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Organ donation in the Philippines: should the dead do more?

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Abstract

This paper asks whether the Philippines should focus on ways of dealing with end-stage renal disease by getting more transplantable kidneys from the dead. Would it be more ethical to put the burden to donate on the dead (who have already lost their chance to consent) than on the living (who can consent)? Given the risks involved in undergoing nephrectomy and the lack of benefits arising from the procedure to donors, the dead should be the first to put their kidneys on the line. In the Philippines, unfortunately, living donors have had to bear the greater burden in this regard. Starting with a brief account of developments surrounding the impact of the Declaration of Istanbul on the situation in the Philippines as well as in other countries, the paper examines what the living have been expected to do, what they have actually done, and what lessons the experience with living donors offers for the understanding of cadaver transplants. The paper then looks at possible ways of increasing the sources of kidneys for transplantation and asks if these ways could be implemented successfully and ethically in the Philippines.

Introduction

Organ transplantation is a medical intervention whose success for a patient is primarily dependent on what another person, living or dead, and who is not part of the medical team, can contribute. A number of organs can be transplanted but for the purposes of this paper, the focus is on kidneys – for transplantation in the context of the Philippines. This paper asks whether the dead should do more. Should the Philippines

focus on ways of dealing with end-stage renal disease by getting more transplantable kidneys from the dead? Would it be more ethical to put the burden to donate on the dead (who have already lost their chance to consent) than on the living (who can consent)? Given the risks involved in undergoing nephrectomy and the lack of benefits arising from the procedure to donors, the dead should be the first to put their kidneys on the line. Unfortunately, that does not seem to be the way things have happened in the Philippines. For a long time, living donors have put their kidneys – and health and safety – on the line for renal patients.

By way of a background, this paper starts with a brief account of developments surrounding the impact of the Declaration of Istanbul (DoI) on the situation in the Philippines as well as in other countries. It is pertinent to ask what the living have been expected to do, what they have actually done, and what lessons the experience with living donors offers for the understanding of cadaver transplants. The paper then proceeds to examine the situation as regards dead organ donation by looking at possible ways of increasing the sources of kidneys for transplantation. We ask if these ways could be implemented successfully and ethically in the Philippines.

Impact of the DoI

As a guidance document, the DoI on Organ Trafficking and Transplant Tourism has had a remarkable impact on the improvement of ethical organ transplantation throughout

the world. Issued in 2008, the Declaration was adopted by the participants in the International Summit on Transplant Tourism and Organ Trafficking Convened by the Transplantation Society and the International Society of Nephrology in Istanbul, Turkey. Many medical societies and national government agencies have supported the implementation of the DoI since the time of its adoption.

Self-sufficiency is one of the principles that lie at the core of the DoI (1). This principle encourages countries to try to meet the needs of patients requiring transplantable organs internally and thereby limit, if not totally eliminate, cross-border transplantation and transplant tourism. Other than simplifying the task of monitoring activities for national authorities, adherence to the principle of self-sufficiency also provides motivation to try to improve deceased donation rates, especially where the latter may be difficult to undertake because of a perception of incompatibility with local religious beliefs. Self-sufficiency is supposed to guide the Declaration of Istanbul Custodian Group (DICG) as it works in partnership with other concerned institutions to implement strategies intended to fight exploitation and ensure that the practice of organ transplantation leaves behind a legacy of celebrating a gift of health by one individual to another rather than a trail of impoverished victims of organ trafficking and transplant tourism (2).

After five years, the DoI appears to have achieved a lot in reducing organ trafficking and transplant tourism across national boundaries. International consensus against these practices has grown, which is reflected in governmental policies and responsive legislation in many countries. For example, the implementation of regulations prohibiting living donor transplants from Filipinos to non-Filipinos has resulted in a drastic reduction of transplant tourism to the Philippines (3,4). Writing about progress made in various countries after the launch of the DoI, Danovitch and Al-Mousawi (2) have cited laws and regulations meant to curb organ trafficking in the Philippines, Colombia, Pakistan, India, Egypt, and Russia. In Israel, a new law on organ transplantation prohibits health insurance companies from reimbursing the medical expenses of patients who travel abroad to receive transplants, criminalises organ transplant brokering, and provides for full reimbursement of legitimate expenses associated with organ donation (5). Since the law was passed, the number of Israeli patients who travel abroad to purchase organs has dropped and living donation within the country has increased (6,7).

