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COMMENTARY

The Pakistani revelation

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In this issue of *Transplant International*, Anwar Naqvi *et al.* deliver a compelling testimony regarding the global state of transplantation affairs [1]. This vivid account documents the realities of organ sales in Pakistan, but it is also well known that this experience of donor exploitation is not isolated to Pakistan. Other destination countries such as the Philippines and Columbia now regularly solicit individuals to undergo transplantation from client countries that geographically span the Middle East, Asia and North America. These events are occurring in the midst of changes in China that has adopted regulatory oversight curtailing commercialism and transplant tourism, previously rampant from the sale of organs from executed prisoners. It should be noted that the number of transplants in China had risen to more than 11 000 annually, so the displacement of organ sales to other locations in the world such as Pakistan and the Philippines is predictable – but just as unacceptable.

And what then of this emerging population live kidney vendors? In Pakistan, the SIUT group has carefully detailed a sample cohort of vendors in follow-up – the outcome all very troubling; but what of the many more in Pakistan and elsewhere? The Pakistani report makes clear that a cash payment does not solve the destitution of the vendor. Who knows about the exploited poor in the Philippines and the Balkans and in Africa and Asia? Some of the information is beginning to surface in other countries by courageous individuals working against the tide but the description is no different from Pakistan. These reports are certainly not a model of ethical propriety and good medical practice!

Transplantation has become a tool, an instrument of brokers and hospitals and physicians and countries to make money by exploiting its poor. Money is dictating transplantation practices rationalized by a recipient focus that conveys a stark approach: satisfy the demand of the recipient at the cheapest cost, and dispense with the donor by a quick fix via the cheapest cash payment.

Thus, the disturbing report by the SIUT group becomes not only an accounting of the Pakistani experience but an indictment of the international transplant community. The widespread dimension of these practices becomes evident when a prominent and highly regarded nephrologist in Port of Spain Trinidad relates that a series of approximately 80 patients has gone from that Caribbean country to Pakistan to buy organs.

Those who wish to delude the realities evident in the Pakistani report by asserting that the vendor has autonomy, please take heed that such an assertion may be comfortable in academic debate but it is no solution for the reality. The poor are compelled to sell their kidneys because they have no alternative to resolve a debt; they remain destitute and then with one less kidney.

What then can be done? As an international community we need to fulfill the goals of the Amsterdam Forum and provide care for the live kidney donor. We need to

dispel the unrealistic notion that these cash payments can be regulated without the influence of brokers. The Iranians are to be commended for trying but they are also to be commended for their candor at a recent international meeting, now well aware of the limitations of a 'regulated' market. Additional and unregulated payments by the recipient become the norm, dictated by brokers. A recent presentation by highly regarded Iranian physicians at a Transplantation Society Key Opinion Leader meeting hosted in Turkey, made evident that the cash payment did not provide for a life changing event of the donor. But then we need alternatives to cash payments that provide a social benefit for the donor. Make the donor a hero, provide care for the donor just as care is provided for the recipient. If there is long-term care for the recipient, why is there no long-term care for the donor? The donor is a patient.

So, we need alliances of TTS and ISN and ESOT and other professional societies, all working with the WHO to influence health authorities and the media and politicians. At a WHO Regional Consultation on Developing Organ Donation from Deceased Donors, held in Kuwait City, representatives from Bahrain, Iran, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen supported the development and expansion of organ and tissue donation from deceased donors. They opposed commercialism and transplant tourism, including brokerage and medical professionals seeking monetary profit as a result of the vendor sale or coerced donation of an organ or tissue. The Kuwait Statement was crafted with an eye towards the following goals:

1 Each country must develop a legal framework and national self sufficiency in organ donation and transplantation.
2 Each country must have a transparency of transplantation practice that is accountable to the health authorities and whose authority is derived from national legislation.
3 Countries in which the buying and selling of organs is outlawed must not permit their citizens to travel to destination countries and return for insured health care in the client country.
4 Insurance companies should not support illegal practices as they are doing preferentially in some countries.

The international transplant community must come together to deliver a concerted message that cash payments are not acceptable, but programs that assure donor safety and provide benefits that address donor needs (with health authority oversight) must be developed in each country. Perhaps Pakistan can become the model if there were to be sufficient attention and concern from transplant physicians working with the SIUT group. The legacy of transplantation is at stake.

Acknowledgement

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Reference

1. Naqvi SAA, Ali B, Mazhar F, Zafar MN, Rizvi H. A socio-economic survey of kidney vendors in Pakistan. *Transplant Int* 2007; **20**: 934.