



## Kidneys for cash and egg safaris — can we allow ‘transplant tourism’ to flourish in South Africa?

Increasing numbers of foreign visitors are seeking elective medical treatment in South Africa. This surge in ‘medical tourism’ is driven by free-market principles, and presents attractive business opportunities to local medical practitioners whose once-suburban practices can now span the globe. For the patients, treatment — virtually all of which is available in their countries of origin — is offered at a fraction of the dollar or sterling cost, and at a standard of expertise and comfort at least equivalent to that available at home. The more traditional tourist delights of South Africa also make it a perfect destination for anyone wanting a few weeks of anonymous healing and adjustment after surgery — particularly cosmetic surgery.

Although the early medical tourists to South Africa sought predominantly plastic and reconstructive procedures, the therapeutic menu currently includes dental prosthetics, elective orthopaedic surgery, ophthalmology, and a host of complementary and alternative therapies. Two Canadian adults intimately known to the author chose to undergo cancer surgery and adjuvant therapies in South Africa after their respective diagnoses were confirmed (personal communication). So why not organ or gamete transplantation? Considering South Africa’s prominence in the history of organ transplantation and what we offer in quality of care, skill and affordability, it’s inevitable that we would attract work from outside our borders. But two discrete trends uncovered in the past year suggest that South Africa has been targeted from abroad as a transplant destination for all the wrong reasons. From an ethico-legal viewpoint we were clearly unprepared for this development.

In December 2003, South African police arrested two Israeli nationals and a Durban businessman suspected of being involved in an international organ trafficking syndicate operating between Israel, Brazil and South Africa.<sup>1</sup> The arrests followed a tip-off from Brazilian federal police who themselves arrested 11 organ trafficking suspects in Recife. The Durban businessman pleaded guilty to 78 counts of contravening South African law, and Section 28 of the Human Tissue Act of 1983 in particular, by virtue of his role as a middleman for the syndicate.<sup>2,3</sup> In evidence before the court it emerged that Israeli patients with chronic renal disease and \$45 000 to spare could approach the syndicate, which would procure a tissue-typed organ from an unrelated living donor in return for payment of between \$6 000 and \$13 000. Not surprisingly, the majority of donors were recruited from the poorest sections of Israeli and Brazilian society. False documents were drafted to indicate a blood relationship between donor and recipient, presumably to imply purely altruistic motives for the donation. Between 2002

and the time of the arrests, at least 38 illegal transplants had been successfully performed at a private hospital in Durban. At the time of writing, a South African police investigation is being conducted on a national scale. Section 28 of the Human Tissue Act<sup>3</sup> expressly forbids payment as an incentive to donate living or cadaveric human tissue for transplantation, although it naturally allows for remuneration of laboratories and hospitals where such procedures are performed, and the doctors who perform them. Section 60 of the National Health Act,<sup>4</sup> which will replace the Human Tissue Act in the near future, reiterates this provision, and also makes it a crime to ‘sell or trade in tissue, gametes, blood or products’, except as provided for elsewhere in the Act.<sup>4</sup>

Then, in mid-April 2004 the printed media exposed advertisements posted on university campuses by an American company, which invited South African woman students to earn up to R13 000 by agreeing to donate ova for artificial fertilisation of infertile American women.<sup>5</sup> The company had set up a website featuring a database of eligible South African donors from all ethnic groups, and details of a South African medical practice where all procedures would be performed. Pressure from the media and the Western Cape Provincial Department of Health convinced the American company to suspend its activities and close down its website within 3 days of the news breaking. The American advertisements offered substantial cash rewards which were clearly exploitative, and once again in contravention of Section 28 of the Human Tissue Act.

It is not the scope or intention of this review to cover the complex interrelationship of ethical, legal, and logistical dilemmas facing human tissue transplantation. Instead, I shall focus on the two main issues highlighted by the revelations described above, namely the use of incentives including financial rewards to encourage organ donation, and South Africa’s emerging status as a destination for ‘transplant tourism’.

The discovery of cyclosporine and subsequent advances in organ preservation techniques and transplant immunology have resulted in vast improvements in 12-month survival rates following kidney and liver transplants over the past 20 years. However, the same advances have also stimulated a proliferation of transplant centres and procedures, and a relative scarcity of donor organs. It is generally agreed that illegal exploitation of human tissue as a tradeable commodity is a direct result of the yawning gap between supply and demand, fuelled by a toxic combination of free-market principles and old-fashioned greed.



Where the limited supply of legally transplantable tissue — live and cadaveric — is concerned, South Africa's woes are as great as those of any other country, with cultural and religious resistance to organ donation highly prevalent within large sectors of society, creating impossible waiting lists for liver, kidney and heart transplants. In some developed countries alternative, facilitative models of consent to donate tissue in the event of death have been considered.<sup>6</sup> The most popular alternative to depending purely on the emotionally charged decision of surviving family members is 'presumed consent' which allows harvesting of the organs of any beating-heart casualty facing withdrawal of life support, provided that there was no objection to donation expressed before death. This 'opt-out' model was pioneered in Singapore, and has been adopted with varying degrees of latitude in Spain, Belgium, Austria, and 18 American states. All 50 American states have passed 'Required Request' laws, which mandate hospital administrators to raise the possibility of organ donation with the next-of-kin of all potential beating-heart donors. The much more prescriptive model of 'mandated consent' whereby every adult's wishes regarding organ donation must be registered with a government body, leans dangerously towards coercion, and is of little more than academic interest anywhere in the world, not least in South Africa.

