

Virtual Mentor

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CLINICAL CASE

Transplant Tourism: Treating Patients when They Return to the U.S.

Commentary by Sally Satel, MD, and by Andrew J. Aronson, MD, MBA, MPH

Mr. Lawrence, a 50-year-old man with diabetes, is on dialysis for chronic renal failure and on the waiting list for a kidney transplant. Because he is in relatively good health, he is low on the list. His physicians advise him that he could be on the list for up to 3 years and that his health during that time would not be jeopardized, aside from the risks and inconveniences associated with long-term dialysis. Mr. Lawrence is divorced and on bad terms with his ex-wife; he has no children and has contacted his sister and her family to see if any of them could be a living donor. His sister is obese, at risk for diabetes, and is not a suitable donor candidate; no other family members or friends are willing to consider donating a kidney to Mr. Lawrence.

Unable to find a living donor and dismayed at the thought of remaining on dialysis for years, Mr. Lawrence decided to use his financial resources to purchase a kidney and undergo a transplant in China. He spent 2 months in China after the surgery, where he was cared for by a local transplant team that provided postoperative care, including monitoring his renal function and managing his immunosuppressant medications. The surgery occurred without any significant complications, and Mr. Lawrence's recovery was excellent.

A month after his return to the United States, Mr. Lawrence ran out of the medications that his doctors in China had prescribed, including his immunosuppressants. He knew that failing to take the medication could cause graft rejection, so he made an appointment with Dr. Roberts, a nephrologist at a local academic center who specialized in care of renal transplant patients. Dr. Roberts was aware that many of the organs secured in China came from executed prisoners who did not always consent to organ donation. Further, Dr. Roberts was wary because purchasing organs was illegal in the U.S. Having worked in the transplant field for several decades and witnessed numerous changes in the regulations about and care of transplant patients, Dr. Roberts understood how difficult it was to secure an organ, but didn't want to be perceived as condoning Mr. Lawrence's actions.

Commentary 1

by Sally Satel, MD

Is it ethical for Dr. Roberts to treat Mr. Lawrence? Yes. Qualms about the circumstances surrounding a patient's activities are not a reliable ethical guide for physician behavior; if that were the case, the American Medical Association would

have condemned the medical treatment of convicted rapists, child molesters, and murderers long ago. Instead, the organization affirms the ethical imperative to treat such patients [1]. Similarly, doctors in the military would have no obligation to treat enemy combatants or prisoners of war, as they do under the Geneva Convention [2].

Mr. Lawrence, himself, is right to feel a sense of urgency. Patients on dialysis have shorter lifespans than kidney recipients. According to the U.S. Renal Data Service, a 50-54-year-old man on dialysis has an expected remaining lifetime of 6 years. With a new kidney, he may expect 16 years of life—a decade more [3]. And while dialysis patients have a significantly diminished quality of life compared to the general population [4], transplant patients report enjoying as good a quality of life as the population overall, sometimes even better [5].

In the nephrology community, my colleagues and I agree that the unspoken standard is to treat patients who have obtained organs overseas. Last year, the ethics committee of UNOS (United Network for Organ Sharing, the federally appointed agency charged with coordinating all organ donations and allocations), resolved that, while the individual physician does not have a duty to treat this type of patient in a nonemergency situation, the medical community as a whole does have such an obligation. In general, the resolution says, “physicians are encouraged to provide care” [6]. My own anecdotal experience reveals that many nephrologists have asked themselves at one time or another, What would I do if I, or a loved one, needed an organ? In the end, it is hard to fault someone who is trying desperately to save his own life.

Some physicians, however, prefer not to treat a person who went abroad for an organ. Doing so, they believe, would make them complicit in organ trafficking. In such instances, the responsible course of action is for the physician to inform the patient of this position up front and, if the patient decides to pursue an organ overseas, refer him or her to a local colleague who is willing to provide follow-up care when he or she returns.

“Transplant tourism” exists because the supply of organs in the United States is inadequate to meet demand. In the U.S, as in all countries except Iran, transplant policy relies upon altruism. While noble in spirit, this mandate creates its own form of coercion. Desperate patients feel they have no choice but to rent billboards to solicit donors, join online organ matching sites, and impose upon ambivalent relatives. Some—no one knows how many—go abroad despite the sickening knowledge that their new organ might come from an executed prisoner in China or an illiterate laborer in India.