Singapore has enacted a Human Organ Transplant Act (2012) (8) explicitly prohibiting payment for living donation. It has also set strict guidelines for reimbursement of legitimate expenses. In Qatar, the 2009 Doha Donation Accord has been touted to be an innovative model of a framework to promote living and deceased donation in a developed country with a large expatriate population (9). Japan passed legislation in 2009 with provisions that could deal with its transplant waiting list without having to depend on external resources (10–12).

In order to discourage Malaysians from going abroad for transplants, the Malaysian Health Minister expressed support

for the WHO Guiding Principles (13) and announced new legislation mandating the government to stop providing free immunosuppressant medications to patients who have commercial transplants performed abroad. The new law took effect in January 2012. It was meant to curb transplant tourism from Malaysia to China to take advantage of Chinese “donors.” More than 60% of the 1500 kidney transplants to Malaysians were performed in China from 2000 to 2010 (14). On the whole then, the promulgation of the DoI and the approval of the WHO Guiding Principles were followed by developments indicating progress in the global campaign against organ trafficking and transplant tourism.

The situation in the Philippines

Developments in the Philippines have followed the global trend to a significant extent. There has been an effort to contextualise transplant tourism and organ trafficking within the broader practice of human trafficking. Issued in 2009, Section 53 of “The Rules and Regulations Implementing the Anti-Trafficking in Persons Act of 2003” (15) expressly states that it is an act of trafficking in persons punishable by imprisonment of 20 years and a fine ranging from one million pesos (approx. US\$ 22,222.00) to two million pesos (US\$ 44,000.00) “to recruit, hire, adopt, transport, or abduct a person”, by means of threat or use of force, fraud, deceit, violence, coercion, or intimidation for the purpose of removal or sale of organs of said person. Thus, IRR9208 provided teeth to the prohibition contained in Administrative Order 2008-0004-A (AO 2008-0004-A) (16) by the Secretary of Health unequivocally declaring that “foreigners are not eligible to receive organs from Filipino living non-related donors.”

A total of 1046 kidney transplants in 2007 were listed in the Philippine Renal Registry, 2009 (17), compared to 690 in 2006. The magnitude of the year on year increase indicates how fast the market in organs was growing during that period. Many patients were desperate enough to buy and many unemployed individuals were desperate enough to sell. Many hospitals and doctors were happy to play along as they also made a lot of money from the commercial transactions. More than 50% of the recipients in 2007 were foreigners and more than 80% of the donors were not related to the recipients (18). From 2002 to 2007, the number of living non-related donations increased from 157 to 844 whereas the number of donations from living relatives increased only slightly from 138 to 173. Cadaveric donations increased only from 10 to 29.

Transplants to foreigners during the same period increased from 40 to 528, whereas the number of transplants to Filipinos increased only from 256 to 510. Of the 510 Filipino patients who received transplants in 2007, 170 got their kidneys from living related donors, 27 from deceased donors and 313 from living non-related donors. A study of 131 kidney vendors between 1999 and 2007 found that “85.2%–93.2% of vendors were unrelated in any way to the recipients....[and that] between 56.3% and 64.3% of the surveyed vendors indicated that their kidney buyers were of foreign descent” (19). It was

obvious that the country had become a transplant tourism destination and foreign patients were coming to the country to be matched with living non-related donors. Up to that point, the burden of organ donation was clearly on the living and on those who were not even related by blood to those who needed transplantable organs.

Now that the government's ban has been implemented, transplants to foreigners have almost ground to a halt. Living unrelated transplants to foreigners fell to 3 in 2009, 2 in 2010 and 2 in 2011 (17,20,21). During the same period, kidney transplants to Filipino recipients decreased in number to 381 while the number of transplants from unrelated donors showed a decline from 313 to 147. It is worth noting that transplants from deceased donors rose only from 27 to 88 (21).

The numbers indicate that the burden of undertaking risks in organ donation lay more with non-relatives than with relatives. Unfortunately, this observation could not be explained in terms of a growth of altruistic fervour among possible organ donors.

