1. Introduction

ELPAT, the European Platform on Ethical, Legal and Psychosocial Aspects on Organ Transplantation

In organ transplantation more and more emphasis is given to the ethical, legal and psychosocial aspects of this life saving medical intervention. The main driving force for focusing on these aspects is, of course, the increasing discrepancy between demand and availability of organ grafts. Organ shortage has been the reason for a number of initiatives to expand the donor pool: extension of deceased donor criteria; the use, and even the promotion, of living donation including by so called "good Samaritans"; attempts to adjust the legal frameworks and to increase public awareness. All these initiatives have met their inherent ethical, legal and psychosocial hurdles and even barriers. Organ shortage also resulted in organ trafficking, which is condemned by both the Council of Europe and the World Health Organization. However, this problem is unlikely to be eradicated in the present situation where each year 8.000 – 10.000 European transplant candidates die on wait-lists. Therefore, as a means to fight organ trafficking, the ethical, legal and psychosocial aspects of alternative solutions e.g. the regulated organ market, should be considered too.

This book presents the proceedings of the European Commission sponsored International Congress: "Organ Transplantation: Ethical, Legal and Psychological Aspects; towards a common European Policy. The congress was organized from April 1-4, 2007 in Rotterdam, The Netherlands by the Dutch Transplant Foundation, The Health Council of The Netherlands and the Erasmus Medical Center in Rotterdam. It followed the successful Munich symposium on these issues in 2002.
The purpose of the Rotterdam meeting was, apart from encouraging the exchange of information, ideas and expertise, to establish a permanent European Platform.
This platform is an attempt to create and structure European research in this field of ethical, legal, psychosocial aspects of organ transplantation (ELPAT).
To ensure continuity of this European ELPAT platform, it will be functioning as an autonomous part of the European Society for Organs Transplantation (ESOT).
Working groups will be established along the lines of the main topics that were discussed during the April 2007 Rotterdam conference.
1. Commercialization and trafficking
2. Legal systems for organ donation and allocation
3. Altruism, counseling and psychological aspects of living donation
4. Minorities, religion and gender
5. Expanded criteria for deceased donors
6. Role of patients, media and industry

The present book is a compilation of invited lectures, free communications, debates and statements that were presented during the Rotterdam conference. Therefore this book may function as the starting point from which discussion within the European ELPAT will be

launched. ELPAT and ESOT will bring together European expertise by organizing working groups meetings on various ethical, legal and psychosocial aspects of organ transplantation. The aims of these meetings are to bring permanency in the dialogue on these complex issues, to overcome discrepancies between European countries and to formulate European Guidelines. Moreover ELPAT will inform transplant professionals, policy makers and the general public about new developments in the ethical, legal and psychosocial aspects of organ transplantation. During each bi-annual ESOT symposium a special ELPAT session will be organized. In October 2007 in Prague the first of these sessions was entitled "Organ Tourism in Europe". For background on this object, the presentations of this 2007 ESOT/ELPAT session and all other ELPAT information you are invited to visit our website: www.elpat.eu.
Finally, the editors want to thank Leonieke Kranenburg, the coordinator of ELPAT and Marian van Noord, secretary of ELPAT for their devoted assistance in the preparation of this book. We also thank the staff of Pabst Science Publications that contributed to this publication.
We look forward to the next major ELPAT congress on Ethical, Legal and Psychosocial Aspects of Organ Transplantation that will be organized in Rotterdam, The Netherlands, April 18-21, 2010.

Rotterdam, October 2007

Willem Weimar, Dutch Transplant Foundation
Michael A. Bos, Health Council of The Netherlands
Jan J. Busschbach, Erasmus University Medical Center Rotterdam

Organ Transplantation – The European Perspective

Michael A. Bos

Health Council of the Netherlands, Vice-chair of the Medical Ethics Committee of The Eurotransplant International Foundation, The Hague, The Netherlands

This introduction intends to provide a birds eye view of the legal, ethical and psychosocial aspects of organ donation and transplantation across Europe. It focuses on a number of issues, e.g. European cooperation, current trends in donation and transplantation, and in particular living donor transplants. Other issues that are discussed are organ tourism, organ trafficking and the impact of commercialization in the field of donation. Finally, some new approaches regarding the allocation of donor organs are highlighted, including the role of the internet.

1. European Collaboration in Organ Donation and Allocation of Organs

The year 2007 marks the 50th anniversary of the Treaty of Rome, which counts as the official birth of the European Union. But it also marks the fact that in 1967, thus 40 years ago, a first proposal was made to establish a pan-European organization for the cross-border exchange of donor organs. This idea was put forward, during an international seminar in Torino, by the Dutch immunologist Jon van Rood, who had played an important role in the unravelling of the complex HLA-system. When tissue-typing and matching, on the basis of HLA, became practically available, this made the use of post mortem donor kidneys feasible and resulted in the successful international allocation and exchange of donor organs. Van Rood thus became the founding father of the Eurotransplant organization, legally founded in 1969, with its headquarters in the University Medical Centre in Leiden, The Netherlands. In the first year of its existence, 11 donor kidneys were actually exchanged; in 2006 that number has increased to 6970.

For a number of reasons, both political and logistic in nature, Eurotransplant did not at the time unite the majority of European countries; in 2007 the foundation regulates organ allocation and exchange in 7 countries. Box 1 shows the characteristics of Eurotransplant in 2007.

