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COMMENTARY

Trade in kidneys is ethically intolerable

DOMINIQUE E MARTIN

Abstract

In India, as in most countries where trade in human organs is legally prohibited, policies governing transplantation from living donors are designed to identify and exclude prospective donors who have a commercial interest in donation. The effective implementation of such policies requires resources, training and motivation on the part of health professionals responsible for organ procurement and transplantation. If professionals are unconvinced by or unfamiliar with the ethical justification of the relevant laws and policies, they may fail to perform a robust evaluation of prospective donors and transplant candidates, and to act on suspicions or evidence of illicit activities. I comment here on a paper by Aggarwal and Adhikary (2016), in which the authors imply that tolerance of illicit commercialism in living kidney donation programmes is not unreasonable, given the insufficiency of kidneys available for transplantation. I argue that such tolerance is unethical not only because of the harmful consequences of kidney trafficking, but because professional tolerance of commercialism undermines public trust in organ procurement programmes and impairs the development of sustainable donation and transplant systems.

Introduction

The use of financial incentives to increase living kidney "donation" has been the subject of debate among ethicists and transplant professionals since the 1980s. The persisting problem of insufficient supply of human kidneys for transplantation in many countries is repeatedly cited as a rationale for the introduction of legal markets in kidneys (1). Illicit trade in kidneys also remains a widespread problem, and some commentators have argued that the introduction of regulated markets – sometimes described as "incentive programmes" – would reduce such trafficking and prevent the harms associated with the black market (eg. 2). Aggarwal and Adhikary draw attention to this complex issue in the context of India, presenting an ambivalent position on the incentive debate (3). In this commentary, I clarify some of the points they raise and contend that a permissive approach to kidney trafficking is ethically unjustifiable. Specifically, I argue that Aggarwal and Adhikary underestimate the negative impact of kidney trafficking on organ sellers, transplant recipients, and the broader organ donation and transplantation system. I further argue that regulated incentive programmes are likely to replicate many harms associated with illicit kidney markets and suggest that a more robust approach to the prevention of kidney trafficking, together with greater investment in efforts to reduce the burden of end-stage renal disease (ESRD) and to facilitate and encourage living and deceased donation, will ultimately improve equitable access to transplantation in India.

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To cite: Martin DE. Trade in kidneys is ethically intolerable. *Indian J Med Ethics*. 2016 Jul-Sep: 1(3) NS:180-3.

Published online on May 9, 2016.

The law governing transplantation in India

Aggarwal and Adhikary refer to the Transplantation of Human Organs Act (THOA), 1994, which was enacted in 1995 (4). It specifically prohibited payment for organs, and required review by an authorisation committee of all prospective living donors who are unrelated to the intended recipient, defined as all those not spouses, children, parents or siblings, but who wish to donate "by reason of affection or attachment towards the recipient or for any other special reasons"(4).[1]

This Act was notably amended in 2008 and 2011 (7), partially to address concerns that the process of the review of prospective unrelated donors was not effective in identifying and addressing cases in which paid "donors" were presented as altruistic unrelated donors. The amended Act now requires verification and countersigning of documents attesting to the identities of and relationships between prospective donors and recipients, and additional approvals for foreign nationals (7). The Act also lays down greater penalties for those convicted of illegal activities (7).

The impact of these recent amendments to the THOA may not be observed for some time. The successful implementation of new policies and guidelines requires motivation, training and a removal of barriers, which may include the negative attitudes of some health professionals. If the ambivalence of Aggarwal and Adhikary reflects that of the broader community of transplant professionals in India, it is conceivable that many may be reluctant to change their practice so as to comply, for example, with more stringent requirements for prospective donor evaluation. Fortunately, the reports of the scandals concerning domestic trafficking noted by Aggarwal and Adhikary suggest that authorities within India support the enforcement of this law. Anecdotally, recent reports of Indians travelling to Sri Lanka to buy and sell kidneys suggest that opportunities to sell within India may have been reduced (8). Nevertheless, trade in organs undoubtedly persists in India, and the support of all health professionals involved in donation and transplantation is essential for the success of efforts to eliminate this market and to ethically provide opportunities for transplantation within India.