Deceased organ donation

The DoI emphasises the need to make up for a decrease in the number of organs available for transplants arising from a global effort to curb organ trafficking and transplant tourism by promoting deceased donor transplantation. In this regard, the DoI notes: "educational programs are useful in addressing the barriers, misconceptions, and mistrust that currently impede the development of sufficient deceased donor transplantation . . ." (1). It is useful, then, to examine some of the measures that have been under consideration to broaden the pool of deceased donor organs for transplant.

Bypass bereaved family consent for deceased organ donation

There are those who maintain the view that the living have a right to the organs of the dead. According to one argument, "it is immoral to require consent for cadaver organ donation [and that] no one has the right to say what should be done to their body after death" (22). Another argument says that "the benefits from cadaver transplants are so great, and the harms done in going against the wishes of those who object so comparatively small, that we should remove altogether the habit of seeking the consent of either the deceased or relatives [and therefore] provide for the automatic or mandatory availability of donor organs" (23). If these arguments were to be accepted, it would seem that the responsibility of authorities would be focused on finding the best way to collect transplantable organs, allocating them according to the fairest criteria, and transporting them as expeditiously as possible to be transplanted to matching recipients.

It is not this paper's intention to take up the rational merits (or demerits) of the arguments for bypassing consent totally. However, it is useful to consider the possible impact of measures that may be based on these arguments. Experience in various countries has shown that it can be counterproductive to try to procure organs from the dead without consent from relatives. There is no reason to suppose that experience in the Philippines will be any different. On the contrary, there is even

greater reason to believe that resistance from families will be greater. In the country, families – rather than individuals – see themselves as the basic social units for making decisions (or for giving consent) relating to emergency healthcare matters. Organ donation comes under the category of emergencies. Organ procurement that bypasses family consent is likely to create enough controversy to guarantee its failure.

Opting out systems

An opting out or presumed consent system can be expected to encounter the same ethical issues that have been brought up in connection with a scheme that bypasses consent, whether by the family or by the deceased. The impact of opting out policies on donation in various countries has been variable. While the system has been associated with an increase in deceased donation rates (24), one cannot be sure that the improvement could be explained adequately by the presumption of consent since there are usually other important factors to consider (25,26). In addition, there are reasons to believe that opting out works only if there is an effective way of seeking family consent and there is a reliable and efficient organ registry (27).

One could also wonder why a country like the USA, albeit without an opting out system in place, is doing better than countries with presumed consent. Even if an opting out policy were in place, there are factors that prevent its implementation from resulting in the recovery of more transplantable organs; if it were not in place, there are other processes or social and cultural factors that can be harnessed to yield higher organ recovery rates. To focus on the opting out or the opting in character of the consent system would not be very useful.

Perhaps the most important reason for opposing an opting out system in a developing country like the Philippines is that relevant government institutions are not always efficient in communicating important information to the public. Comprehensive and reliable systems of communication are not in place. It would not be reasonable to presume that people who do not opt out of the organ donation system, even after the conduct of an information campaign, have had a chance to reflect freely and intelligently on the possible significance and consequences of not opting out. An information campaign addressed broadly to certain groups or sectors cannot be sufficient. One can only be confident that essential information has been conveyed and properly understood if such information is conveyed directly to specific individuals. Done in this way, conveyance and understanding of information can be verified. When communication is directed to the public in general, it would not inspire confidence that the message has been adequately understood.

For example, it would be possible to use verifiable criteria that an aggressive campaign to seek the consent of relatives who have custody of the newly deceased has been successful. The focus on specific individuals makes individual confirmation of degree of understanding and freedom of decision-making possible. This approach to potential sources of transplantable organs should be taken up more seriously in the Philippines, not as a part of an opting out policy but as an independent measure regardless of the context of donor enlistment. In

this regard, one should see the importance of an efficient and comprehensive system of donor registration. Such a system is badly needed for the purpose of implementing a serious programme that could have reasonable prospects of success.

