

'I'm not Sherlock Holmes': Suspensions, secrecy and silence of transplant professionals in the human organ trade

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Abstract

This article presents the results of a qualitative interview study amongst 41 Dutch transplant professionals. The overarching aim was to acquire in-depth understanding of transplant professionals' experiences with and attitudes towards patients who purchase kidneys. We found that transplant professionals occasionally treat patients who are suspected of kidney purchases abroad. However, they turn a blind eye to their patients' suspected purchases. Secrecy and silence function as a tacit agreement between patients and their caregivers that keeps the subject of kidney purchase at a safe distance and allows transplant professionals to ignore its suspected occurrence. They thus participate in the building of walls of secrecy and silence in the organ trade.

Keywords

Disclosure, ethics, kidney transplantation, medical tourism, organ trafficking, professional

Introduction

The human organ trade is receiving increasing attention from international (transplant) organizations, the media, researchers and non-profit organizations. According to the Council of Europe, this trade constitutes a 'major threat to the public health' (Council of Europe, 2014). The World Health Organization (WHO) first condemned it in 1987, declaring that 'payment for organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, leads to profiteering and human trafficking [and] conveys the idea that some persons lack dignity, that they are mere objects to be used by others' (World Health Organization, 1987, 2010). The trade is prohibited worldwide, except in Iran (Budiani-Saberi and Delmonico, 2008).

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Nevertheless, a growing number of reports suggest that the organ trade is proliferating around the globe. Although reliable data about the scope are lacking, the WHO has estimated that 5–10 percent of all organ transplantations take place illegally each year (Shimazono, 2007a). Owing to the lack of available organs, large numbers of patients are travelling outside their home country to purchase an organ (Albugami et al., 2017; Ratkovic et al., 2018). Some patients have been reported as paying up to US\$300,000 for a transplantation (Ambagtsheer et al., 2016; Greenberg, 2013; Khalaf et al., 2004). Organ sellers, by contrast, receive next to nothing in return for their organs (Lundin, 2012; Scheper-Hughes, 2014; Tong et al., 2012). Intermediaries such as brokers, doctors, recruiters and corrupt police officers reportedly reap most of the profits (De Jong, 2017; Pascalev et al., 2016). According to Global Financial Integrity, the trade features in scale and profit alongside the illicit trade in drugs, wildlife and weapons, with an estimated annual profit of US\$1.7 billion (May, 2017). Defined as a form of human trafficking, the prevailing discourse on the organ trade is that of an organized crime, driven by mafia-like networks that exploit the poor for their organs (Franko Aas, 2013; Scheper-Hughes, 2003; United Nations, 2000).

Condemnation of the organ trade is not, however, as widely accepted as is assumed (Evans, 2008; Greenberg, 2013). There has been widespread criticism of its prohibition since the WHO first denounced it (Matas, 2004; Radcliffe-Richards et al., 1998). Numerous authors point out that the grounds for prohibition are questionable and that prohibition has increased exploitation rather than prevented it (Cherry, 2015; Working Group on Incentives for Living Donation, 2012). After studying the organ trade in Cairo, Columb (2017) concluded that, ‘while the organ trade is publicly maligned, in practice organ markets are considered a solution to the surplus demand for organs’. The growing body of empirical research further suggests that the organ trade is not necessarily exploitative and that not all cases take place through organized crime. Rather, studies show that the organ trade involves a variety of practices that can be placed along a spectrum ranging from exploitation to voluntary, mutually agreed benefits (Fry-Revere, 2014; Heidary Rouchi et al., 2009; Van Buren et al., 2010). Such benefits are particularly reported from Iran, which, as we will point out, is the only country that has adopted a government-controlled programme that pays donors in return for their kidneys (Mahdavi-Mazdeh, 2012). In other countries however prohibition has, amongst others, led to illegal transplants being disguised as ‘altruistic’ donations between relatives and to the increased risk of vulnerability of patients and donors (De Jong, 2017). Codes of secrecy and ‘the impunity enjoyed by a professional medical elite’ are said to impede research into illegal transplants in medical facilities (Scheper-Hughes, 2004).

Global trends and patterns in the organ trade

The organ trade is fuelled by a worldwide organ scarcity. With the ageing of populations and the growth in diabetes and vascular diseases, the number of people with organ failure is growing exponentially. Of all organs, kidneys are in highest demand (Shafran et al., 2014). At the end of 2016, 191,874 patients were registered on kidney transplant waiting lists worldwide (Newsletter Transplant, 2017). However, only 62,333 (32 percent)

received a deceased or living kidney transplant that year. Average wait times for kidneys are 3–5 years and annual mortality rates are estimated to lie between 15 and 30 percent (Commission of the European Communities, 2007).

Despite strategies to enlarge the donor organ pool, such as adopting presumed consent systems, expanding donor criteria and increasing the number of living (kidney) donations, the worldwide organ shortage persists. Organ transplant waiting lists continue to grow every year. Furthermore, many countries still lack the resources to offer transplantations to their citizens (White et al., 2014). The worldwide transplantation activity is reported to be less than 10 percent of the global need (Global Observatory on Donation and Transplantation, 2015).