Regardless of its legality, trade in kidneys is an unhelpful "solution" to shortages

Aggarwal and Adhikary suggest that it is unclear whether recipients of commercial transplants benefit and kidney sellers are harmed in the long term. However, evidence from the black market in kidneys in India, Pakistan and elsewhere, and from the legal, albeit poorly regulated market in Iran, shows that kidney sellers do suffer long-term harms (9). Although there are limited data concerning the long-term outcomes, the majority of kidney sellers studied experience a decrease in their economic, psychosocial and physical health status (9). Loss of employment opportunities, social stigmatisation, and ill health experienced following the sale of a kidney are likely to exert a negative influence on the long-term well-being of kidney sellers and their communities, especially in the absence of a substantial increase in their financial status as a result of the sale.

Recipients of transplants using organs from paid "donors" may also fail to obtain the anticipated benefitsof their purchase. Those who travel abroad to purchase kidneys ("transplant tourists") have higher rates of complications such as infection and poorer graft survival (10). Within domestic markets, a study in Pakistan found that recipients of kidneys from paid donors were thrice as likely to suffer complications as those receiving related donor transplants, with five-year graft survival being 45% and 80%, respectively (11).

Illegal trade in kidneys has a negative impact on legitimate programmes of organ donation and transplantation. As Aggarwal and Adhikary note, where there is an opportunity to buy a kidney, people are often unwilling to solicit or accept a kidney from a related donor. Awareness of the trade among the public and health professionals fosters a perception that access to transplantation is determined by ability to pay, and that professionals involved in donation and transplantation are likely to be influenced by opportunities to profit from organ procurement. Unfortunately, such perspectives may partly reflect the reality. The resultant distrust in the integrity and justice of programmes and professionals responsible for organ procurement from the living and the deceased, and the stigmatisation of donation as a commercial activity performed by the financially desperate undermine participation in altruistic donation opportunities.

Despite the claims of those who advocate a regulated market in kidneys from living "donors", many of the ethical concerns about illegal trade are unlikely to be addressed through regulation. I have argued elsewhere that market regulation may be less effective in addressing concerns about harms than advocates suggest, even in a more robustly regulated healthcare setting such as that of the USA (12). This is partly due to the fact that where payments are used to incentivise kidney "donation", the burden of donation will fall disproportionately upon the poorest members of society. This population is particularly vulnerable to the risks associated with kidney donation, as its members often lack resources such as access to primary health services which may serve as protective factors; and face higher lifetime risks of illness, injury and psychosocial insults that may influence the outcomes of elective nephrectomy (12). Careful screening of all prospective kidney donors to ensure that risk factors may be addressed, eg through the provision of long-term follow-up care, and that high-risk candidates are deferred is essential. The poor should not be categorically excluded from donation opportunities – the success of the altruistic related donor programme at the Sindh Institute of Urology and Transplantation in Pakistan shows that a predominantly poor donor population may have excellent outcomes (11,13) – but the provision of a lump sum payment designed to recruit rather than to care for donors exploits society's most vulnerable for the benefit of the rich.

Iran's oft-cited "model" of a regulated market in kidneys reveals disturbing similarities with the black markets of Asia and Latin America. Kidney sellers are predominantly poor, young and under-educated men (14). The prices of kidneys vary according to the availability and desperation of sellers, and the ability of transplant candidates to pay (15). The quality of the evaluation of prospective kidney sellers also varies, and this influences the potential risks accepted by the sellers and recipients. The informed consent process may also be flawed, and there is limited follow-up care and monitoring of sellers, such that the actual risks of selling a kidney in Iran are difficult to estimate

(14). The existence of a market has effectively "crowded out" living related donation, with stigmatisation not only of living but also deceased donation, despite the fact that payments are not made to deceased donor families. Although not all reports of outcomes for kidney sellers in Iran are negative, it is by no means an exemplar of ethical policy and practice. Furthermore, it has not solved the problem of organ shortages in Iran; a recent report states unequivocally that "the never-disappearing waiting list for kidney transplantation [in Iran] will be growing steadily" (16).