Donor registration

In June 2002, Administrative Order No. 124 (28) issued by the Secretary of Health of the Philippines provided for the creation of a Donors/Recipients Registry Unit that was to be responsible for preparing a list of all living non-related donors (LNRDs) and lists of all patients seeking kidney transplantation using LNRDs. The registry unit was to be responsible also for developing a mechanism for comprehensive psychosocial and economic profiling of the prospective donors and for facilitating transplantation, organ exchange, as well as information/technical exchange. It was clear that the focus of that administrative order and the registry unit was on living donors. One can now say in hindsight that the accent on living donors had the effect of crowding out deceased organ donation. As pointed out above, the number of cadaveric donations ranged only from 10 to 29 between 2002 and 2007. In 2011, the number of cadaveric donations rose to 88. One can only hope at this point that a determined effort to increase cadaveric donations would reverse the trend in relation to living organ donation.

In 2010, another administrative order was issued by another Secretary of Health creating, among other agencies, the Philippine Network for Organ Sharing (29). Officially established on 10 June 2010, the Network was mandated to implement policies on deceased donor allocation, act as the central coordinating body to ensure that all donor organs from deceased donors are allocated according to established criteria, and to maintain national registries of kidney transplants performed, of living related and non-related donors, and of all patients seeking kidney transplantation. The mandate for the Network represents an improvement on the mandate for the Registry Unit created in 2002 in that the newer network clearly encompasses deceased organ donation. One has to be clear about the specific steps that need to be taken in order to ensure that the initiative translates into more actual transplants as it moves forward.

One of the problems that need to be overcome has to do with the crowding out effect of living non-related organ donations on deceased organ donation. The situation has hardly improved since then. Whereas transplants from Filipinos to unrelated foreigners have been stopped, transplants between unrelated Filipinos abound. We still read many accounts of misrepresentation, monetary compensation, coercion, and illegal detention pertaining to transplants from unrelated living donors (19,30–32).

Efforts at donor registration in the Philippines have had to deal with bureaucratic hurdles. One example relates to competition among hospitals with transplant facilities. Transplant facilities appear to have pursued donor recruitment on their own, thus posing a barrier to an expanded and dynamic system of sharing that could improve the chances of finding the best matches

among donors and recipients. In addition, there is the matter of harmonising the tasks and involvement of foundations that have given financial and other types of support for the transplantation of organs from resource-challenged donors. Institutions organised for a noble and charitable purpose could occasionally engage in rivalry and thereby jeopardise the very purpose for which they have been established. More effort should perhaps be invested in streamlining procedures across institutions and people responsible for perpetrating bureaucratic obstacles to urgent beneficent initiatives should be made to realise the ethical (or unethical) impact of their action or inaction.

Against this backdrop, it is heartening to note that PHILNOS has been very active in donor registry recruitment. For example, a recent activity has been touted as a potential entry for the Guinness Book of World Records for “Most people to sign up as organ donors for one hour single site” (1). The event took place on 28 February 2014, when 3548 registrations were reported at the Polytechnic University of the Philippines in Manila and 2981 registrations were reported in La Union, a province north of Manila, thus beating the previous record of 2755 for one-hour single-site registrations at a similar event in Gujarat in India on 17 September 2013.

However, a hefty increase in donor registrations does not necessarily translate into a corresponding increase in the number of deceased donor transplantations. In the USA, a “proliferation of donor registries ... since 2006, ... [has seen] the total number of registrants increasing from approximately 60 million to 100 million people.” Moreover, “in all 50 states, an individual’s designation as a registered donor is now honored with no further requirement for family authorization.” Unfortunately, “... there has been a disconcerting lack of growth in the number of deceased donor organ transplantations taking place” (33).

This point should not be lost on those responsible for improving donor registration in the Philippines. The increase in registration has to be complemented by an improvement in the attitudes of family members. The attitude needs to be characterised by an enlightened understanding of the significance of donor registration and a willingness to support the declared intent of the registrant after her death. When authorities try to bypass family members altogether on the grounds that there is no legal requirement to seek family authorisation, they run the risk of generating controversies that create distrust on the part of the public for the institution of organ transplantation in general. One reason why this kind of policy generates controversy is that a legal authorisation does not necessarily convey a privilege that the bereaved recognise as ethical.