- Participating countries: Austria, Belgium, Croatia, Germany, Luxembourg, The Netherlands and Slovenia.
- Service area: 120 million inhabitants
- 69 transplant centres
- Waiting list (2006): 15805 patients
- CAD donors (2006): 2021 (16.1 pmp)
- Total transplants (2006): 6681 CAD transplants, 1014 LD transplants
- Exchange rate: approx. 20% of all kidneys

Box 1: Eurotransplant Foundation, 2007

Although Eurotransplant did not achieve real pan-European cooperation in organ allocation and exchange, the basic idea of organ exchange was quickly followed by other countries. Today, national and supranational exchange organizations are active all over Europe (figure 1). Service areas vary from 120 million inhabitants (Eurotransplant) to 7.3 million (Switzerland) (see box 2).
The rationale for this national and international cooperation is to be found in the clear benefits it achieves:
- Better matched transplants, resulting in better quality of life
- Less waiting time for vulnerable patients (children, highly urgent patients, rare tissue types)
- Optimum utilization of the organ supply
- Equal access to scarce resources, justice in allocation
- Shared protocols and procedures.

- Eurotransplant: 120 million inhabitants
- UK Transplant: 64 million
- EfG, France: 60 million
- CNT, Italy: 58 million
- ONT, Spain: 41 million
- Poltransplant: 39 million
- Scandiatransplant: 25 million
- HNTO, Greece: 11 million
- Lusotransplante: 10.5 million
- Hungarotransplant: 10.5 million
- Czech Transplant: 10.5 million
- Swiss Transplant: 7.5 million

Box 2: Service areas of European organ exchange organizations

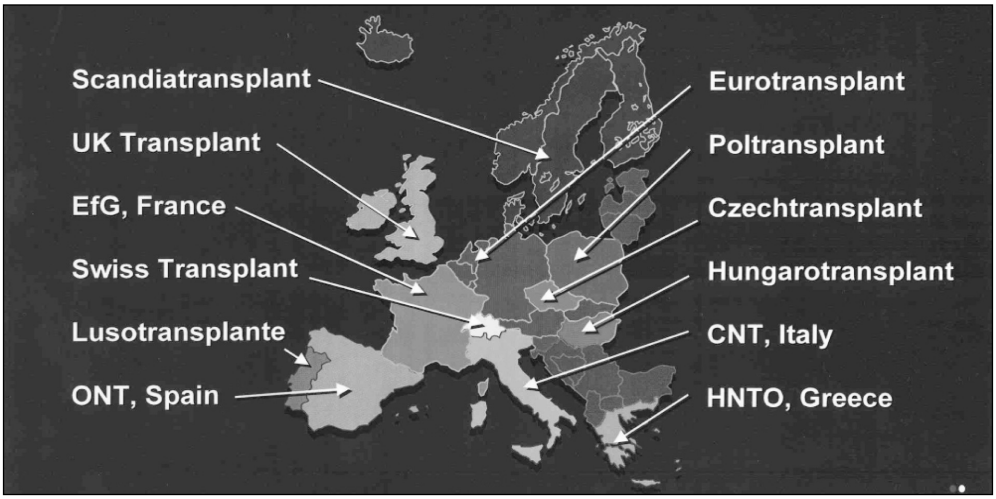


Figure 1

2. Trends in Organ Donation in Europe – 2005

General trends:
– CAD donors and transplants remain stable
– LD transplants increase
– NHB donation practised in few countries

In 2005/2006 the number of deceased donors that were reported and used has remained stable in most countries throughout Europe; however, an increase was reported in Spain, Estonia, Belgium and Austria. The total number of CAD donors in 2005 was 8516, which results in a European mean of 18.8 donors per million population. The total number of CAD kidney transplants remained stable at 13.950 (30.7 pmp), while the number of living donor kidney transplants continued to grow: total of 2216 (4.9 pmp).
Non-heart-beating donation is performed in just a few European countries (mainly The Netherlands, UK and Spain), and is slowly increasing: 344 transplants in total in 2005 (0.7 pmp).
In the whole of Europe a total of 65.000 patients were on the waiting list for transplantation in 2005. Some 5000 patients died while waiting. In comparison: In 2005 in the USA around 95.000 patients were placed on the transplant waiting list. Mortality on that list was reported to be much higher than in Europe: around 20.000 in 2005.

Donor Rates in Europe - 2005

In Figures 2 and 3 the number of donors (per million population – pmp) for European countries in 2005 is represented.

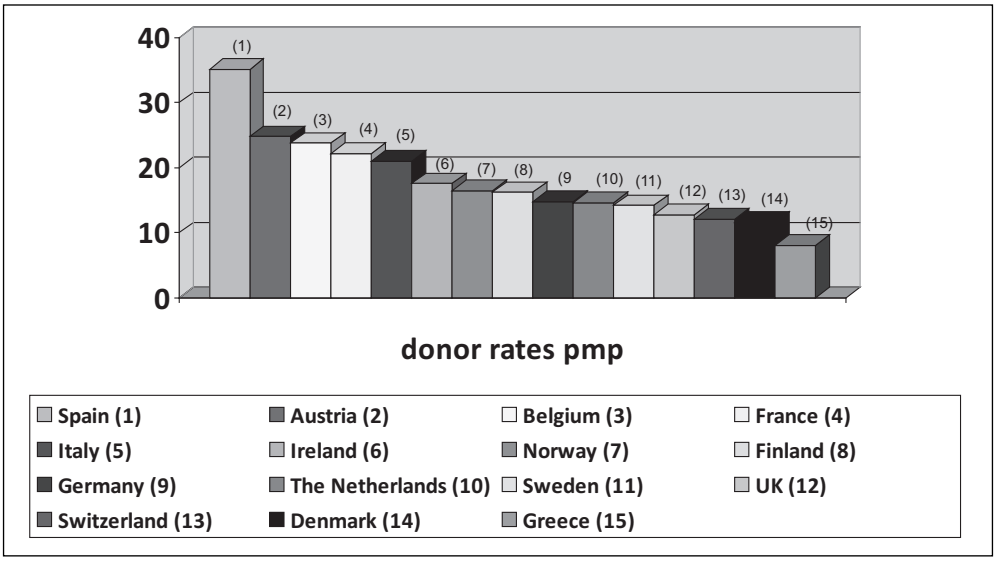


Fig. 2: Donor rates in 'old' EU member states (+ Norway and Switzerland)