Patients who travel abroad for organ transplantation are often presumed to receive these organs illegally (Sajjad et al., 2008). The most commonly reported traded organs are kidneys (Shimazono, 2007b). Between 1971 and 2013, 6002 patients were reported to have travelled to another country for transplantation. Of these, 1238 (21 percent) were reported to have paid for their organ transplants. Patients made payments to hospitals, brokers, private companies and donors (Ambagtsheer et al., 2016).

Recurring organ trade patterns evolve around a group of ‘demand’ countries (where patients travel from) and ‘organ selling hotspots’. Although Taiwan and South Korea are the most commonly reported departure countries (Kwon et al., 2011; Tsai et al., 2011), large numbers of patients are also known to have travelled from the United Kingdom (Cronin et al., 2011), the United States of America (Merion et al., 2008) and Canada (Gill et al., 2011). Common destination countries are India (Budiani-Saberi et al., 2014), Pakistan (Yousaf and Purkayastha, 2015), Egypt (Columb, 2016) and the Philippines (Yea, 2010). These countries are renowned for their ‘kidney bazaars’, where large groups of impoverished kidney sellers report detrimental outcomes in health, finances and overall well-being after selling a kidney on the black market (Tong et al., 2012). The most popular destination country is China, which is known for procuring organs from executed prisoners (Matas and Kilgour, 2009; Sharif et al., 2014).

As mentioned, Iran is the only country that has legalized kidney sales through a government-regulated living kidney donation procurement programme. Confronted with low deceased donation rates, the government introduced a model of ‘rewarded gifting’ in 1997 to promote living kidney transplantation (Mahdavi-Mazdeh, 2012). People who wish to donate can contact a government institution that matches them to a prospective recipient. Intermediaries and brokers, it is claimed, remain uninvolved (Ghods and Savaj, 2006). The programme grants donors free health insurance for one year, exemption from Iran’s two-year mandatory military service, and a financial gift of 1 million tomans (approximately US\$4000 in buying power) (Fry-Revere, 2014). Donors also receive payments from their recipients. This reward is considered a private matter that is not interfered with (Simforoosh, 2007).

The Iranian model is based on the premise that regulating organ sales may be less harmful than strictly prohibiting them. Iran also claims to be the only country with a successful transplant programme and no kidney transplant waiting list (Fry-Revere, 2014). This model has received criticism for failing to eliminate harms to kidney vendors (Capron et al., 2014; Koplin, 2014; Zargooshi, 2008). Yet the reported harms are less severe than those reported on black markets (Fry-Revere et al., 2018; Tong et al., 2012).

Some claim that incentives for donation could – and should – also be explored in other countries to increase the number of donations and reduce black market abuses (Hilhorst and Van Dijk, 2007; Working Group on Incentives for Living Donation, 2012).

Prohibition and transplant professionals' fight against the organ trade

Whereas the WHO was the first to condemn organ trade, the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children was the first international instrument to prohibit 'trafficking in human beings for the purpose of organ removal' (United Nations, 2000). According to this definition, the organ trade becomes trafficking in persons if individuals are threatened, coerced, deceived or otherwise exploited for their organs. This definition has been widely embraced by the international community. More than 100 states have codified it into their national legislation (UNODC, 2016).

Since the start of the millennium, a strong anti-organ trade lobby has arisen among transplant professionals involved in transplant organizations (Danovitch et al., 2013; Domínguez-Gil et al., 2018; Efrat, 2015). For instance, in 2008, the International Society of Nephrology and the International Transplantation Society, in collaboration with the WHO, established the Declaration of Istanbul on Organ Trafficking and Transplant Tourism (Steering Committee of the Istanbul Summit, 2008). The Declaration was recently updated and defines and denounces transplant tourism and organ trafficking, and calls upon states to ban these practices (Declaration of Istanbul, 2018). Although nonbinding, its impact has been significant. Over 100 transplant organizations endorse its principles. Since its establishment, countries including China, Israel, the Philippines and Pakistan have passed new legislation or strengthened laws against the organ trade (Efrat, 2013).

Despite strengthened legislative responses, the number of organ trade convictions remains very low. Approximately 15 convictions have been reported worldwide, of which only 4 involved human trafficking for organ removal (UNODC, 2018; OSCE, 2013). To strengthen the law enforcement response, transplant professionals are increasingly encouraged to collect data on the organ trade and to report this information to law enforcement (Capron et al., 2016; Domínguez-Gil et al., 2018).

Over the last few decades, a growing number of medical professionals have published reports in which they state that they are 'unwillingly confronted' with patients whom they suspect underwent illegal organ transplantations abroad (Albugami et al., 2017; Gill et al., 2011; Ivanovski et al., 2011). Most of these patients return with serious complications in need of post-operative care, with implanted grafts whose origins are unknown (Wright et al., 2012). Caulfield et al. (2016) have stated that, given their interactions with patients who purchase organs, 'professionals seem well placed to play a role in the monitoring and, perhaps, the reduction of organ trafficking practices'.