Donors with infections

The use of transplantable organs from people with documented infections can also add to the donor pool. This should be seriously taken into account as people infected with human immunodeficiency virus (HIV) have been shown to have

acceptable long-term outcomes from transplants (34–37). In the Philippines, the impact could be significant considering that the number of HIV-infected persons has been reported to be rising at a “fast and furious” rate (38) with UNICEF recording a 79% increase in newly reported HIV cases, compared to the same period in 2012. Moreover, 1 out of 3 new infections are found among the 15–24-year-old population (39), suggesting that prospective transplant recipients could have a lot more benefit from the procedure, should it become necessary. This can be supported by findings of initial success in transplanting kidneys from HIV-positive donors to HIV-infected recipients. Reporting about their experience, Muller and Mendelson observed: “12 months after transplantation, all patients had good renal function, did not have clinically significant graft rejection, and have not needed dialysis since the procedure” (40)

Apart from ethical concerns about the safety of recipients of organs from donors with known infections, controversies may arise regarding the eligibility of transplant beneficiaries with similarly dangerous infections. In transplanting organs from donors with infections to recipients with infections, it may be argued that the latter will provide unfair competition to those without similar infections, all other things being equal. Medically, they will not have equal chances of survival after transplant as possible recipients who do not have such infections.

A possible response might invoke solidarity – one HIV patient acting in solidarity with another, although the donor would have been dead at the time of transplant as the reference is to deceased donors. As HIV patients share concerns, they can also share transplant organs (posthumously for one of the parties). One could speak of the identification with others of the same kind that draws them together to depend on one another for their specific needs or to help to provide for those needs. Even as current policies actually discourage transplants between infected and non-infected patients, it would be useful to keep an open mind about the possible involvement of HIV-infected persons either as eligible transplant recipients or as posthumous sources of transplant organs.

Financial assistance for donors

The use of financial incentives to make more organs available for transplant has always aroused controversy. Are there significant ethical differences between financial incentives for living organ donation and those for dead organ donation? Would financial incentives be ethically different from financial assistance of some other kind? The Nuffield Council (41) appears to have thought there are significant differences among these that could be relevant in considering some forms of intervention that may not necessarily be incompatible with an approach to donation that rests on altruism:

We distinguish between altruist-focused interventions (that act to remove disincentives from, or provide a spur to, those already inclined to donate); and non-altruist-focused interventions (where the reward offered to the potential donor is intended alone to be sufficient to prompt action)... (41:p 5)

The reimbursement of funeral expenses.....is ethically difficult. If offered directly to bereaved families who would otherwise refuse permission, it would very clearly constitute a ‘non-altruist-focused intervention’. While there would be no risk of the donor suffering physical harm, it might be argued that any decision by their family to consent to donation solely for financial reasons would constitute a very clear example of that person’s body being used as a means for others’ ends and not as end in itself.

The situation would seem rather different if the payment of funeral expenses was triggered by the future donor signing up to the ODR (Organ Donor Registry), rather than being offered to the bereaved relatives at the time of death. To the extent that our Intervention Ladder is appropriate in such a family-based scenario, the intervention might constitute ‘rung 4’: acting as a final spur for a person already inclined to donate, with the added altruistic feature that others, and not the donor themselves, would benefit. Alternatively, the incentive might seem sufficiently strong for someone to decide to register as a donor simply to spare their relatives the financial burden of a funeral. However, in such a case, the decision would still include an altruistic component, with the aim to benefit others (the donor’s relatives)... (41:p 174-5).

The Intervention ladder consists of six rungs, the fifth and sixth of which are regarded as not being acceptable because they serve as incentives that encourage those who would not otherwise donate or that leave the donor in a better financial position as a result of donating.

Is it ethically relevant that whereas in the case of living donation the person who could be incentivised to donate is the person whose organ is proposed for transplant, in the case of dead organ donation it is the bereaved family that could be incentivised to make a donation out of a relative’s organ(s)? Ethical issues arising from cases of the first type are not necessarily applicable to cases of the second type. This point has implications for the way we interpret some of the rungs in the Nuffield Council’s Intervention Ladder, especially when we have to come to grips with practical realities characterising the context in which financial assistance is sought by or given to bereaved relatives of prospective organ sources.

By looking at practical realities, one can highlight not only (i) the fact that in many developing countries many families are unable to provide, on their own, for a dignified or decent burial or to pay for the cost of hospitalisation that may have come unexpectedly before the death of the relative, but also (ii) the narrow temporal window of opportunity for transplant coordinators to communicate with the bereaved about organ donation.