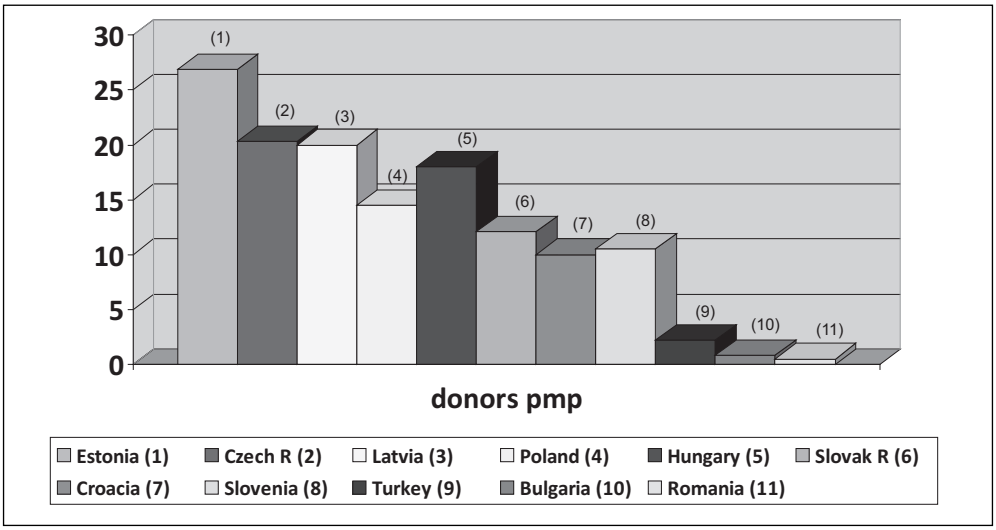


Fig. 3: Donor rates in 'new' EU member states (+ Turkey)

Comparing Europe and USA at a Glance - 2005

In table 1, the key figures for organ donation and transplantation in Europe and the USA are compared:

Tab. 1: Comparison of USA and European data

Transplants	**Europe**	**USA**
Population	454 millions	297 millions
CAD donors	8516 (18.8 pmp)	7150 (24.1 pmp)
HNB donors	344 (0.7 pmp)	600 (2.0 pmp)
Kidney transplants	16.176 (33.6 pmp)	16.001 (53.9 pmp)
LD kidney transplants	13.7% of all kidney Tx	41% of all kidney Tx
Liver transplants	6095 (13.4 pmp)	6168 (20.8 pmp)
Heart transplants	2004 (4.4 pmp)	2055 (6.9 pmp)

Some overall conclusions that can be drawn: The US has a considerably higher rate of organ procurement in comparison to Europe. This leads to higher transplant rates for all organs. Living donors in the US have a much higher contribution to organ transplants than in Europe.

3. Living Donor Transplantation in Europe

General trends:
- *Living donors legally accepted in all countries*
- *Number is steadily increasing*
- *Increase of unrelated donors, but restrictions*
- *More preemptive kidney transplants*
- *Start of cross-over programs*
- *Debate over altruistic donors*

The use of living donors for transplantation (mainly kidney, also liver transplants) is generally accepted in Europe. However, the rate of use differs widely across countries, reflecting both logistic and cultural differences between countries and regions.
In table 2 the rates for both cadaveric and living donor kidney transplants are shown.

Some conclusions:
Countries with a high yield of cadaveric donors make relatively less use of living donors (Spain, Austria, Belgium, Finland), while countries with stagnant numbers of cadaveric donors need to supplement this with living donors (Germany, Netherlands, Sweden, UK).

Tab. 2: CAD and LD kidney transplants across Europe (2005)

Country	CAD ktx pmp	LD ktx pmp	LD as % of ktx
Spain	47.9	2.0	4.0
Austria	45.2	4.3	8.6
Estonia	44.6	1.6	3.4
France	38.4	3.2	7.7
Czech Rep	37.6	2.6	6.6
Belgium	34.4	3.1	8.2
Portugal	33.0	4.0	10.5
Finland	30.8	1.0	3.0
Norway	30.8	18.9	38.0
Italy	29.3	1.8	5.7
Germany	26.6	6.3	19.2
Netherlands	25.7	16.8	39.4
Sweden	24.3	19.1	44.0
Switzerland	24.0	11.1	32.8
Denmark	22.3	8.7	28.0
UK	22.2	9.2	29.3
Turkey	4.0	9.7	70.5
Bulgaria	1.1	2.1	66.6
Romania	0.9	7.8	89.5

Some countries rely almost exclusively on living donors, because of poor organizational infrastructure for cadaveric donation (Turkey, Greece, Bulgaria, Romania).

Use of Unrelated Living Donors

Generally speaking, in countries where living donors are well accepted and frequently used, there is a tendency to use increasing numbers of (genetically) unrelated donors. Table 3 shows the development in Eurotransplant countries.
Although their use is legally accepted, many countries strictly monitor the use of unrelated donors, especially from others than spousal donors. Some countries legally restrict unrelated donation to (married) partners with a proven, longstanding emotional relationship (e.g. Germany, France).

Tab. 3: Use of unrelated living donors in Eurotransplant

2001	**2006**
208 living unrelated kidney transplants	381 living unrelated kidney transplants
Spouse: 86%	Spouse: 74%
Other: 14%	Other: 26%

Preemptive Living Donor Kidney Transplants

Studies have shown that living donor kidney transplants will have the best outcome when they are being performed pre-emptively (prior to starting dialysis treatment), resulting in a 10% survival benefit in the long run (see figure 4). Other benefits include: short waiting time for transplant, less mortality, no shunt-related complications and considerable cost savings for the health care system. In children preemptive transplantation is of special importance, because it prevents growth complications caused by dialysis. However, in most countries the percentage of preemptive LD transplants is still low and there is considerable room for improvement.

