accused by a Brooklyn grand jury for mutilating human remains sent to them for embalming and replacing the bones with "creative carpentry and plumbing work." (Farrell 2006: 5).

Organ transplantation is now a permanent part of our society. In recent years, a significant number of Nigerians have been transported abroad for organ transplants. When organ transplantation and donation are seen superficially, there may be no harm to morality, especially if it is viewed as a heroic and honourable act to use a latent body part (such as a kidney) to save a dying person. But how can one justify mutilating the body of a deceased person or hastening the death of a sick person in order to harvest their body parts? What is the moral justification

for investing such a large number of scarce resources to transplant the tissue of an elderly person who may not survive the rigours of the surgical procedure?

As regards foetal tissue transplantation, various scholars support its use such as Coutts (1993), Sanders, et al (1993) and others. They argue that though there are serious debate on the issue, the success rate in the treatment of Parkinson's disease is promising and could be accepted in the future. However, Bregman (1989), Sedlak (1990), Robertson (1993) and Ekeke and Uchegbue (2012) see it as morally wrong and therefore advocated for a regulation. First, the process of getting foetal tissue from an aborted baby is questionable from a moral point of view. This will encourage the inducing of abortion to harvest the brain of the baby for the treatment of Parkinson's diseases and the rest (Ekeke, 2009). In addition, Campbell et al (1977) have provided additional argument against the ethicality of foetal tissue transplantation. Their explanation states that foetal tissue transplants are deemed inappropriate due to insufficiently promising experimental outcomes that would justify their clinical use (3). According to Jones (2013), it is considered unethical to use novel techniques or processes until they have been thoroughly tested in laboratory research. Conducting impromptu clinical research without a well-defined protocol that includes standardised patient selection, surgical technique, and thorough follow-up among the participating centres is also considered unethical (Campbell et al 1977: 94,95). From the perspective of utilitarianism, this position of Campbell et al (1977) may be accepted because it brings solution. However, the application of patient-centred deontological theory will make this practice morally absurd. Though this position may stand as a fact against the use of foetal tissue for treatment, it encourages that it should be postponed to a later date when the proper procedures are accomplished. But the stand of this paper based on deontological theory explained above is that it should not at all be encouraged whether now or even in the future because one human life should not be sacrificed to treat another human life. This is the view of patient-centred deontological theory discussed earlier, which prohibits the unauthorized use of another's body, labour, and talent without proper consent.

Again, the harvesting of body parts should be done with the consent of the donor. The donor should not be coerced by the family members into accepting but it should be purely by voluntarily consenting to it having known the pros and cons of the donation. The medical doctors should be able to explain to the donor the consequences of his action and what he should and should not do to keep himself healthy after the donation (Abouna 2003; Akinyemi et al 2020).

Since consent is necessary for the medical profession, no dead person's body should be mutilated to harvest the body parts without the consent of the dead person. This consent should have been made in writing while the person is still alive or by the surrogate of the deceased who must not do it just for monetary gain. Michael Goldrich cites the 1992 CEJA report, which states that organ donation after cardiac death requires prior consent from the deceased or their surrogate. Performing perfusion without obtaining consent for organ donation is a violation of the informed consent requirements for medical treatments and is not allowed. Utilitarians view abortion as accepted in all cases provided it brings pleasure to those involved. However, some conservatives who are mainly deontologists see it as immoral and hence never generally permissible except where it is done to save the life of the mother or where the foetus has been deformed. Shorr (1994) opines that embryo research and foetal transplantation are more immoral and should be avoided as there is a strong connection between foetal tissue research and abortion and so should be rejected on moral grounds.

Donating an organ or biological tissue from a living or deceased person to a living transplant recipient is called organ donation. (Richie Organ Donation 2018, 1). The surgical removal of body tissue or organs from the donor to the recipient is called transplantation. Liver, lungs, pancreas, heart, bones, aborted infant brains, skin, etc. can be transplanted. However, as earlier observed by Ekeke (2011: 126), transplantation success depends on the degree of compatibility between the donor and the replacement organ or tissue. Patient-centred deontological theory's application in this regard is necessary because of the theory's focus on the rights of individuals not just on their duty. Harvesting of human parts for donation and transplanting ought to be based solely on right and consent of the donor or surrogate.