In many cases in the Philippines, the stress and confusion associated with failure to provide a decent burial or to pay hospital bills become disincentives for organ donation. As transplant coordinators tell us, these are even disincentives for a mere conversation about organ donation. It would be almost

foolish to start a conversation in the Philippines with the family of the deceased about the possibility of organ retrieval for the purpose of transplantation when that family has to deal with issues about hospital and funeral expenses.

Removing disincentives versus providing incentives: a tough call when there is a narrow window of opportunity to strike a conversation with the bereaved.

Would it make a difference that an offer of assistance constitutes the removal of a disincentive rather than the provision of an incentive? Would it make an ethically significant difference if material assistance were offered or provided by a party different from that which is responsible for exploring the possibility of organ donation? It is not easy to provide answers without looking at the details of actual circumstances.

And what if a transplant coordinator waits until an agent for a charitable organisation has had a chance to inform the bereaved about the assistance they are willing to provide before quickly introducing a conversation about organ donation? Seizing the opportunity in this way makes sense because there is a very narrow window of opportunity to engage in a conversation exploring the possibility of organ donation with the bereaved relatives between the time of the declaration of death and the retrieval of a transplantable organ.

One can imagine a transplant coordinator having a database of charitable organisations and local politicians who are willing to provide material assistance to people in this kind of situation and offers information to the bereaved before initiating talk about the possibility of an organ donation. It would not be correct to say that she is providing compensation for a transplantable organ but would she be exploiting financial assistance provided by another party in an unacceptable manner? Could she not be regarded as attempting to overcome a disincentive?

In these situations, the notion of compensation or bribe may not come into the picture at all. An urgent need for material assistance arises independently of the possibility of organ donation. Because of the narrow time frame, and because there are different parties talking to the bereaved, things can easily get mixed up.

There are many informal mechanisms for providing material assistance to the bereaved that are in place, regardless of the possibility of organ donation. For many who are poor, the absence of material assistance for a decent burial or for settling hospital expenses pose obstacles and disincentives to organ donation for the simple reason that bereaved relatives would be too worried about these things to have clarity of mind to even consider the possibility of donating the dead's organs. Preoccupation with these material concerns is something that needs to be overcome if conversation about the possibility of an organ donation is to be introduced at all. Many opportunities for altruistic organ donation could be lost if there is not enough readiness for these types of situations.

When obstacles exist in the kind of situation described, the matter of donating or not donating has not yet come into

the picture – one could not correctly speak of a disinclination that could be overturned by an action meant for the purpose of “offering associated benefits in kind to encourage those who would not otherwise have contemplated donating to consider doing so,” placing it on the “non-altruist focused” fifth rung of the Nuffield Intervention Ladder. There may not be an inclination because the matter has not been brought to the bereaved relatives’ attention but to say outright that there is a disinclination (not the same as not having an inclination) is to underestimate the capacity of the poor (or poor relatives) for altruism.

While occasions such as these could provide opportunities for the exploitation of the vulnerabilities of the poor, these could also be excellent opportunities for the poor to be able to exhibit positive virtues, including altruistic organ giving. The latter should not be ruled out altogether because of a general desire to protect those who may be abused. Rather than an absolute prohibition, what is perhaps more appropriate is a calibrated response that would give transplant coordinators confidence to speak to bereaved families without fear that they could be stepping into a situation without showing sensitivity to the families’ concerns, or that they could be seen as taking advantage of the vulnerabilities of the poor. Specific protocols for dealing with these circumstances can be formulated, and should be observed. In the context described, material assistance given to the bereaved is not to be construed necessarily as compensation. In resource-challenged settings, assistance of the kind is commonplace and a real necessity –something that the poor have come to expect already, in the absence of better alternatives to look forward to. They have to be carefully set up and monitored.

