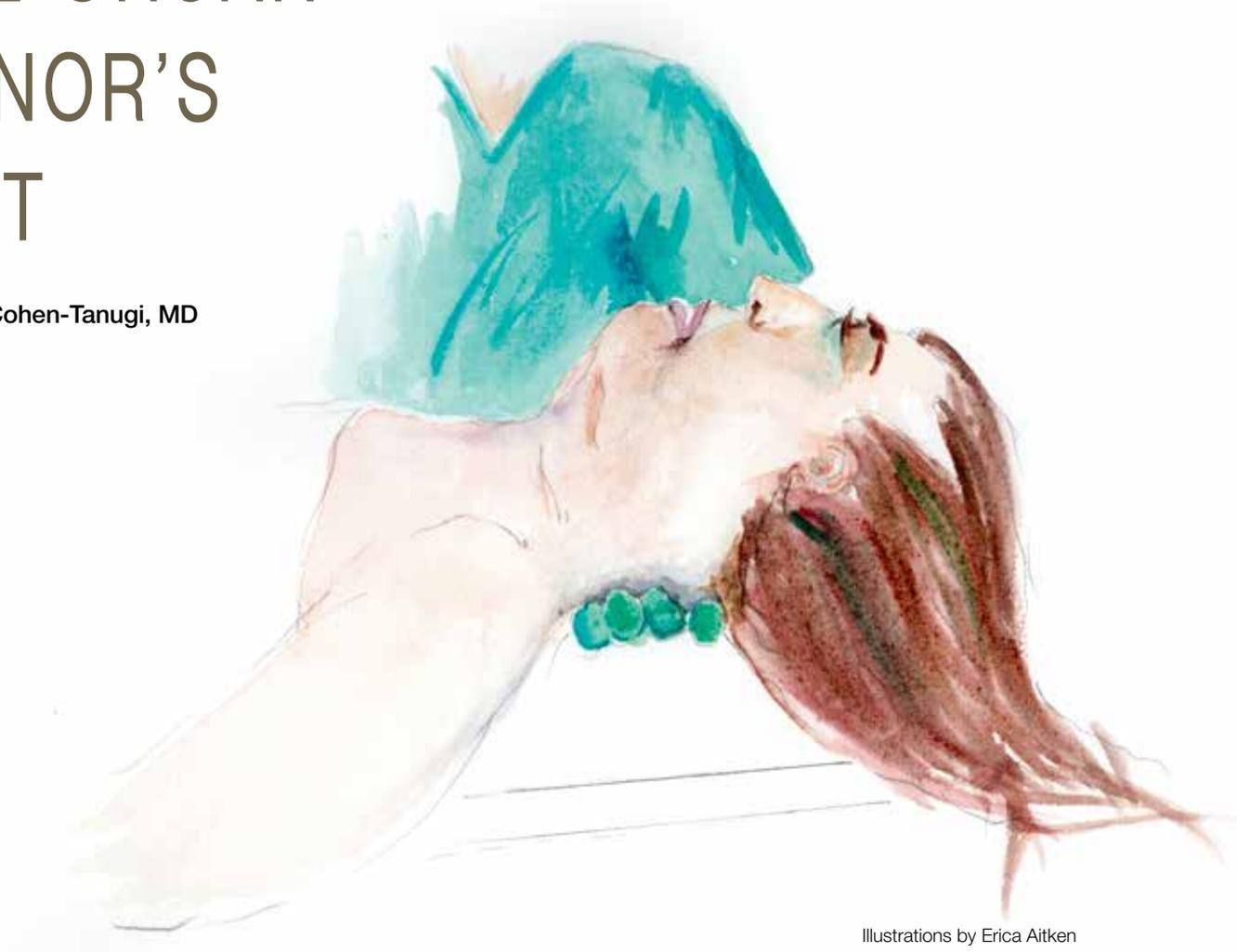


THE ORGAN DONOR'S GIFT

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Early one June afternoon, in the final weeks of my first year of medical school, the transplant pager I was carrying went off. The team—a transplant fellow, a surgery intern, and me—was flown by private plane to a distant hospital.

Upon arrival, we were told that the patient was being transported to Operating Room 10. The word patient made me pause. Was this really the right term? Wasn't the woman dead? Describing her as a patient felt deceitful; we weren't doing anything to help her. The brain was dead, which meant the person was dead too. But using the word

body sounded shady, like she was the victim of an underground organ-trafficking operation. I turned to the intern: "What do you call it? The body? The patient?"

"The donor," she said.

"The donor," I repeated. I liked it. Donor emphasized neither living nor dead. It implied intentionality and respect. Something was being given. The donor was a person who, while alive, had decided to donate their organs. Now, they were dead—brain dead, that which constituted their person was gone.

They were no longer a patient, yet more than just a body. This, I would soon realize viscerally, was the paradox of organ recovery—the donor must be dead, but their body is still full of life, and that is their great gift.

A young woman, hooked up to a ventilator, was rolled

into the OR. I knew that she had committed suicide as a prison inmate, and had hepatitis C. Lying there, she could have been a woman under anesthesia, her chest rising and falling with each mechanically-induced breath, her limbs flushed with blood. "Push her shoulder up," the fellow told me, as he prepared to slide her onto the operating table.