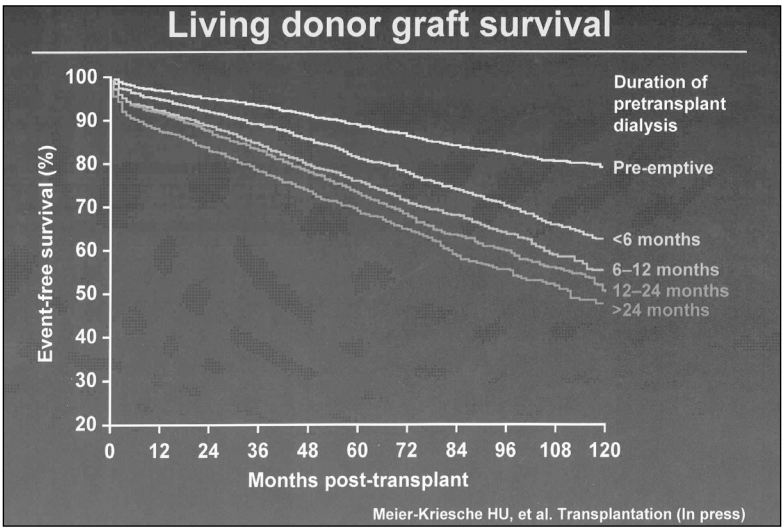


Fig. 4: Living donor graft survival (prior and after dialysis)

Cross-over Kidney Transplantation

Cross-over kidney transplantation (or: paired exchange) started in 1990s in South Korea (by Prof. Kil Park). The rationale is to make possible donation between donors and recipients with blood group incompatibility or a positive cross-match (antibodies against the donor). This procedure involves a complicated logistical set-up, in which two surgical teams perform donor and recipient operations simultaneously, sometimes in different hospitals. Most recipient-donor pairs prefer to remain anonymous to the other pair.
In Europe, cross-over programs have so far started in The Netherlands and Romania, and are planned to start in the UK and Germany. The program in The Netherlands commenced in 2004; this is a national program in which all transplant centres participate. From 2004-2007, 172 incompatible couples were enrolled, 86 new pairs were matched and 64 transplants have so far been performed (till April 2007). The computer-based match program achieves a better than 50% success rate. Problems are encountered with blood group O recipients, for whom a suitable match is difficult to achieve. In the near future an expansion of cross-over exchange is to be expected: The Netherlands program has already performed exchanges involving three and four couples, and may introduce a swap-around program (figure 6). List exchange is also considered for the benefit of blood type O recipients. However, in some countries (e.g. Germany) cross-over programs still face legal restrictions and hurdles.

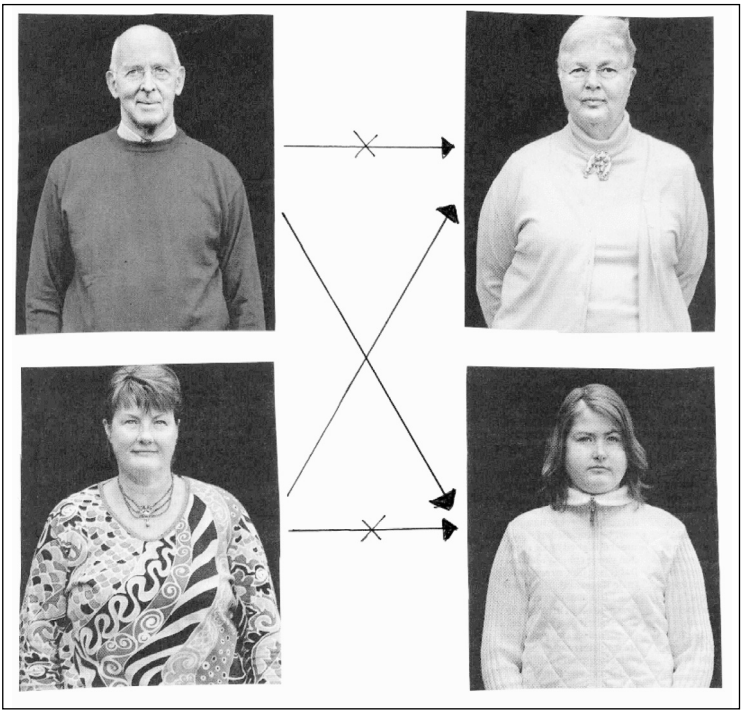


Fig. 5: One of the first Dutch cross-over couples

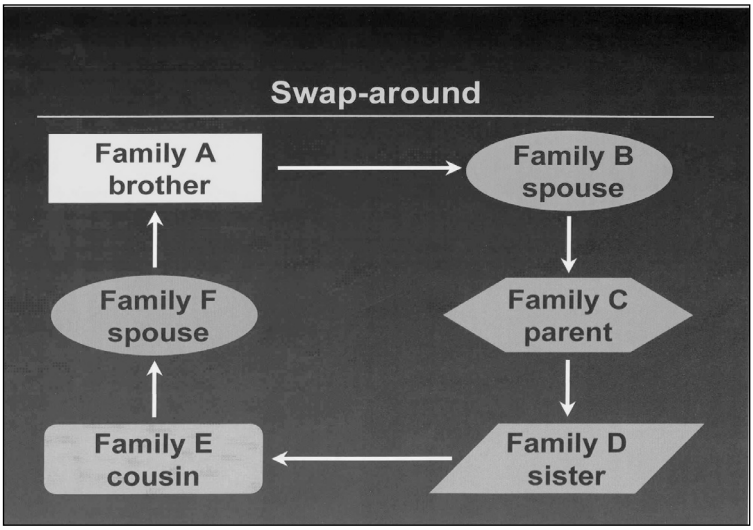


Fig. 6: Swap-around exchange

Altruistic Living Donors

Living donation is sometimes performed by donors who have no genetic or emotional relation with their recipient; this is also known as 'Samaritan' donation. However, this type of donation is as yet not legally allowed in the majority of European countries (among them Germany and France). In countries that do accept altruistic donors, a strict psychosocial assessment is required and donations are usually made in an anonymous way to the waitlist (e.g. The Netherlands, UK). Currently it is debated if altruistic donors can be allowed to donate to specific (groups of) persons: directed donation.