(b). Sketches in Organ Transplantation

The first successful skin autograft occurred in 1822 (Berg 2001, 29).The number of transplants decreased by 27% in 2004 compared to 2003. There were 28 heart, 5 lung, 8 kidney/pancreas, 8 liver, and 252 kidney transplants. 744 South Africans had corneal transplants to regain their sight. The first organ transplant in Nigeria occurred in 2001. The kidney transplant was done at St. Nicholas Hospital in Lagos. (Emmanuel and Nabena 2020). With only 200 live-related kidney transplants performed in 7 centres in Nigeria as of 2016, Nigeria remains behind in this sector (Okafor 2016, 113).

The above statistics represent the trend in organ donation/transplantation.

(c). Types of Transplantation

Autograft: This is the transfer through grafting of a tissue into a new position of the same individual. This implies that the transplantation is done from one body part to the other of the same person.

Allograft: This type of transplantation involves harvesting tissues or organs and transfer of the same to the body of a genetically non-identical individual of the same species (Berg 2001, 28).

Xenograft: Xenotransplantation involves transplanting living cells, tissues, or organs from one species to another. The actual tissue or organ being transplanted through this procedure is called a xenograft.

Ethics: The Need, the Means, and the Motives.

Ethics as a concept can be seen as being necessitated by the fact that human actions have consequences. Hence, to guard against injury, both of interest and otherwise on others, ethics emerges as a basic concept in human relationships. In the general sense, ethics defines the ideas of rights and wrongs. Ethics is a system of rules and regulations that specify what should be done and how in a given situation. It measures and limits human behaviour. Ethics, a part of philosophy, focusses on establishing principles and laws to guide human behaviour (Tzafesta, 2016: 13). Thus, ethics is essential in a world with diverse interests. According to Steinberg (2018:1), ethics is the philosophy of morality.

Thus, ethics has three branches: meta-ethics, normative, and practical. Unlike meta-ethics, which investigates morality and moral judgement, normative ethics focusses on the norms, regulations, and set of principles and processes that should guide behaviour in given situations. Applied ethics investigates how ethical rules should be applied in real life. An application of normative ethics is applied ethics. The practical application of ethical theories is examined in applied ethics. Applied ethics includes medical, legal, bioethical, and corporate ethics (Tzafestas 2016: 15).

Existing ethical guidelines and concepts are put to the test by the reality of life's complexity. In normative ethics, it is easy to assert that killing is wrong, but in applied ethics, we attempt to determine if such wrongness extends to situations such as capital punishment, killing in self-defence, and termination of a foetus to save the life of the mother. If life is sacred and must be maintained with dignity and autonomy, is it right or wrong to harvest the organs or tissues of a deceased individual to save the life of another individual who requires a transplant for survival without the surrogate's consent? It is evident that basic responses to the few questions provided above are as challenging as the issues themselves.

Biomedicine, Ethics and Organ Donation/Transplantation

Bioethics is a response to the rapid development of medical technology. While it is indisputable that many lives have been spared, saved, and healed by the use of technology in medicine, it is equally undeniable that some lives have been ruined, misused, exploited, wasted, and manipulated in order to save other lives through organ transplantation. These processes include the harvesting of bodily tissues, the transplantation of foetal neural tissue, and the sale of human parts (Ekeke 2011: 126). According to a report by the US Congress (1993) titled "Biomedical Ethics in U.S. Public Policy", certain issues in the late 1990s and early 1970s prompted an overhaul of opinion on how Americans viewed the growing innovation in the area of biomedical research (US Congress 1993, 2). Injections of liver cancer cells into patients at the Jewish Chronic Disease Hospital in Brooklyn, New York, and the purposeful infection of Willow Brook State School for the Retarded students with hepatitis are listed in the study. This is merely an indication of how far medical scientists have taken their techniques. While it may be argued intellectually that such risks are required to protect humanity from future health risks, the argument for sacrificing one life to save others continues to elicit varied responses from distinct ends. The American Medical Association released its first biomedical ethics paper in 1858, and the British Medical Association published its first code of medical conduct for physicians. The 1948 Declaration of Geneva by the World Health Organisation is regarded as the first global medical ethical code (Steinberg 2018: 4).