As I lifted her up, I reflexively placed a hand under her neck for support, as if I were worried I might jar her out of sleep. I looked up, wondering if anybody had noticed my overly gentle gesture, thinking it foolish. She was quickly undraped, her body fully uncovered, and her arms were strapped to her side to keep them from flailing around lifelessly. I took in the contours of her body. She was an obese woman. Her breasts were large and drooped to either side. Her pubic hair was untrimmed. Does she need to be so exposed? I wondered.

I was soon caught in the whirlwind of preparatory activities—a ritual of cleaning the donor's body, preparing the sterile field, and scrubbing in. The first incision was pronounced, and I was handed a suction instrument and retractor.

We burrowed through layer after layer of fat, creating a topological landscape not unlike a canyon, from the highest peaks of her breasts, down the precipitous walls of fat to the thin layers of abdominal muscle, which we cut through along the midline.

"Bone saw for the sternum," called the fellow.

The fellow cut through the sternum, from the bottom up. This was when I realized we were doing permanent damage to this body, that preserving it was not part of our mission, that we were operating on, and for, the organs, and whatever was in the way had to go.

The open rib cage revealed its precious contents. I was struck by the perfect shape of the organs and their vivid colors. The shift from my cadaver's organs back in the anatomy laboratory to those of the donor was like moving from the black-and-white world of Kansas to a technicolor Oz. My cadaver's lungs had been gray, his blood vessels white, what remaining fat hadn't already liquefied into pools of greasy fluid was a dull cream color, and his muscles were a faded brown. The firm layer of fat around the donor's heart was yellow, the highly vascularized lung tissue was pink, and her liver was burgundy red.

After exposing the liver, the team was faced with the decision of whether to proceed with the retrieval. Was this liver in good enough condition? Would a surgeon be willing to transplant it? Biopsy samples were collected and analyzed, pictures were taken, and the fellow called his attending.

I listened to the conversation, which did not sound promising. A hepatitis-C-infected liver, abnormally large and fatty. Biopsy shows early signs of cirrhosis and fibrosis...All the while, my eyes remained fixed on the donor's pulsing heart.

"You can touch the organs if you want," said the intern.

I began by tentatively placing my fingers just below the heart, to feel its pulse. I closed my eyes and let my fingers slide up onto the heart's surface, and around the pulsing ventricles. Nobody had ever held this woman's heart quite like I was, I thought to myself, feeling its powerful beat right against my palm. I wondered whether her heart was the place she had felt the unbearable pain that had driven her to take her own life.

Next, I explored her right lung, the way the slightest of pressures depressed the tissue like a moist sponge, how each breath compressed the fingers I had slid in the fissure between lobes. I moved down the abdomen. As I manipulated parts of the bowel, the intern stepped beside me to engage me in an anatomy lesson. As we worked our way through the GI tract she showed me a trick to differentiate healthy from ischemic bowel—a sharp flick of the finger on healthy intestinal tissue would cause it to contract like a sea anemone. The bowel is alive, I thought, which reminded me that brain death does not include the enteric nervous system.

The fellow and attending decided to proceed with the recovery of the liver and kidneys. The dissection resumed as I held the intestines out of the way.

Suddenly, slushy ice was poured into the abdominal cavity, signaling that the end was near. The aorta was clamped above and below the abdominal organs and tubes were inserted into vessels.

"This is when it can spray," warned the fellow. "Be careful. She's HepC positive." He then severed one of the large vessels. A gush of blood spurted in the air. He repositioned himself and made a second cut. More blood sprayed. I was out of the way but both the fellow and intern were splattered bright red. The heart was exsanguinating with every beat, and I continued to suction the blood now pooling at an alarming rate.

I kept my eyes on the donor's heart, watching it beat wildly, irregularly, with decreasing vigor. Colors changed before my eyes. As blood drained away, organs lost their vivid sheen, replaced with a dull, gray tone.

When the heart's pulse was no more than a twitch, I reached out, and again rested my hand on its surface to feel the last, disorganized, contractions that had beat the rhythm of this woman's life from before her birth to the

moment she was found and proclaimed dead, and kept beating even after that.

This, I thought, is the death of the body. I had to remind myself that she was dead long before entering the OR. It was hard not to see the people standing around, the calm urgency, and the gushes of blood as elements of a ritualistic sacrifice.

The liver was collected and placed in a bag of ice, followed by the kidneys. The fellow went to scrub out, and instructed the intern and me to close. After the last suture, the intern left the room. I looked at the organs in their ice bags being placed into a blue box. Our work was done.

It was 1 a.m. by the time we boarded the four-seater plane, blue box in hand. The flight crew greeted us with a late dinner of bar-b-qued ribs. I looked at the charred meat and my mind jumped to the human flesh and bones we had just cut through.

After take-off, the fellow and intern fell asleep, leaving me on my own to make sense of the entire experience. I had been part of a team assigned to recover organs from a recently deceased person. That we have learned to integrate organ recovery and transplantation into our medical arsenal in the endless quest to cure disease and alleviate suffering is a testimony to the miraculous progress of medical science. Yet, few medical interventions lend themselves to dystopic scenarios as disturbing as organ recovery.

It is our responsibility to never forget the donor, to never trivialize their gift or the beautiful, and at times uncomfortable, process by which it is given.

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