

Selling Organs for Transplantation

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Abstract

The need for transplant organs has far outstripped the supply of available cadaveric organs. Hundreds of people on waiting lists, who could be saved by transplantation, die each year. This severe shortage has justified the extension of transplantation to the use of living donors, but there are still not enough organs to meet the need. This paper discusses the justification for changing policies in order to encourage organ donation. It presents reasons for allowing payments to be made to families that donate cadaveric organs. It also presents reasons for allowing payments to be made to living donors, and guidelines for how an ideal policy could be structured.

Key Words: Selling, payment, organs, transplant, financial remuneration, presumed consent, altruism, ethics.

LIVING DONOR ORGAN TRANSPLANTATION is the only field of medicine in which two individuals are intimately involved: the donor and the recipient. It is also the only field of medicine in which altruistic giving of oneself is the basis of the medical practice. I have been asked to address a very specific aspect of this process, that is, living organ donation for financial remuneration. No other subject in the transplant experience is as controversial. Many of those involved in the field—surgeons, physicians, social scientists, ethicists, and theologians—have expressed an opinion on this issue.

As a result of impressive gains in this field, organ recipients now have a significant chance for both long-term survival and a reasonable quality of life. These successes have led nearly 80,000 individuals to opt for transplantation as a form of therapy. Unfortunately, the number of organs available has lagged far behind the demand. Every year thousands die while waiting for the gift of life that an organ transplant could provide.

In the case of cadaveric giving, the family of the brain-dead person is asked to donate.

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There is a serious shortfall in cadaveric organ donations, with only 40–60% of U.S. families consenting to organ recovery. Countries that have adopted the doctrine of “presumed consent” (such as Spain, Austria, and Belgium) have a much higher rate of organ recovery. In these countries, families can “opt out” of donation; if they do not, the organs of deceased family members can be used for transplantation. In most of the rest of the world, families have to “opt in” before organs can be used for transplantation. “Presumed consent” countries that require “opting out” obtain more than 40 donations per million population, as contrasted with half that amount elsewhere. The lower rate is obviously not adequate for meeting current needs.

The number and rate of donations have reached a plateau and leveled off following the enforcement of lower speed limits for automobiles and the introduction of seat belt laws. It is said that donation is a middle class, suburban phenomenon; those groups donate at a somewhat higher rate than others. Why is the rate of donation lower among the poor and in the big cities? We truly do not know. Education, family cohesiveness, trust in medicine, and moral and religious sensibility may all play important roles.

In light of the gap between organ need and organ donation, we are beginning to consider various forms of financial incentives to families as a stimulant for donation (1, 2). I am not re-

ferring to the token \$399 that the state of Pennsylvania has offered for funeral expenses. That amount would hardly pay for a plain pine coffin. Nor am I referring to the more than \$10,000 state income tax credit that the Wisconsin senate approved in January 2004 (3). That incentive would be of little use to the poor. I am referring to a substantial amount, to be included in the financial transactions that occur during the transplant process.

Organ transplantation involves payments of large sums of money. Huge sums go to the hospitals, the transplant surgeons, the physicians, the ancillary staffs and the insurance companies. And most of the money actually goes to the pharmaceutical industry. Many millions of dollars flow into their coffers for the immunosuppressants, antihypertensives, antibiotics, anticholesterols, antacids, and so on, that recipients routinely receive in the course of their treatments. The only people who are not being remunerated are the families of the donors. They alone are being asked to be altruistic.

Just try to do a transplant today on an uninsured patient. I can assure you, the patient will not get through the front door. Medicaid will pay for dialysis treatment of an uninsured alien. But Medicaid will not pay for his or her transplant.

What would be the harm of providing a payment to the donating family of, let's say, \$20,000? A liver transplant can cost upward of \$300,000, a heart transplant \$200,000, and a kidney transplant more than \$100,000. In kidney transplantation, even the insurance company would benefit from the payment, since they would no longer have to pay for dialysis therapy.

The most controversial remuneration of all is payment to a living donor who has no relationship to the recipient. Because of the organ shortage, most centers in this country accept the donations of living donors who are related, or emotionally related (for example, a spouse or a friend) as the source of transplant organs. In situations where there is an obvious relationship between the donor and recipient, people find no violation of ethical principles. In spite of the inherent risks of donating a kidney or a segment of liver, and the pressures and emotions related to the desire to save a loved one, these organ donations are found acceptable.

But, what of the donor who has no obvious relationship to the recipient? What should we say of someone who only wants to donate an organ to someone with the means to pay for it, perhaps out of financial desperation? About

twenty years ago, a foreign-born nephrologist at our institution offered me the opportunity to perform more than two hundred kidney transplants each year. He proposed bringing donor-recipient pairs from his country to our hospital for the surgery. I was to be paid a sizable sum. The apparently wealthy recipients would pay all the involved expenses, and each donor would receive approximately \$2,000 for his or her kidney. Apparently, \$2,000 was then a substantial sum for a poor person in his country. According to my nephrologist friend, that amount of money would change the donor's life and the standing of his family for generations. Yet even aside from the legal considerations, I rejected the offer outright, because it included no assurance of the donor receiving adequate long-term aftercare. I also felt a sense of revulsion at the idea of a poor, desperate individual peasant being used in this manner by some wealthy businessman or aristocrat.