Medical ethics encompasses rules like the Hippocrates Oath and applying ethical concepts to clinical practice and research (Steinberg 2018: 3). Steinberg (2018) expands the phrase to "biomedical ethics," which encompasses all domains of knowledge relevant to life and health. Ethical rules are needed since biomedicine is sensitive and can give one party advantages and happiness while causing the other irreparable loss and misery. Though designed to guide and regulate medical activities, medical ethics or bioethics as a component of applied ethics has drawn perspectives and contributions from law, religion, philosophy, politics, and the medical profession. This interdisciplinary collaboration shows that biomedicine cannot be disregarded without serious ramifications for society and social connections.

Herein is the role of the church in the present endeavour. The Nigerian church, although having a vast following and a powerful voice in social concerns, has failed to play a crucial role in communicating her ethical and moral perspective. With the exception of the encyclical from the papacy, the Catholic Secretariat of Nigeria holds essentially no comment (CSN). The Christian Council of Nigeria (CCN), the Pentecostal Fellowship of Nigeria (PFN), the Organisation of African Instituted Churches (AIC), and the Evangelical Churches of West Africa (ECWA) have either remained silent or claimed ignorance regarding organ donation and transplantation. These Christian church leaders' position as the conscience or moral compass of the society in all things is not demonstrated.

While bioethics is not a tool or collection of principles designed to impede the advancement of research or success in the medical sector, it does strive to establish a fair, safe playing field for the practice in order to prevent unethical behaviour. In a world where morals, facts, values, and aspirations are rapidly becoming relative based on utilitarian calculus, it is simple to discern the divergence of view regarding what constitutes right and wrong in the medical sciences. The sanctity of life is one of the factors that contribute to divergent bioethical viewpoints. Therefore, according to certain conservative deontological ethicists, all life is significant and must be revered. Therefore, the human body is sacrosanct even after death. To the conservatives, it is a breach of an individual's dignity and autonomy to perform an organ transplant from the deceased in order to save the life of another human in need of a transplant without their consent. How to persuade a person to give body organs/tissues, and whether such persuasion should incorporate monetary incentives, continues to be a source of contention with regard to the live donor. According to the preceding assertions, there are two types of donors: living donors and cadaveric donors (also called the non-living donor or deceased donor).

Living donors

These are donors who donate body tissue or body organ for transplant while they are still alive. According to the Health Resources & Services Administration (HRSA) in the United States, nearly 6,000 living donations take place each year and this figure only represents 4 out of every 10 donations (HRSA 2022). Organs that can be donated by living donors include one of two kidneys, one of two lobes of the lungs or part of a lung, part of the intestine, pancreas, skin, bone, umbilical cord, blood, amnion (after childbirth) and 40,000 transplants took place in 2021 alone in United States (HRSA 2022). However, in Nigeria, it is easier to find living donors where the person needing a transplant is a relative, than it is to find those who are willing to donate to unknown beneficiaries (Bakari et al 2012). This reality has led to a shortage in the availability of organs for those eligible for a transplant in Nigeria. Moreover, the fact of the underdeveloped nature of Nigeria's health system poses a grave risk for living donors if there are any medical complications (Nwabueze 2016). The church is expected to make a case for donation where proper consent is realised and it is regarded as a sacrifice to save one's neighbour not for monetary gain.

Cadaveric donors

Cadaveric donors are donors whose organs are being harvested for a transplant after their death. Hence, an individual may will his body tissues and organs for a transplant. A person becomes a cadaveric donor when he indicates his interest to donate his organs at death. According to a report by the University of Minnesota's Centre for bioethics (2018: 6), such decisions are either expressed or documented on a driver's license or in a health care directory or registry. The report also indicates that, while indicating one's desire to donate an organ on a driver's license is legally binding in states like Minnesota, it also acknowledges that some state hospitals in the United States, however, have a policy that requires family consent for organ removal regardless whatever wishes were expressed by the deceased. Where the consent was given before death, it is called post-mortem consent (WHO 2004, 10).