4. Non-heart-beating Donation

General trends in 2005:
- *Slow increase of NHBD in Europe*
- *Practised in only few countries*
- *Considered valuable source of transplantable organs*
- *Outcome comparable to HD kidney transplants*

Organ donation by persons who die following cardiac arrest (in the US named: DCD – *donation after cardiac death*) is slowly increasing across Europe: The total number increased from 203 NHB donors in 2004 (resulting in 468 kidney transplants) to 344 NHB donors in 2005 (resulting in 507 kidney transplants). This means 0.7 NHB donors pmp and 1.1 NHBD transplants pmp.
NHB donors are as yet procured in only few European countries, as is shown in figure 7. The use of these organs is still surrounded with ethical questions and debate. In some countries

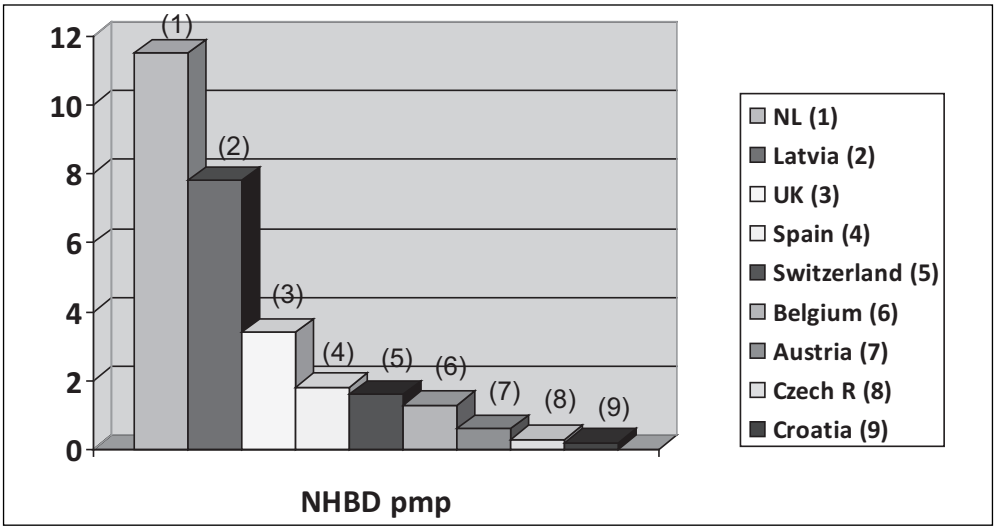


Fig. 7: Number of NHB donors procured in 2005

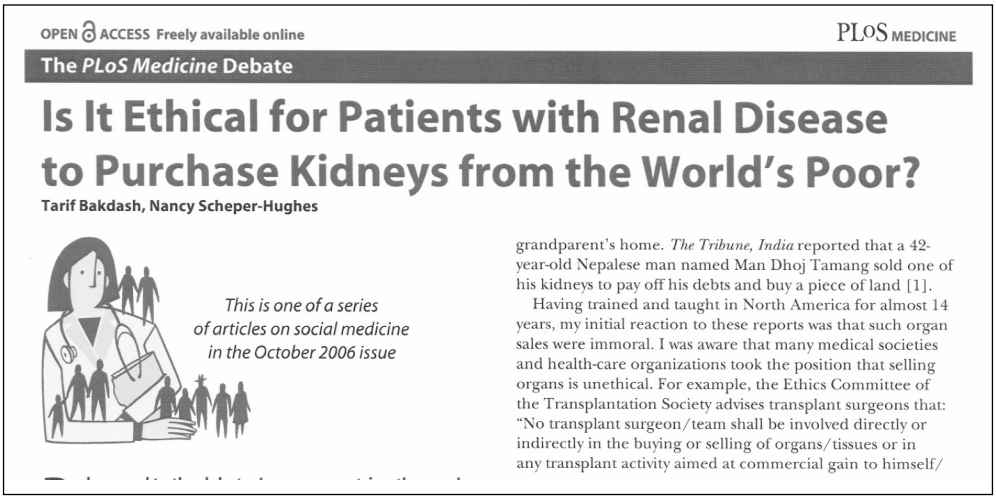
(e.g. Germany) the use of NHB donors is legally not allowed. Also, a number of individual transplant centres will not accept NHBD organs for transplantation, as they are considered 'marginal' organs with suboptimal outcomes.
However, in the countries that have pioneered NHB donation, this has become a valuable and important source of transplantable organs, and outcomes in the long run have been favourable.

5. Paid Donation and Organ Commerce

Payment for organ donation is legally not allowed in any European country, and officially it is not practised. However the stagnant and insufficient supply of organs and the ever growing demand for transplants has rekindled the ethical debate over the use of financial incentives, for both living and cadaveric donation. Within the transplant community some ideas are put forward to reward living donors and start a regulated organ market. However, no government has as yet taken up this possibility. For the moment any buying and selling of organs remains illegal and punishable by law.

Organ Tourism and Trafficking

The UN Protocol on Human Trafficking (2000) defines trafficking as follows: 'Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by any means, for forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.' Under the Council of Europe Bioethics Convention (2001 – Additional Protocol): 'The human body and its parts must not give rise to financial gain', and 'Any trade in organs and tissues for financial gain is prohibited'. In 2004 the WHO Assem-



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The *PLoS Medicine* Debate

Is It Ethical for Patients with Renal Disease to Purchase Kidneys from the World's Poor?