What has to be avoided is the association of this assistance (or offer of assistance) with organ donation. Obviously, the narrow temporal window for any conversations with the bereaved could present problems. When the motorcycle accident victim is declared brain dead, the funeral parlour representative could be waiting for the first opportunity to offer services, encouraged perhaps by a promise that cost is going to be covered by a predictable and reliable local politician known to their company. A good transplant coordinator also has to be on the scene, ready to grab the first opportunity to start a conversation. Understandably, it will be most prudent for the coordinator to wait until the relatives are assured that their burial and hospital costs are going to be covered. But the transplant coordinator cannot wait too long. As mentioned above, what can be recommended is the adoption of specific protocols to be observed in introducing conversations exploring the possibility of organ donation that clearly state that the organ donation is not a precondition for any material assistance (funeral or hospital costs) offered by anybody.

Conclusion

The analysis above indicates assistance that would be acceptable to the Nuffield Intervention Ladder. There would have to be clear protocols indicating what information needs to be given to relatives and when and how that information

is going to be provided. When all announcements are made in a timely manner and protocols are clearly defined and observed, the possibility of making an organ donation could be something for family members to discuss among themselves and prepare for. To be sure, there is a lack of specificity in the proposal at this point.

It should be added that transparency and fairness have to be observed at all stages. In the interest of transparency, pertinent information about the policy has to be disseminated in advance and not be limited only to those who are facing bereavement already. In addition, the approach has to be the same for all and not only for those who are economically challenged.

Something also needs to be said about the prevailing idea that organ transplants from living donors are medically better than transplants from dead donors. Some physicians have been known to tell their patients who are in need of transplants to wait until they can have living donors rather than go for cadaver organs. This attitude has encouraged dependence on living donors by renal patients and, to that extent, has resulted in the crowding out of dead donor transplants.

While it may be true for some specific kidney patients that it would be better for them to receive a transplant from a living donor than for a dead organ donor, it is misleading to declare in general that transplants from living donors are better than organ transplants from dead donors. To say the latter is to look at things purely from the perspective of the recipient. However, better or worse has to be seen from the perspective of the two parties involved and if we take into account the risks to the organ donor we can easily see why it is grossly erroneous to say that the use of transplant organs from living donors is always better than the use of transplant organs from dead donors.

It seems we have not taken the help that the dead can provide seriously enough and the living could be suffering because of that attitude. Now is as good a time to start as any, but we have to make sure that organ trafficking and the exploitation of living donors is not crowding out the opportunity to shift the burden of responsibility to the dead.

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Reaching self-sufficiency in deceased organ donation in Asia: harsh realities and ethical concerns

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Although trials to exchange failing human organs with new ones started in the beginning of the past century, the first breakthrough came in December 1954, when the first successful kidney transplant between identical twins was performed in Boston, USA, by Dr Joseph Murray. Since then transplantation has come a long way to be recognised as the treatment of choice for thousands of new patients afflicted yearly with organ failure around the world.

The World Health Organisation (WHO) estimates indicate that over a million transplants are required every year to satisfy the global need, but the actual number of transplants does not exceed one hundred thousands, ie only 10% of the need (1). There are many causes for this disparity including economic, social, and organisational factors but shortage of organs is the restricting factor in many parts of the world. Needless to say that in Asia this disparity is most obvious (1,2).

Sources for organs

Organs come from two sources: living and deceased human beings. Living donors are limited to donating either one of double organs (kidney) or part of a single organ such as the liver, whereas multiple organs and tissues can be recovered from a single deceased donor allowing multiple transplants from one source. In the developed world, both sources are

used to the maximum in order to decrease the gap between availability and demand for organs, leading to high rates of transplantation of various organs, especially in Europe and North America.

On the other hand, deceased donation is uncommon in Asia and the majority of transplants are limited to organs that can be obtained from living donors. This limitation has severely affected both number and type of transplants performed.

Consequences of organ shortage

The success of transplantation in saving lives and improving its quality has increased demand for organs and created an illegal and unregulated market in many parts of the world. WHO estimates that 10% of all kidney transplants in the world come from paid donors.

These practices are more common in regions with a shortage of deceased organ donors when living donors cannot satisfy the need. An abundance of poor and vulnerable people in many Asian countries, willing to sell their kidneys (3,4) in return for a few thousand dollars, created a wave of transplant tourism since the 1980s. A large number of patients, from well off countries, travel to countries such as India, Pakistan and the Philippines to buy kidneys from vendors and intermediaries. These organised