Nowadays, this form of commercialism is prevalent in the Third World, where either there are no laws prohibiting these transactions or existing laws are not enforced. I shall not address those practices. Instead I want to consider payment for organ donation in an ideal situation. I want to consider the situation where the donor and recipient are carefully selected and carefully matched, and where the operation is well controlled. The donor would be offered long-term care, and the recipient would pay the donor a significant sum. There would be no "middle-men" or brokers involved, and the allocation process would be carefully controlled by the national or regional organ allocation mechanism. Under such circumstances, would it be ethically acceptable for one individual to use another for his own survival and well-being? Would the infliction of pain and suffering on one individual be justified by the benefit to another individual? Should someone with the financial wherewithal be allowed to purchase transplant priority? Does allowing such financial transactions undermine what has been a truly altruistic practice? Would payment to living donors inevitably undermine the public's faith in the process?

Let us examine the proposal in light of the ethical principles involved, to see if they would be violated. But first, I would like to rule out several factors that would be inconsistent with the organ exchange ideal that I imagine:

1. **The donor comes from a country where aftercare is deficient or unavailable.** Such a situation would subject the donor to an

unacceptable risk of harm and would therefore exceed a reasonable balance of harms and benefits.

2. **Third-party brokers, profiteers, or entrepreneurs are involved in the transaction.** Removing any portion of the transplant process from the oversight of medical professionals would remove it from the fiduciary relationship that assures that the donor's life and health would be safeguarded. And commercialism introduces possibilities of exploitation and conflict of interest.
3. **The donor does not truly understand the nature of the donation and the potential risks involved.** Evaluation of the donor by an impartial psychiatrist would be a crucial element in assuring that the donor is making an informed choice that reflects personal values and priorities.
4. **There are bidding wars for organs.** The assurance of donor and recipient safety must be a crucial feature of living donor transplantation. Organ auctions could compromise long-term safety or lead to unexpected and untoward outcomes of living donor transplantation. Auctions can only assure price compatibility between buyer and seller. While the selling price should be set high enough to elicit donors, the larger process must take into account the costs of long-term care and emergencies such as primary non-function of the transplanted organ, or organ rejection. Because the transplantation community has the ultimate responsibility for the careful management of these situations, the transplant community must have oversight of any financial exchange.

I would like to summarize the considerations that incline me to accept payment to organ donors in the ideal situation.

1. **Autonomy.** Certainly the donor and the recipient have the right to proceed if those involved in their care are assured that they have freely accepted the transaction with a complete understanding of the risks and benefits involved.
2. **Beneficence.** Both the donor and the recipient stand to gain from their contract, as does everyone else on the waiting list below the recipient. All of the others waiting for a

cadaveric organ will benefit by moving up a notch in the process.

3. **The “do no harm” principle (*primum nolle nocere*).** There is obviously some harm done to the donor in the surgery involved in organ donation. There is also the immediate exposure to surgical risks, and the certain disfigurement and loss of an organ. Also there are possible long-term consequences of organ loss. These risks of harm are so well defined in the kidney transplant experience that donors can be assured that the risks, both long- and short-term, are minimal. The risks associated with the liver, lung and pancreas donation process are not as well defined. Perhaps this element of uncertainty justifies a moratorium on these donations until the risks can be carefully assessed in well-controlled clinical studies.
4. **Justice.** I am less confident about whether an ideal organ payment system will conform to the basic principle of fair and equitable distribution of benefits and burdens. The main benefit of payments for organ procurement would go to relatively privileged individuals. They would get transplant organs more readily than others, in addition to all the other privileges that accrue to the wealthy (e.g., better homes, health care, service, etc.). Yet no one else would be harmed by the paid organ donation, unless there is a general loss of faith in the donation process, with a fall in the rate of altruistic giving. This is an empirical question that can only be answered by a trial.

It is clear that I have changed my position somewhat, on this form of donation. I have accepted the libertarian thesis that selling one's organs does not necessarily violate the right of self-determination, and should fall within the protected privacy of free individuals on the basis of the principle of autonomy. I have also been persuaded by pragmatic and utilitarian considerations—the current system is failing, and the benefits for all recipients of an increase in available organs outweigh most objections.

Of course, I would insist on controls. The donor must be healthy, both physically and mentally, as determined by competent physicians and psychiatrists who are not directly involved in the transplant process. We must be assured that the donor fully understands the risks

involved and must sign a statement demonstrating true informed consent. Paid donors must be guaranteed long-term medical care and life insurance for themselves and their families in the event that complications occur. The transplant should be controlled by medical professionals and medical agencies that are intimately involved in transplantation and that can administer the process with due care and impartiality.

I offer a final personal note. I am not entirely pleased that I have had to reach this decision. I would certainly prefer that an ample source of cadaveric organs be available to those in need. Available organs would allow us to avoid the dilemmas of living organ donors and paid donations. But for the time being, while

my patients are dying for want of an organ, I have accepted this libertarian, utilitarian approach. We do not live in ivory towers. In life, we have to make hard decisions and accept the consequences when all of our options have serious flaws.

References

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