Tarif Bakdash, Nancy Scheper-Hughes

This is one of a series of articles on social medicine in the October 2006 issue

grandparent's home. *The Tribune, India* reported that a 42-year-old Nepalese man named Man Dhoj Tamang sold one of his kidneys to pay off his debts and buy a piece of land [1].

Having trained and taught in North America for almost 14 years, my initial reaction to these reports was that such organ sales were immoral. I was aware that many medical societies and health-care organizations took the position that selling organs is unethical. For example, the Ethics Committee of the Transplantation Society advises transplant surgeons that: "No transplant surgeon/team shall be involved directly or indirectly in the buying or selling of organs/tissues or in any transplant activity aimed at commercial gain to himself/

Fig. 8: World wide exploitation of poor and vulnerable populations

bly accepted the following resolution: 'To provide support for Member States in their endeavours to prevent organ trafficking, drawing up guidelines to protect the poorest and most vulnerable groups from being victims of organ trafficking'. Also recently (2004), the European Union and European Parliament have launched measures to combat organ trafficking. However, the grim reality is that worldwide every year around 10.000 kidneys are transplanted that are harvested illegally from paid living donors: from the poor to the rich, from underdeveloped to rich countries, from black/coloured people to white people, and often from women to men. This has been called by some a form of 'Medical Apartheid' (see figure 8).

Organ Trafficking in Europe

Although until recently organ trafficking mainly occurred in countries such as India, Pakistan, the Philippines, China, Brazil, Mexico etc., today there is a flourishing organ trade also in Europe, making use of paid donors from a wide range of countries in Eastern Europe. There has been evidence of paid donation and trafficking in Estonia, Russia, Bulgaria, Romania, Moldova, Georgia, Belarus, Albania, Bosnia, Ukraine and Kosovo. The Council of Europe in 2003 has published the findings of investigative report that has located trafficking networks in these countries. Patients who are seeking these organs come mainly from Israel, the Gulf States, the USA but also from Western Europe. Transplants are illegally performed in countries such as Turkey and South Africa. A rough estimate is that every year 150-250 illegal donations/transplants take place. Donors are paid as little as €2200 and are often pressured into donating.

BMJ 2003;327:249 (2 August), doi:10.1136/bmj.327

News roundup

Kidney trafficking is "big business," says Council of Europe

Budapest Carl Kovac

The Council of Europe's parliamentary assembly has issued a report saying that, because of a rapidly increasing demand for kidney transplants, trafficking in kidneys has become a hugely profitable business for international organised crime—and for the doctors who perform the procedures.

Between 15% and 30% of European patients die while waiting for a kidney transplantation, owing to a chronic shortage of organs, the report says, noting that the average wait for a legal transplant is now three years and is expected to increase to 10 years by 2010.

Trafficking networks target poor European countries such as Estonia, Bulgaria, Turkey, Georgia, Russia, Romania, Moldova, and Ukraine, where people are pressured into selling their kidneys for as little as $2500 (£1550; €2200), the report said.

6. New Approaches to Organ Procurement and Allocation

Today, in Europe there is a mix of opting-in (explicit consent) and opting-out (presumed consent) systems for organ retrieval. It seems very difficult to bring any harmonization to this and there are no plans in this direction. However, since most countries are faced with a dire shortage of transplantable organs, some ideas are put forward to introduce new systems of organ retrieval: e.g. routine salvaging, societal appropriation, and use of financial incentives. Incentives could also be provided by introducing other mechanisms of allocating organs, e.g. by a system based on reciprocity where those willing to donate get bonus points for receiving an organ themselves.

Other incentives are to better involve minority groups and promote organ donation among them, since these groups often have low donation rates but a high prevalence of organ failure, e.g. education programs for Hindu and Islamic communities in UK and The Netherlands. Finally, there is an increasing role for the internet to explore and achieve donor-recipient matching for the benefit of individual patients. However, this raises also concerns and ethical debate since it may lead to undue solicitation, illegal payment and inequity in the allocation of organs.

Transplant Tourism and Organ Trafficking, an American Perspective

Francis L. Delmonico

Harvard Medical School, Massachusetts General Hospital, Boston, USA

The extent of organ sales from living vendors has now become apparent to the international transplant community. Despite the growing market for body parts and products, there remains a strong societal taboo not only against buying solid organs from living people but also against buying and selling dead bodies or certain parts of dead bodies, including solid organs. These reasons hold even though a few analysts argue that it would be cost effective to pay individuals as much as $90,000 to provide a kidney for transplantation. This article argues against such a regulated market for organ sales. Instead, The Transplantation Society in partnership with the International Society of Nephrology now seeks to convene an international conference that would derive a consensus of practice that employs acceptable incentives for organ donation and yet sustains the dignity of the human person. These incentives would prohibit cash payments but provide benefits that address donor needs and improve the quality of life of the living donor.

Introduction

The extent of organ sales from living vendors has now become apparent to the international transplant community. At the Second Global Consultation on Human Transplantation in Geneva in March 2007, Yosuke Shimazono (University of Oxford) estimated that 5-10% of the kidney transplants performed annually around the globe are currently related to transplant tourism. Patients with sufficient resources in need of organs regularly travel from one country to another to purchase a kidney (or liver) from a poor person. Today, "destination" countries such as Pakistan and the Philippines are now well known to permit the sale of organs to "tourist" recipients. These countries permit their poor to sell kidneys to the rich patients from the "client" countries of the West and Far East to attain the economical gains for hospitals, physicians, brokers and perhaps the lobby forces that enable the transactions. Insurance companies in United States, Canada and in the Middle East are now taking advantage of the cheaper costs associated with buying the organs with little regard to the unsafe, coercive and exploitative circumstances associated with these sales. The ill-fated donor or vendor is clearly being exploited with no other recourse to escape destitution than to sell a kidney within the society that has insufficient opportunities for employment.