Though UNOS opposes transplant tourism, the practice theoretically lightens the agency’s allocation burden [7]. After all, every time a person removes himself from the waiting list, he helps other candidates advance in the queue because there is one fewer claim on the limited pool of cadaver organs.

The most critical point in any debate about physician responsibilities to transplant tourists is that organ trafficking is a symptom of a shortage. To view organ trafficking simply as a moral failing of the patient or a contained problem in and of itself is woefully misguided. Underground markets develop predictably when demand is great and supply is small. And given the symbiotic nature of the relationship between trafficking and the global shortage, it will be nearly impossible to affect one but not the other. Thus, clamping down on illicit sales without first expanding the pool of available organs will mean more deaths from end-stage renal disease. Most likely, it will also drive trafficking rings further underground, increasing the risks to recipients and donors.

Possible Solutions

The way to starve this corrupt and unauthorized market is to make it easier to obtain an organ in the U.S. To do so, Congress would have to lift the ban on incentives for donations so that the effect of donor compensation on the organ pool could be studied. Transplant surgeons, legal scholars, and economists have long urged the application of incentives to motivate donation.

What kinds of incentives could be offered to individuals amenable to relinquishing a kidney while still alive? Perhaps the federal government could offer lifetime Medicare coverage or a deposit into a 401(k) retirement plan, tax credits, tuition vouchers for the donor's children, long-term nursing care, family health insurance coverage, life and nonfatal injury insurance, a charitable contribution in the donor's name, or cash payments distributed over time. Under this scheme, Medicare would underwrite the incentives in light of the fact that it already pays for dialysis treatment, which has greater long-term costs than transplants [8].

A central concern about any enrichment plan is the potential for donor exploitation—especially of low-income individuals who will be the most likely to find incentives for donation attractive. This is why donor protection is the linchpin of any compensation model. Standard guidelines for physical and psychological screening, donor education, and informed consent could be formulated by a medical organization, such as the American Society of Transplant Surgeons, or another entity designated by the federal Department of Health and Human Services. A waiting period of 3 to 6 months could be built into the process to ensure that the prospective donor has had ample time to think through the implications of the commitment. Monitoring the donor's posttransplant health is also important and should include annual physicals and laboratory tests for 1 to 2 years after donation. With such protections guaranteed, the motive for relinquishing a kidney—out of generosity or self-interest—is less important than increasing the supply of kidneys to ameliorate suffering.

These broad proposals and variants on them need considerable elaboration. There is no denying the political and practical challenges that come with introducing compensation into a 20-year-old scheme built on the premise that generosity is the only legitimate motive for donating an organ. Yet, as death and suffering mount,

constructing an incentive program to increase the supply of transplantable organs becomes a moral imperative.

Many of the quandaries that plague transplant medicine—from optimal allocation policy to the relationship of American physicians to the worldwide organ market—flow from the need to ration scarce resources. Without bold and creative steps to increase the supply of transplantable kidneys, there will be no respite from tragic choices such as the one that Mr. Lawrence made out of desperation. It is vital that physicians like Dr. Roberts treat patients who have made these choices.

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Sally Satel, MD, is a resident scholar at the American Enterprise Institute and a lecturer in psychiatry at the Yale University School of Medicine in New Haven, Connecticut. She is co-editor of *When Altruism Isn't Enough: The Case for Compensating Living Kidney Donors*, to be published by the AEI Press in the fall of 2008.

Commentary 2

by Andrew J. Aronson, MD, MBA, MPH

There is professional consensus that the recipient of an illegally obtained organ is medically disadvantaged for several reasons—increased morbidity due to a greater risk of infection, lack of indicated medications, and greater frequency of postoperative complications [1]. The American Society of Transplantation (AST) declared in its “Position Statement on Transplant Tourism” that it “strongly supports the provision of optimal medical care to all transplant recipients, including those who receive a transplant abroad whether from a living or deceased donor, kidney or other organ” [2]. I have no doubt that this is the standard accepted by the transplant community because patient welfare, which includes trying to avoid the need for retransplantation, is the primary concern of all transplant physicians.

