Transplant International

GUEST EDITORIAL

Striving to achieve a national self-sufficiency

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This issue of *Transplant International* provides a comprehensive review of the global practices of organ donation and transplantation. Data and commentary are provided from international experts revealing the current realities that transplant professionals are addressing. The shortage of organs is evident but so too is the resolve to enhance the availability of organs from deceased and live donors. A new paradigm has emerged that all countries must consider. The World Health Organization is calling upon each country to achieve a national self-sufficiency in the organ donation and transplantation needs of its people. Countries can no longer abdicate that responsibility or leave its patient population without vital assistance that results in substandard transplantation in destination countries arranged by unethical brokers. Debra Budiani-Saberi and her colleagues describe the extensive exploitation that has occurred in Egypt; but that experience of transplant commercialism has also affected many other countries with transplantation services. The indictment of a broker in New Jersey, the continuing brokerage from Canada sending patients to Pakistan, or the ongoing use of prisoners executed in China, convey widespread illegal patterns of practice that are contrary to the WHO guidelines – now endorsed by the 63rd World Health Assembly in May, 2010. Organ markets (unregulated or mythically proposed to be regulated) should be prohibited. The Declaration of Istanbul has similarly made a profound objection to transplant commercialism that has been endorsed by more than 100 organizations around the world. A principle of the Declaration of Istanbul (and the Amsterdam Forum preceding Istanbul) is for the living donor to be fully informed of the consequences of being a donor and to receive appropriate care. Follow-up care of the live donor following the operative procedure is an obligation of the transplant center to the donor. Dr. Budiani-Saberi emphasizes that such care must be provided not only to living altruistic organ donors but also to victims of organ trafficking. The report from Budiani-Saberi and colleagues alarmingly reveals that the vendors may be medically unsuitable candidates for kidney donation and subject to poor surgical procedures. The discussion by Dr. Connie Davis regarding approaches to living donation becomes a timely reflection to note that an ethically proper program of paired donation can expand the opportunity for kidney transplantation around the world. Much can be done in countries with such a system that utilizes donor recipient pairs with established relationships. Alternatively, these same countries resort to organ purchases in foreign destinations as the inadequate solution to addressing of the donation needs of its people.

The use of kidneys from deceased expanded criteria donors distributed sensibly to older age recipients is championed in the report by Matesanz and the ONT. Deceased donation must be improved internationally but especially in Asia. As one stands on the shores of Beirut and looks east, there is virtually no deceased organ donation throughout the rest of that part of the world. In North America, the percentage of organ donors from the deceased is the highest in the world at 50%. The US is certainly to be commended for the successful Organ Donation Collaborative detailed by Wynn and Alexander in the report from UNOS; but UNOS must also contend with its controversial experience. US transplant centers discard more than 2500 deceased donor kidneys annually – kidneys that have been recovered for the purpose of transplantation. That practice is unacceptable especially as recent (yet unpublished) data reveal a substantial proportion of these kidneys to be medically suitable for transplantation. However, the report by Wynn and Alexander is encouraging to note the development of a new kidney allocation system under consideration with the inclusion of age matching as an important component of the allocation system. Wynn brings this proposal to attention with the hope that older age candidates will accept otherwise suitable kidneys from older age donors and reduce the inappropriate discard of such kidneys. This system is also well described in the article by Rahmel and Roels and again a model for utilizing efficiently all recovered organs in providing the benefit of transplantation.

Deceased donation is hard work and it requires an efficient organization. The model of the ONT as described by Matesanz and colleagues is the premier effort of the world in the coordination of donation activities. The ONT serves as the interface between the technical expertise and political forces international support of deceased organ donation. At the hospital level, an organ donation coordinator is designated to undertake the activity of organ donation in the end-of-life care. The critical path-

way developed by Dominguez-Gil and colleagues through the WHO is an important framework to assess retrospectively deceased organ donation performance and prospectively to monitor opportunities for donation. The use of the donor after circulatory death (DCD) is anticipated to be a necessary approach to solving the organ donor shortages. Yet, to be accomplished is the repair of such DCD organs *ex vivo* after their recovery and yet prior to transplantation.

Alexandra Glazier brings a thoughtful discussion of the principles of gift law to the approaches of explicit consent for deceased donation (opt-in) versus the alternative approach of presumed consent (characterized as opt-out). Gift law supports both practices but the opt-in system clearly is an approach that fully endorses the donation intent of the deceased. Family consent (or objection) should not be a barrier or overrule the final testimony of an individual to be a donor. Professor Glazier's discussion of donation also takes the reader to an issue of the necessary consistency within a culture in the support of deceased organ donation. Those countries that accept organs from the dead for transplant recipients should not object by a cultural assertion that they are unable to support deceased donation. If you can be a recipient, you can be a donor. Similarly, the Declaration of Istanbul calls for the fair distribution of organs among the people. The poor should not be the source of deceased organs for the rich; if you can be a donor you should be able to be a recipient.

This issue of *Transplant International* clearly challenges all of us to do better than the experience so vividly described by these reports. The patients we serve need our help to fulfill their needs. This issue of Transplant International also makes clear the commitment and confidence to do so.

Francis L. Delmonico
Massachusetts General Hospital,
Boston, MA 02114 2696, USA
e-mail: francis_delmonico@neob.org

Correction added after online publication 1 April 2011: Correction of Debra Budiani's name to Debra Budiani-Saberi on page 315 (three occurrences).