Deceased versus Live Donation

Kidneys transplanted from living donors have become the most important source of organs in many resource-poor settings where the framework for developing an organized system of deceased donation remains to be established. For example, there is virtually no deceased organ transplantation in the under- developed countries of Africa and Asia. In African countries such as Mali and Nigeria, resources have not been available thus far to provide the extended end of life care in an intensive care unit necessary to make a determination of brain death possible or for the opportunity for donation after cardiac death to be realized. In other regions, particularly the Middle East, cultural objections to deceased donation influence the high prevalence of living kidney donation.
Given the increasing reliance on living donor or vendor as the international source of kidneys, the responsibility to accurately inform donors about the risks of donation and to provide safeguards against such risks is growing. Burdens assumed by living donors are also greater than previously acknowledged, with significant physical and financial implications. Thus, transplantation laws and regulation are now under discussion in a growing number of countries where both non-commercial and commercial living donation is prevalent (e.g. Pakistan, India, Egypt and Saudi-Arabia). A primary goal of these regulatory and legal efforts is to create a transparent environment that is safe and non-exploitative for the live kidney donor.

The Opposition to a Regulated Market for Organ Sales

The buying and selling of kidneys has become an ethical issue for transplant clinicians everywhere in the world. Even physicians who would have no part in the organ trade bear the unwanted responsibility for the medical care of those recipients who return to their home countries having undergone organ transplantation from an unknown vendor. These recipients arrive at physician offices for example in Toronto and Trinidad with inadequate reports of operative events and unknown risks of donor transmitted infection (such as hepatitis or tuberculosis) or a donor transmitted malignancy. Vendor sales impact the outcome of the kidney transplants resulting in increased graft loss when compared to transplants from altruistic donors.
Statutes have been crafted in most developed countries to emphasize a societal prohibition to organ sales. The European Union has condemned the practice. In the United States, Section 301 of the 1984 National Organ Transplant Act (NOTA) proclaimed that: „it shall be unlawful for any person to knowingly acquire, receive or otherwise transfer any human organ for valuable consideration for use in human transplantation" „Valuable consideration" is considered a monetary transfer or a transfer of valuable property among vendor, recipient, and/or organ broker in a sale transaction.
Recently, the Institute of Medicine published a consequential position paper with the following testimony: "Every society draws lines separating things treated as commodities from things that should not be treated as things "for sale". Despite the growing market for body parts and products, there remains a strong societal taboo not only against buying solid organs from living people but also against buying and selling dead bodies or certain parts of dead bodies, including solid organs. These reasons hold even though a few analysts argue that it would be cost effective to pay individuals as much as $90,000 to provide a kidney for

transplantation and even propose changes in the laws to permit such a payment in a regulated market. These proposals have yet to gain traction in the United States because they are incompatible with the fundamental values and norms that govern transplantation and because international markets in organs from living individuals appear to involve the exploitation of relatively impoverished people.

The 1991 Resolution of the World Health Organization on organ transplantation included a guiding principle that: "the human body and its parts cannot be the subject of commercial transactions". More recently, a 2004 WHO resolution called for the international transplant community "to take measures to protect the poorest and vulnerable groups from "transplant tourism", and to bring "attention to the wider problem of international trafficking in human tissues and organs".

If a market were established in a developed country, presumably the price would be set in the development of a "regulated" market. However, the intent to price fix would create an international competition for individuals to preferentially buy or sell in that country. For the recipient, the cheapest price might be to buy a kidney in the Middle East such as in Pakistan or in the Philippines. For the vendor, the best price to sell might be in the US where an estimate has been given at $90,000. This means that donors and recipients might travel about the world to get the best price; but then who would be responsible for their care?

Second, the proponents of a "regulated" market claim that the price could be fixed (in that country). But when one is dealing in markets, what market principle demands a fixed price? If one is dealing with the commodity of a human organ, would the price not be adjusted by gender or ethnicity or the age of the vendor/donor? Does the kidney from a 25 year old male vendor (with blue eyes) bring the best price? Under the table payments are a natural evolution of market forces that have brokers and agents.

What Solutions can be Developed in the Future

The most formidable challenge for the international transplant community is to address the ongoing shortage and source of donor organs. A respect for the dignity of the human person should be a universal principle in living and deceased organ transplantation. However, approaches to living organ donation that can fulfil that principle vary considerably throughout the world. The psychosocial evaluation of the live donor must be carefully addressed. With living-related donation the hazard is coercion; with living-unrelated donation the hazard is to make an inadequate assessment of motivation.

The Transplantation Society in partnership with the International Society of Nephrology now seeks to convene an international conference that would derive a consensus of practice that employs acceptable incentives for organ donation and yet sustains the dignity of the human person. These incentives would prohibit cash payments but provide benefits that address donor needs and improve the quality of life of the living donor. The implementation of these incentives could include post donation care, with insurance plans to accommodate the risk of death and operative complications that necessitate hospitalization after live organ donation. We seek to develop a model program that can fulfil the guiding principles established by the World Health Organization to provide care, assure donor safety, and sustain a respect for the human living donor.

Organ Transplantation: A Developing Country Perspective

Leonardo D. de Castro

Dept. Philosophy, University of the Philippines, Quezon City, Philippines

The objective of this paper is to develop a minimal framework for dealing with transplant tourism. The framework has three components: transcending the payment versus non-payment debate, focusing on the protection of donors, and emphasizing the need for greater responsibility on the part of the countries of origin of organ transplant recipients. From the part of the donors, there seems to be evidence that there is a difference between being a plain vendor and being a donor who receives recognition from society for his contribution. The acceptance of the difference presents an opportunity to transform purely commercial transactions into reciprocal arrangements recognizing the autonomy and dignity of all individuals concerned.

This presentation revolves around stories concerning individuals whose experiences are repeated over and over in the Philippine context and, to my knowledge, in other developing countries in Asia. In the end, the objective is to develop a minimal framework for dealing with transplant tourism. The framework has three components: transcending the payment versus non-payment debate, focusing on the protection of donors, and emphasizing the need for greater responsibility on the part of the countries of origin of organ transplant recipients.