In keeping with the spirit of the AST position statement, I do not believe that Dr. Roberts faces any legal or ethical constraints in providing care to Mr. Lawrence. Presumably Mr. Lawrence has the same insurance benefits he did before his transplant, which makes the financial aspect of his long-term care less burdensome. Although Dr. Roberts might disapprove of Mr. Lawrence’s traveling abroad and participating in “transplant tourism,” he certainly knows that the wait for a kidney by an adult with diabetes can be very long and that the morbidity and mortality of dialysis patients are significant. I think it is realistic to assume that anyone facing this reality who had the means to procure an organ abroad would at least consider it. No matter how Mr. Lawrence went about obtaining his new kidney, his postoperative care now takes priority over any other concerns, and Dr. Roberts is in no way condoning his patient’s actions by treating him.

The most tragic aspect of this case is that the U.S. shortage of organ donors is so dire [3]. Our current organ donation system is based on a model of altruistic donation. Unfortunately the difference between the number of organs needed and the number donated continues to grow wider despite increased efforts to promote both cadaveric and living organ donation by government agencies, transplant and nephrology organizations, patient organizations, and others. It is projected that by 2010, the UNOS kidney waiting list will have 100,000 patients and that the average wait time will be nearly 10 years [4]. The transplant community has responded to the shortage by developing strategies to expand the number of available organs by, for example, accepting donations after cardiac death and from live donors and by using extended criteria donors—that is, allowing patients between the ages of 50-59 with two or more specific conditions that would have previously excluded them (cerebrovascular

death, serum creatinine levels greater than 1.5 mg/dL, and a history of hypertension) to be donors [5]. Moreover, governmental agencies have initiated first-person consent programs so that family members need not be consulted about a person's interest in organ donation [6].

Taking a different approach, others have advocated a regulated system of financial incentives for living kidney donors. Arthur Matas has proposed a model using the infrastructure already in place for deceased donor evaluation and allocation [7]. He suggests providing living donors with long-term health care and posttransplantation follow-up. Before this can happen, UNOS and Congress would have to agree on legislation to relax the current restrictions that prohibit financial compensation for the donation of an organ [8]. A widely held concern about any compensation system is that it would exploit the poor and members of minority communities who would be disproportionately tempted to donate. I have been told by Francis L. Demonico, MD, that The Transplantation Society has been crafting a statement against organ trafficking, commerce in organs, and the exploitation of the poor. Michelle Goodwin [9], however, writes persuasively that these predictions are not necessarily going to come true, and she argues that, in fact, the communities that The Transplantation Society is trying to protect would benefit from the increased availability of both compensated and altruistic donations.

Clearly those who do purchase organs abroad—despite the restrictions—and have successful transplants decrease the number of patients who are on the U.S. waiting list for organs and also, potentially, lower the cost of medical care in the U.S., since the patients who travel abroad pay their own expenses. Even though they may be at higher risk for some complications, treatment for these patients is not likely to be as costly as the actual surgery and associated hospital care. There have been proposals by both insurance companies and legislative bodies, for example in the West Virginia legislature, that encourage health care tourism and may lead to an increase in the practice [10], which contradicts the position of UNOS and federal legislation.

In conclusion, efforts are being made to increase the availability of organs in the United States so that it will be unnecessary to worry about the increased risks and uncertainties of going abroad or the exploitation of vulnerable people in the U.S. The current shortage of organs and the growing number of those on organ wait lists places pressure on the medical community to find ways to encourage both cadaveric and living donations. These pressures will undoubtedly change our current approach to organ donation and require the cooperation of medical communities, patient advocacy groups, government agencies, legislatures, and insurance companies.

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Andrew J. Aronson, MD, MBA, MPH, is director of inpatient pediatrics and pediatric nephrology in the Department of Pediatrics at Advocate Illinois Masonic Hospital in Chicago. He is a professor of clinical pediatrics and an attending pediatric nephrologist at the University of Illinois Chicago. Dr. Aronson is also a lecturer in pediatrics at Loyola University in Maywood, Illinois, and at Rush University in Chicago, and is a voluntary attending physician at John H. Stroger, Jr. Hospital of Cook County in Chicago.

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