In Nigeria, Ulasi and Ijeoma (2016) suggest that cadaveric donation is hindered by a number of reasons, including communal hegemony, respect for ancestors, and religious views. The bodies of the deceased should be maintained without mutilation for the deceased's next of

kin. Before burying the deceased in certain Nigerian communities, the elders must ensure that every body part is present.

Also, if the next-of-kin of the deceased offers surrogate agreement for the deceased's organs to be donated for transplant, this reality confronts us with a crucial question that has previously been answered from a different perspective. Death is the topic of inquiry. When is a person considered to be deceased? Let us attempt to address this question by studying the many medical and legal methods for establishing death.

In biomedical ethics, not only is there a vast gulf of opinion at the beginning of life, but also at the end of life; these divergences of view are intense and consequential. According to pro-abortion advocates, life begins at birth, while "conservatives" believe it begins at conception (Ekeke 2009). It is amazing to see that, in an effort to discover and define the meaning of life, mankind has participated in a heated debate on the true value and worth of their own existence. From a philosophical perspective, many doubt and question the truth of their very existence, yet some who pretend to acknowledge the validity of their existence express uncertainty as to when they first came into existence. Ultimately, the same debate led to the person's demise. Consequently, while some are arguing the genesis of life, others are engaged in an intellectual exercise regarding when life might be considered to have terminated.

Legal death

Legal death is defined as the point at which an individual experience either: a. Permanent and irreversible cessation of circulatory and respiratory activities; or b. Permanent and irreversible cessation of all functions of the entire brain, including the brain stem (Davis 2021:1). Sarbey, (2016) explains further that death is associated with two major aspects namely: Cardiopulmonary death refers to the permanent loss of both heartbeat and respiration; and brain death refers to the permanent and irreversible loss of brain activities.

The above definitions of death also raise sharp arguments and concerns on its implication. It implies that the definition of total brain death (Sarbey 2016) is ethically and religiously problematic. Ethicists, especially from the Christian perspective, however, argue against brain death. For example, according to Heather (1985), the brain (Central Nervous System), circulation, and breathing are the primary systems that unify the body. It is not proper to embrace death, even in the event of the loss of just one of these systems.

To Heather (1985), brain death can be a tool of exploitation and devaluing the worth of the dying to save a presumed more valuable life through a transplant. Thus, from this ethical point of view, it is murderous to declare one dead as a result of the failure of only one out of the three vital organs that sustain life. There are also worries that validating brain dead can lead to foul play by encouraging negligence on the part of medical caregivers to do all that is possible to resuscitate the supposed brain dead, especially where the prospects of organ transplant are in view.

Discussion and Analysis

The Issue of Presumed Consent and the Church

Some countries, in an attempt to boost the availability of organs for transplant, have made legislations that compel body organs of the dead (i.e., cadaveric donors) to be harvested where the deceased had not, during his lifetime opted out from having his organs donated at dead. Hence, the assumption is that silence or failure to opt-out equals consenting to be a cadaveric donor. Let us here examine some biblical criteria for authenticating death.

Cessation of breath precedes death

In reporting the death of the patriarch Abraham in Gen. 25:8, the Bible clearly states that “Abraham breathed his last and died at a good old age.” Thus, we see that Abraham was not declared dead until his respiratory organ ceased to work. Also, we see a similar criterion being employed to describe death in other instances. Both Jacob (Gen. 49:33) and Jesus Christ (Luke 23:46; Mark. 15:37) are said to have breathed their last before being declared dead. Hence, the idea of being brain dead runs contrary to the scripture and the teaching of the church, and anything done to the body of a brain-dead patient without a medical confirmation of the permanent failure of the respiratory system is mutilation and violation of the right to life. The church should understand this and take a strong position on it.

Life is in the blood

While affirming the sacredness of blood, the Scripture attests that “...the life of every creature is in its blood” (Lev. 17:14). Here is evidence that in the Scripture, the determination or focus of life is not in the brain but the blood. Consequently, it is a case that until the respiratory system fails, thereby permanently terminating the circulation of blood to the body cells, one cannot be said to be dead. The salvation price paid by Jesus has its efficacy in his blood and not in his brain. Hence, Christians appeal to God for mercy through the blood of Jesus that was shed on the cross of Calvary and not his brain that was dead thereat.