The experiences referred to in these stories are real, and so are the characters. The stories have the following titles: "The returning specialist," "The poor altruist and other donors," and "The man who wouldn't be called 'vendor.'" These stories will be used to illustrate some of the major ethical issues that arise in connection with organ transplantation in developing countries.

Since this is a presentation on a developing country perspective on organ transplantation, the expectation must be that this will deal with organ selling and trafficking. Indeed, the presentation will deal with ethical issues within a context characterized by organ selling and trafficking. However, the first story focuses on other things that relate more broadly to health care policy and the training of health care professionals, as well as the impact of these factors on organ transplant practices.

The Returning Specialist

"The Returning Specialist" is the story of Dr. A, who went to the US for residency training after earning his medical degree in the Philippines. He took the path to specialization that has been taken by the large majority of the graduates of his medical school for decades. After a few years, he returned to his native country as a renal transplant surgeon.

By returning to the Philippines, Dr. A broke away from more than half of his class who chose to remain in the United States to develop their medical careers and earn good pay. Thus, he resisted the leakage of health professionals to other countries that has plagued health service in a number of developing countries.

Dr. A went back to his university to serve in its faculty but he realized very soon that he had to struggle to find ample opportunity to practice his craft. He personally had the expertise that could be used to provide an important medical service to his people but there was no existing organ transplantation program. He had to beg government officials to put money into building one. He had to lobby very hard so that the necessary facilities could be acquired.

When the facilities finally became available, Dr. A and his medical colleagues had to contend with another problem – finding organ donors. The medical procedure was still new, and few people had heard of organ transplants. No one wanted to be an organ donor. The search for a solution led Dr. A to the Bureau of Prisons to try to convince the Director of the Institution to find prisoners to donate kidneys. Using television sets as incentives, the Prisons Director did not have a very hard time getting "volunteers." Dr. A's Organ Transplant Program was off to a commercial start. The donors were materially compensated and some of them were victims of deception – they donated under the impression that they could be pardoned or their sentences could be commuted.

In the meantime, legitimate ways of soliciting organ donations had to be encouraged. The Organ Transplant Act was passed, defining brain death and allowing the head of a hospital to authorize the harvesting of organs from a brain dead patient whose relatives could not be located. An accident that led to the brain death of a pedestrian provided the first opportunity to exploit the provisions of the new law.

Since the accident victim carried no useful identification on his body, police authorities were unable to trace his relatives. Satisfied that the provisions of the law were met, the head of the transplant center authorized the removal of the accident victim's organs for transplant. Two of his organs were transplanted to a single patient. That happened to be the first success at double organ transplantation at the center so they proudly proclaimed their accomplishment in the newspapers. But what called the public's attention to their success also called attention to what the relatives were to claim as a "transplant murder."

What ensued was a long and heated court case that proved to be traumatic for the doctors involved, as well as for the transplant program of the country. The newspapers bannered headlines of "doctors killing for organs." Prospective donors became wary of getting involved and, for a while, organ transplantation stood still.

Lessons from the Story of Dr. A

Some of the lessons that could be learned from the story of Dr. A are quite clear. One lesson is that we cannot have a narrow view of medical training that leaves out the ethical, legal and social issues that arise in medical practice and research. The transfer of technology

often occurs in a context that does not necessarily carry with it the ethical, legal and social framework in the source country. Such a framework has to be the product of deliberation and socio-cultural evolution. Just like a human organ, it requires immunosuppression when transplanted. Otherwise, it is almost certain to invite rejection.
A related lesson is the importance of cultural and social suitability and sensibility of medical practice. While the aims of medical practice are noble and either life-saving or life-enhancing, these aims cannot be pursued with arrogance and a disregard for the rights and interests of others, no matter how trivial those rights and interests might be when compared to medicine's aims.
The third lesson I want to mention has to do with the medical brain drain. Given the developments in the countries concerned, medical brain drain is something that relates also, in a profound way, to organ trafficking. The two phenomena are similar at least in that they both involve the movement of resources across national boundaries. In both cases also, the movement is from developing countries to developed countries. And in both cases, the extent of the movement of resources has come to such a large degree that, in order to even attempt solutions, we have to view developments from a global perspective. Moreover, considering that the developed countries almost inevitably end up with the greater benefits from the movements, they must be seen to have a greater social responsibility in ensuring that there is justice and equity in the ongoing practices.

The Poor Altruist

The next story concerns a poor altruist – an organ donor who earns the equivalent of 2 euros a day. He does not actually earn that much on a regular basis. As a construction worker, he could not find someone who needs his services regularly.
The poor altruist donated a kidney to a well-off community leader who has done good things for their neighborhood. When he did so, he was not expecting payment or reward. Indeed, after the transplant, he was not paid or rewarded. His family continues to subsist on 2 euros a day. They rarely have enough to eat, and occasionally they have nothing to eat at all.
No one in the family has medical insurance. They have to go to a government hospital for emergency health care. There, they have to wait for hours – sometimes, even days – and the facilities and health care staff are not enough. On those occasions when they are prescribed antibiotics, they can only manage to buy the pills (if at all) for a day or two.
Was the poor altruist in this story exploited when he donated a kidney to someone who was economically well off? We might require some discussion concerning the meaning of exploitation before we could agree on an answer. But we will probably accept the view that there is at least some unfairness in the poor altruist's inability to obtain proper medical services, much less obtain a kidney transplant if he were to need it himself.

The Poorly Paid Donor

Like the poor altruist, the poorly paid donor earns 2 euros a day, but not on a regular basis. He cannot find regular employment. He donated a kidney to someone he did not know, expecting to get paid as promised by an illegal agent. After the transplant, he was paid enough money to buy a television set, a DVD player and good food for a few weeks.