Claims in the USA that the current shortage of kidneys there would be resolved by the introduction of an "incentive programme" for donors remain speculative (1). In the Indian context, it is probable that the creation of a legal market in kidneys would increase supply at least in the short term, assuming the eligibility criteria for selling a kidney would not exclude those suffering a financial crisis, lacking long-term health insurance and so on. There is a sufficiently large population of Indians for whom selling a kidney would represent the best – if not the only – economic solution to an immediate financial crisis. Such a market would nevertheless be harmful to the participants, exploitative and inequitable, just like the existing illicit market in kidneys.

Although an individual market transaction may on occasion benefit both transplant recipient and kidney seller, and in many cases will result in the saving of a life, such benefits do not provide sufficient justification for a public policy legalising trade. What an individual may be justified in doing in the absence of alternative options is not always justified on the part of governments and health professionals, who have the obligation to consider the broader impact of individual actions and the interests of all societal members. For example, although lives may regularly be saved when members of the public break into pharmacies to steal medications required by critically ill children, it does not follow that governments should legalise the *ad hoc* robbery of pharmacies. Rather, governments should consider the most effective, sustainable and least harmful means of achieving the overarching goal of saving lives. With regard to the goal of preventing deaths from ESRD, markets in kidneys are neither the sole, nor the optimal solution; nor are they a solution to endemic poverty.

Ethical solutions to the kidney shortage

There is enormous potential to develop both living and deceased organ donation programmes in India. The success of deceased donation programmes in Tamil Nadu and Chandigarh demonstrate that dramatic improvement is possible in the current performance of organ procurement programmes across India if sufficient efforts are made and support provided (17). In addition, many strategies that have proven successful in other countries are yet to be fully explored in India, such as those noted by Aggarwal and Adhikary: kidney paired donation and the use of extended criteria deceased donors. The costs of becoming a living donor may prevent many from donating to their relatives, especially in the absence of universal health coverage. Financial barriers to living donation have been observed in many countries, and will undoubtedly influence donation rates in India. Reimbursing or covering the costs of living donation– and even deceased donation, where necessary – is not ethically contentious: the World Health Organisation, the Declaration of Istanbul, and many national, regional and international professional societies actively encourage efforts to promote financial neutrality in organ donation (5).

Those who cannot afford donation are also likely to be excluded from transplantation due to financial barriers. Thus, when evaluating the scope of the ethical duty to save the lives of those with ESRD and when advocating strategies to address the organ shortage, policy-makers and health professionals must carefully consider whose lives may be inadvertently prioritised, and who may bear the burdens associated with particular strategies. If the aim is indeed to maximise the saving of lives of people with ESRD, the most effective method of doing so is surely to invest in the prevention of ESRD rather than the recruitment of living donors.

Tolerating occasional violations of the THOA on the grounds that deceased donation programmes in India do not yet provide sufficient kidneys for transplantation is not an ethically justifiable strategy. It suggests a lack of moral courage and a willingness to make use of the poor for the sake of the privileged few. All those responsible for legislation, policy-making, and clinical practice in donation and transplantation in India must make an unequivocal commitment to best practice, which means ethical practice. Compromising on ethics undermines the societal and professional foundations on which successful and sustainable altruistic living and deceased donation programmes are built.

***Competing interests**: None*

***Funding support**: None*

Note [1] The definition of "unrelated donor" differs according to the laws governing organ procurement in each country. The term should not be considered synonymous with paid donors. Covering the costs that may be associated with living donation, such as loss of income during time off work, should also not be confused with payment for organs. Covering such costs does not leave the donor financially better off, and thus provides no financial incentive for donation (5). Aggarwal and Adhikary incorrectly suggest that Singaporean law permits the sale of organs. Like many countries, Singapore permits donation by a range of genetic relatives and emotionally related individuals, and does cover some costs associated with living donation for eligible donors. However, trade is strictly prohibited and a comprehensive screening programme seeks to identify and prevent commercialism (6).

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