To encourage cadaveric donations, both the British and American medical associations have debated the possible roles of financial inducements or rewards,<sup>7,8</sup> for example direct payments to funeral homes to cover the cost of a dignified funeral for the donor. In Pennsylvania, USA, state law has been passed to allow such 'rewarded giving', exploiting a loophole in the National Organ Transplant Act of 1984<sup>9</sup> which prohibits sale or trade of organs, but does not specifically rule out payments to third parties. Could such a strategy be ethically feasible in South Africa where lavish spending on funerals often has more to do with cultural expectations than budgets, and can prove crippling to families with limited or no income, especially if the deceased donor happens to have been a primary breadwinner? Perhaps even worse than the lure of money is the risk of igniting within laypeople an insoluble conflict between the imprint of custom on the one hand, and economic seductions on the other, a risk that the South African health care establishment as a whole cannot ignore.

From an ethical perspective at least, transplantation of organs between first-degree living relatives is the purest transaction as the donor's decision is assumed to have been voluntary, informed, and free of any incentives other than those of love and altruism. Granted, hundreds of people with no relationship to the future recipient donate blood and gametes throughout South Africa each week, but donation of replaceable tissues is protected from illegal solicitation by a number of factors, foremost being the absence of a critical supply problem which is the lifeblood of any black marketer.

But what about kidneys and livers? Transplanting organs from live unrelated donors is not forbidden in South African law, or in UK or USA federal law, enabling donation between spouses, life partners, close friends, etc. However, in South Africa high unemployment and a bipolar economy makes the use of live unrelated donors difficult to dissociate from the risk of illegal payments, and therefore an unpopular choice for bio-ethicists and physicians alike. In the UK, all live unrelated donations require prior approval from the Unrelated Live Transplant Regulatory Authority (ULTRA) which carries statutory powers in terms of the Human Organ Transplants Act of 1989.<sup>10</sup> In the USA, the National Organ Transplant Act provided for the establishment of an Organ Procurement Transplant Network (OPTN) to ensure thorough screening and equitable allocation of donated organs. In South Africa, donor screening is subject to less stringent control, being the responsibility of a transplant co-ordinator attached to the hospital where surgery is proposed. Even though the most diligent screening for possible commerce or coercion cannot be foolproof, it remains difficult to understand how no suspicions were aroused or inconsistencies spotted during workup for 38 transplants in Durban, all of which involved donor-recipient pairs from different parts of the world, all of them apparently 'first cousins'. Were accurate donor registers kept? Were those registers inspected annually by the Provincial Inspector of Anatomy? Were they submitted to the Director-General of Health each year? Were they scrutinised at national level? These are all statutory obligations spelt out in the Human Tissue Act of 1983,<sup>3</sup> and regulations<sup>11</sup> which should normally safeguard against illegal practices. If we fail to observe or enforce these regulations rigidly, organ traffickers will be quick to notice, and attempt to achieve in South Africa what is diligently guarded against elsewhere.

Within the debate around boosting donor rates, the argument for limited, legal payment of live donors is gradually gaining momentum,<sup>12,13</sup> certainly in the Western world. Proponents cite the 'willing seller, willing buyer' principle, arguing that proper legislation, state monitoring and enforcement could allow an official organ procurement body to recruit live donors and to award compensation on a set scale. Proper checks and balances would discourage trafficking or similar abuses. How could this possibly work in South Africa? For if we cannot ensure compliance with the current legal provisions, how can we begin to commit ourselves to ensuring that legalised payment of donors would not be infected by corruption and human rights abuse?

So the first mandatory step is to shake up our medico-legal and regulatory systems and send out a clear message to the rest of the world — virtuous men and criminals alike — that South African transplant units function within the law and do not welcome any proposal that might be tainted by illegal methods of organ or gamete procurement. Any medical



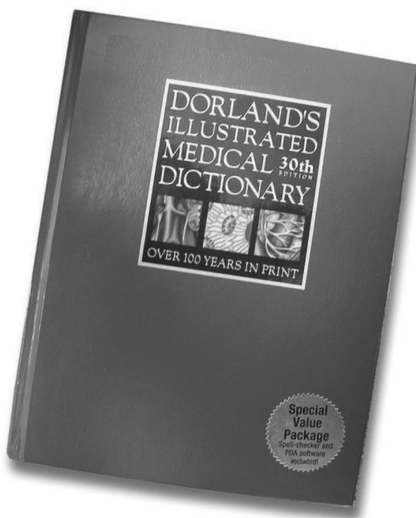
practitioner practising tissue or gamete transplantation in South Africa should read the Human Tissue Act, the National Health Act and the respective regulations carefully, and practise within them. In the event of criminal proceedings, no one associated in any way with an illegal transplant should hope to build an effective defence based upon ignorance of either the law or the facts. Having said this, the law is in itself not a guarantee against criminal misdemeanours or human rights abuses. Without thorough and regular monitoring by provincial and national departments of health of all facilities licensed to acquire and transplant human tissue and gametes, and prosecution of offenders, the temptation to 'pull a quick one' over South African authorities will always lurk. The onus is on the State as much as the health profession to eradicate that risk.

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