In relation to presumed consent, Abouna (2003, 56) cites the core principle supported by Pope John Paul II in 1992 on behalf of Christianity, stating that organ transplantation can be carried out from a deceased donor if it is necessary to save a human life and if the family's permission is not required. This is because human organs are considered to belong to God rather than the family. At prima-facie, the above declaration has issues of contention to be settled. First, it is agreed that the body organs belong to God who is the giver of life. If life originates from God, and he said life is a gift from God, it is criminal to interfere on how one’s gift of life (resident in the body) should be dispensed with, because the receiver of the gift is accountable to the giver on how the said life was used.

Since this research is from the Christian perspective, it is also pertinent at this moment to consider another implication of presumed consent which is the possibility of a miraculous resurrection as seen in the case of Lazarus in the Scriptures (John 11) and some other verifiable examples in the contemporary world. However, since a miracle is a religious experience or concept that cannot be studied empirically to accentuate its truth claims, the researchers shall attempt mild compromise to accommodate thinkers from the scientific field by adopting a relatively synonymous term that is acknowledged in the medical profession as “Lazarus Syndrome”. Moyer (2021) defines Lazarus Syndrome as auto-resuscitation after a failed cardiopulmonary resuscitation.

Lazarus Syndrome documents a case of one Judith Johnson, 61 who has a cardiac arrest at Beebe Medical centre in Lewes, Delaware, United States in May 2007. Following her declaration of death at 8:34 pm, she was subsequently found to be alive and exhibiting signs of respiration in the mortuary. She filed a lawsuit against the medical institution seeking compensation for the neurological issues resulting from the incident. From the above scenario, the question that “pro-presumed consent” ethicists would have to answer is, what happens if a patient who was declared brain dead and based on the legislation of presumed consent, had his or her kidney and some body tissues harvested suddenly resurrects after a few hours or days; what justification will be given to, on waking up to discover that his or her body parts were mutilated? What would be done to repair the psychological and emotional trauma from such an experience?

Rewarding Organ Donors Financially

While organ donation is supported or meant to be a gift or charitable act to save other lives, through a voluntary donation of one's body tissues or organs; another ethical concern is whether the donor should be rewarded financially? The answer to the above question outweighs a straightforward 'yes' or 'no'. To some, the financial reward will equal to sale of body organs which is both unethical and illegal and leads to organ trafficking in Nigeria and other parts of the world (Bakari et al 2012). Also, those against financial reward argue that there is a possibility of a potential donor being blindly lured by the reward to donate without a full grasp of the implication of his actions (Finkel 2001). Others argue on the other hand, that considering the shortage in organs and the ever-increasing rise in the toll of patients eligible for a transplant for survival, financial incentives (not payment) could serve as a motivation for a voluntary donation. This includes the potential for the commercialization of body parts (Nwabueze 2016). It is therefore, pertinent in the light of the above fears expressed, to investigate the means and the motives behind the financial incentives or rewards. Recently, a BBC World Service report of June 13, 2018, revealed an illegal blood bank run by a medical laboratory scientist in Lagos, Nigeria. According to the said report, the illegal blood bank has been in operation for about 4 years and unsuspected members of the public were induced with a payment of N2,000.00 (about $5 as at 2018) per pint of blood donated. The discovery was made when one of the donors, a 17-year-old who donated 4 pints of blood within a space of six days was found in a critical condition. The situation above calls for prudence in introducing financial incentives for organ donors. In their investigation of the ethical issues on financial incentives for organ donation, Bakari et al (2012) recommend some incentives to cadaveric donors. Such incentives include buying little presents for whoever indicates interest, provision of the subsidized medical bill, priorities on the waiting list should the person ever need a transplant, sponsoring of the funeral cost, etc. From the perspective of the above recommendations, such incentives are made for indication of interest and not as a payment for the organ. On living donors, caution is needed to guard against exploitation and foul play.

