

Editorial

Who Cares? A Lesson from Pakistan on the Health of Living Donors

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As a fresh-faced first year medical student in London several decades ago I was approached in hushed tones by one of my classmates who feared he would lose his prestigious spot on the university rugby team because of an abnormal urinalysis. He needed a pristine sample of urine that I happily provided, several times in fact, until his place in the team was secured. Twenty years later the tables were turned on me when purchasing a life insurance policy. The 'doctor' evaluating me accompanied me to the lavatory door, and although he didn't enter, he checked the temperature of the resulting sample!

For reasons that will become apparent, I was reminded of these long-forgotten urinary adventures reading the remarkable article by Rizvi et al. (1) in the current issue of AJT. Rizvi and his colleagues in Karachi compared the medical outcome, several years following nephrectomy, of over 100 kidney vendors, most of whom were poor bonded laborers, to a matched group of related donors. In the vending group there was an alarming incidence of hepatitis, a disturbingly high incidence of hypertension, and evidence of impaired kidney function, compared to the controls. Though it is difficult, from the other side of the world and a culture different from my own, to assess the closeness with which the two groups were matched, the study adds an important element to the growing body of empirical evidence not only from Pakistan but also from Egypt, India, Iran and the Philippines (2–4) suggesting that the outcome for kidney donors who sold their organ is worse than that of those who donated it without financial gain. Worse, not only from a strictly medical point of view, as Rizvi et al. have shown, but also from a psychosocial one. It is also not surprising that, as has been repeatedly reported, the unsus-

pecting recipients of these vended organs suffer from a high rate of serious infectious complications (5).

The question that begs itself, of course, is whether this data from the so-called 'developing world', is relevant to the debate in our 'developed world' regarding the wisdom or otherwise of permitting commercialization of living kidney donation. To address this question we need to try to understand why it is that the kidney sellers in Pakistan and elsewhere have a poor outcome. It will always be those under financial duress that sell their kidneys and in developing countries vulnerable populations are an obvious target for organ brokers and their ilk. The donation transaction is primarily a commercial one and the donor likely does not have the benefit of a trustworthy advocate to care about his or her interests. Neither is there good reason for the donor and the recipient to care much about each others welfare since there is no mutual interest in a good outcome. Is it not surprising that in such an atmosphere there is a propensity to withhold or not to seek out critical medical information, with potentially disastrous consequences for both the donor and recipient? Someone is lying when a hepatitis positive Pakistani kidney vendor sells a kidney to an unwary customer.

In the United States, surely, regulation could prevent such abuse (6): perhaps to some extent it could. But what kind of regulation would be required? Even if the destitute were somehow excluded from the donation process (and it is not clear how this could be legally achieved), the kidney seller would still be someone in need of some serious money and perhaps desperate to receive it. Consider for example, such a potential donor who was required to repeat an abnormal urinalysis, as was my medical school buddy so many years ago. Would the passage of the urine sample need to be monitored, as my insurance 'doctor' monitored mine, to ensure that the donor was indeed the source of the sample? Whose responsibility will it be to verify that there is no family history of renal disease; or gestational diabetes; or kidney stones; or use of antihypertensive medications; or a distant melanoma; or covert high-risk activities; or blackmail and coercion, none of which can be detected on a routine physical exam and laboratory tests (5). And the larger the amount of money at stake the greater may be the propensity to conceal critical information (7).

It has been suggested that the abuse of kidney sellers reported from the developing world could be minimized by

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ensuring that paid donation was regulated within geopolitical borders (6). Is it rational to suggest, in the current international political environment, that there would be some overarching international agreement that would fix the price of vending to prevent donors from 'shopping around'? At a time when governments of the developed world, our own for example, are having considerable difficulty controlling illegal immigration and passing effective legislation to effect such control, whose responsibility will it be to verify citizenship, or naturalization documents, and recognize identity theft? Physicians and transplant professionals are not trained as private detectives or agents of the US Immigration and Naturalization Service, neither should they take this role upon themselves. And even if we were to accept the dubious ethical and practical arguments in favor of commercialization we would be left with the complexities and uncertainties of 'regulating' a system which would undoubtedly engender a destructive schism in the professional transplant community; a drop in noncommercial living donation; and possibly also of deceased donation (8). Commercial and noncommercial organ donation do not cohabit well together (9).

Dr. Rizvi and his colleagues deserve much credit for their efforts to follow-up on the Pakistani kidney sellers and to arrange treatment for those of them who clearly had not been cared for in the distorted 'evaluation' process that preceded their donation. They also deserve acknowledgment for their support of their country's legislation that makes such exploitation illegal. In the international arena the legislative news is encouraging. The Chinese government is making a concerted effort to stop foreign patients from using executed prisoners as a source of donor organs (10),

the Israeli government has passed progressive legislation to outlaw organ trafficking and brokering¹, while the government of the Philippines has revoked an Administrative Order² that sanctioned the country's exploitation of its vulnerable underclass.

There is a cautionary tale for both the developed and the developing countries in the experience of our Pakistani colleagues. A successful outcome for a living donor transplant requires that both the recipient and the donor do well, in the short term and the long term. Caring and trust remain at the core of all good medical care and an organ market, regulated or otherwise, will not provide them.

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¹Israel Transplant Law 2008 addendum 68A. March 2008

²Republic of Philippines Department of Health AO 2008-0004 March 2008