

The Hazards of Transplant Tourism

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In the November issue of the *CJASN*, Jagbir Gill *et al.* present a University of California Los Angeles (UCLA) series of 33 patients that underwent kidney transplantation in a foreign country and returned to the United States for post-transplant care. “Transplant tourists” are traveling to established destinations to obtain readily accessible organs for transplantation, available from the poor of that destination country who sell mostly kidneys, but in some instances, a lobe of the liver or a cornea. These practices have been well known for more than a decade. In 2004, the World Health Assembly (WHA) issued a resolution urging member states “to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs.”

Although the WHA 2004 resolution was unambiguous in its objection to trafficking and transplant tourism, a comprehensive description of these unethical practices was still needed. To address the concerns of the WHA, a Summit Meeting of more than 150 international representatives of scientific and medical bodies, government officials, social scientists, and ethicists was held in Istanbul, Turkey from April 30 to May 2, 2008. The result of these deliberations was the *Istanbul Declaration on Organ Trafficking and Transplant Tourism*.

Gill describes the transplant tourist as a resident of the United States who underwent transplantation outside the United States and then returned for follow-up care. The UCLA group makes no conclusion regarding the ethical propriety of this practice, disclaiming social circumstances that may have propelled these patients to travel for transplantation. The *Istanbul Declaration*, however, distinguishes travel for transplantation from transplant tourism by means of the following: “travel for transplantation is the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes transplant tourism if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centers) devoted to providing transplants to patients from outside a country undermine the country’s ability to provide transplant services for its own population.” The practical basis for concern arises when the destination country

places its own resident patient population at disadvantage for gaining access to the list because lucrative arrangements for patients from the client countries simultaneously claim an allocation priority. Meanwhile, in the client country, readily available access to organs (in the destination country) prevents deceased-donor programs from gaining widespread support.

Nevertheless, not all recipient travel for transplantation in a foreign country is unethical. The *Istanbul Declaration* provides additional guidance that travel for transplantation may be ethical if the following conditions are fulfilled:

For Live Donors

if the recipient has a dual citizenship and wishes to undergo transplantation from a live donor that is a family member in a country of citizenship that is not their residence;

if the donor and recipient are genetically related and wish to undergo transplantation in a country not of their residence.

For Deceased Donors

if official regulated bilateral or multilateral organ sharing programs based on a reciprocated organ sharing programs exist between or among countries or jurisdictions .

Gill reports that 17 (52%) of the 33 UCLA tourist patients had infections, with nine requiring hospitalization. The 1-year graft survival was 89% for tourists and 98% for the matched UCLA cohort. The comparative outcome of the tourist patients is a compelling revelation of the hazards of undergoing transplantation in a foreign country. These data are important to transplant physicians who advise their patients not to undertake such risks without some acceptance of the fate that comes with an unpredictable transplant experience. Donor transmitted infection may not be surprising if the kidney is obtained from an executed prisoner in China, where tuberculosis and hepatitis are more prevalent, rather than a deceased donor in the United States.

Notwithstanding these UCLA data, the transplant physician ultimately has to care for the transplant tourist, despite the appropriate admonition to such a patient. The transplant physician has an obligation to care for patients and not judge them. Nevertheless, the Israeli Ministry of Health has recently developed a more practical approach: if it is illegal to undergo transplantation in a foreign country (for example, now in the Philippines), then insurance companies should not condone or provide support for such an illegal activity. This approach

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would not solve the conundrum of care for the physician, but it would be a substantial deterrent for transplant tourists who seek to undergo the procedure in a foreign country.

The UCLA data and the *Istanbul Declaration* represent a concerted effort to establish a national self-sufficiency in every country with transplantation practices. Client countries should

no longer presume that donor organs from the poor will be preferentially available to their rich patient population because of their affluence and ability to travel. The data from this UCLA report should also be a stark reminder that transplantation care requires an expertise best provided by a transplant center that is devoted to the patient's interest, not to the patient's resources.

See related article, "Transplant Tourism in the United States: A Single-Center Experience," on pages 1820–1828 of the November 2008 issue of *CJASN*.