Who Gets the Organ?

One question that the researchers observe has been ignored or remained unanswered is whether a living donor has the right to know the beneficiary of the transplant. It is understood that where the person needing a transplant is a family member or a close relative, such knowledge is almost inevitable since the person in need is often involved in soliciting for or negotiating for the organ (Finke 2001). The researchers are of the view that legislation empowers the donor (where such desire is expressed) to know who is benefiting from his gift in Nigeria. No person should be coerced into the donation of his/her organ, especially from the family (Popoola et al 2018). This proposition is without any malignant intent or prejudice on the end recipient but is a way of possibly encouraging a more eager voluntariness to donate. Also, such knowledge proves needful because, for instance; the donor may suffer irreversible psychological trauma that may even result in suicide if he or she discovers that the beneficiary of his donated organ was legally proven to be responsible for the gruesome murder of his or her relative, or possibly responsible for damage that has left him or her with an emotional scare.

On the other hand, one may also be more motivated to donate part of his organ to a person needing a transplant if he knows the financial or social state of the person. For instance, in our society, one is more likely to be moved to help the indigent poor and needy than they would help a corrupt politician out of a straight. Such knowledge does not in any way discredit the value of the donation as it would also be accompanied by another legislation that will protect the beneficiary from exploitation and harassment of any kind in the future (Nwabueze 2016). Knowledge of the beneficiary of the donation (by the donor) will also help clear the air of all suspicions of the beneficiary being charged for the organ at the transplant centre. In a way, even Jesus Christ who donated his life as a ransom for humanity had a good knowledge of what he was to suffer and who the beneficiaries of such a price would be.

Recommendations

The following recommendations are hereby presented:

1. No life is so debilitated that its value becomes worthless to be destroyed or hastened to death in order for another life to survive. Therefore, human life is sacred and should be preserved.
2. Presumed consent does not consent and should not be accepted. To this end, proper consent should be secured from a surrogate before harvesting body parts from a cadaver.
3. Nigerian church should not always stand aloof as biotechnology is advancing with dehumanisation of human life for the purpose of research and treatment of another person.

Ethics is not meant to discourage medical advancement but is meant to keep them on their toes to remember that human life is valuable irrespective of one's value orientation.

Conclusion

Organ donation is not outrightly condemned in Christianity. The Christian faith encourages all acts that are aimed at saving human life. However, concerns in this practice set in when it is observed that procurements of body organs and tissues are being made through questionable and criminal means and motives. In some cases, the ethical principle of utilitarianism, whether the act or rule, which is based on the claim that the rightness or wrongness of every action or rule depends purely on the non-moral good (such as "joy, happiness, knowledge, or satisfaction the individual obtains") created as a result of carrying out that action or adhering to that rule, becomes the driving force in obtaining such body organs for transplantation.

On the other hand, the deontological ethics which encourages duty-centred and adherence to individual's rights is not considered in some cases. Deontological ethical principles uphold the sanctity of human life and warns against exploiting even the frailest and smallest life in an attempt to benefit another. Also, it is imperative to state that consent is not truly consent if obtained either by questionable legislation, unhealthily incited, or obtained by fraud without a proper understanding of the pros and cons of the consent by the donor. Organ donation is a great good done by biotechnology, however, such good must be done and monitored under strict observance of laid down ethical rules and practice.

The Nigerian church, apart from the Papal encyclical on organ donation by Pope John Paul 11, does not have any statement on the issue of cadaveric organ donation which does not actually exist now in Nigeria due to socio-religio-cultural inhibitions mentioned above, commercialization of body organs, religious and cultural beliefs on cadaveric donation. The remaining four blocs, Christian Council of Nigeria (CCN), Pentecostal Fellowship of Nigeria (PFN), Organisation of African Instituted Churches (OAIC) and Evangelical Churches of West Africa (ECWA), apart from Catholic Secretariat of Nigeria, should make a clear statement on how the church should relate to the issue of organ donation and transplantation. This requires that they should set up a body that will study the practice and carefully examine the biblical position and come out with a position paper.

Conflict interest(s)

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Ethical considerations

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