Research amongst transplant professionals in the organ trade

The foregoing reveals a shift in the (perception of the) role of medical professionals as being only the caregivers for patients (Gill et al., 2010). However, available research amongst medical professionals in the organ trade is limited and sheds little light on

professionals' knowledge of illegal transplants and their reaction to patients who buy organs and reveals no information on how they perceive their roles and responsibilities in relation to the organ trade (Ambagtsheer et al., 2013; Columb, 2017; De Jong, 2017; Tong et al., 2014).

In 2014, we conducted an explorative survey amongst 546 transplant professionals in The Netherlands to describe their experiences, attitudes, behaviours, conflicts of duties and needs towards patients who purchase kidneys abroad. The professionals included all people who are involved in the pre- and/or post-operative treatment of kidney patients and donors in transplant centres and dialysis clinics across the country. The survey was completed by 241 respondents (44 percent). Because patients were treated by more than one transplant professional, this number does not represent the number of patients who had travelled. However, the survey was completed by transplant professionals from all transplant centres, and all centres reported clusters of patients who had travelled.

The results revealed that almost half of the transplant professionals involved in the care of kidney patients had treated patients who had travelled to a country outside The Netherlands for a transplant between 2008 and 2013. Although a majority suspected that the patients had purchased the kidneys, one-third reported that they were certain that patients had bought the kidney. Their reported reasons were that the patient said that he/she had bought the kidney, because the patient said that the donor had received money for the kidney and/or because the purchase was mentioned in the patient's medical record. A majority reported a conflict of duties because they felt unable to protect the victim-donor and because they felt unable to prevent the crime. Almost all reported a need for guidelines in treating patients who buy organs.

Yet, in the absence of a qualitative research component to this study, it remains unknown what knowledge professionals may have about illegally obtained organs. It is also not known how they respond to patients who (are suspected to) have purchased organs and whether/how their rights and duties affect their attitudes towards these patients.

Rationale, scope and aims of the study

The underlying article presents the results of a qualitative interview study amongst transplant professionals in The Netherlands with the aim of acquiring an in-depth understanding of their experiences with and attitudes towards patients who are suspected of kidney purchases. Building further on the results of the aforementioned survey, this article poses the following questions: What are transplant professionals' experiences with patients who purchase kidneys and how do they deal with these patients? What are their attitudes and behaviours towards these patients and how can these be understood and explained? Finally, how do they perceive their roles and responsibilities in preventing organ purchases?

Acquiring information about these aspects can help clarify how professionals perceive their roles in fighting and deterring the organ trade. This knowledge may contribute to exploring measures to engage transplant professionals in worldwide efforts against the crime. At the time of writing (2018), this is the first in-depth qualitative study to shed light on this topic.

Methodology

We interviewed 41 transplant professionals based in hospitals throughout The Netherlands, most of whom completed our survey and who reported having treated patients whom they suspected or knew had purchased kidneys abroad (Ambagtsheer et al., 2015). The respondents comprised 29 nephrologists (N), 5 nurse practitioners (NP), 5 social workers (SW), 1 research nurse and 1 transplant surgeon. Nephrologists constituted the largest group of respondents who received and completed the survey, which is why most interview respondents were nephrologists.¹ To ensure full geographical coverage, we interviewed transplant professionals based at all transplant centres across the country.² The respondents ranged in age from 31 to 67 years (mean age 49.2 years). Their career duration was 0–37 years (mean 13.7 years).

The respondents were contacted by email. All were informed beforehand that their names and the names of their institutions would be kept confidential. The interviews took place between 2011 and 2015, were tape-recorded, semi-structured, lasted between 45 minutes and 1.5 hours and took place in the respondents' offices. The interviews were recorded, transcribed and analysed through a mixture of thematic and open coding, using QSR*NVIVO software. The participants' names were coded to ensure anonymity. For the coding process, we used a list of predetermined criteria that we defined based on our research questions. We then assessed and compared codes, discussed overlaps and differences, and integrated them into one coding structure.

The interviews covered the following themes: professionals' experiences with patients who purchased kidneys abroad, their opinions and attitudes towards these patients, and their ideas and views on their roles and responsibilities in deterring organ purchase. With the transplant professional being the main focus of this article, the results reflect and represent their experiences, values and perceptions.

Transplant professionals' suspicions of kidney purchase

Transplant professionals' experiences with patients who purchased kidneys abroad are shrouded in suspicion, secrecy and silence. A social worker explained:

We never know whether the kidney was paid for. We always have a suspicion. We ask them but of course we don't get an honest answer because people aren't stupid. They won't tell us: 'Yes, I paid thousands of Euros for it.' We all have a gut feeling but we can't prove it. (SW28)

The professionals experienced the issue occasionally. The majority had treated 1 to 2 patients who had travelled abroad to obtain a kidney transplant that was assumed to have been bought. They spoke of patients who travelled between 2006 and 2013 but they also treated patients who had travelled before that time. Most travelled to Asian and Middle Eastern countries for kidney transplantation; a minority went to Western countries (Europe, Canada and USA). Many were still under the care of professionals when the interviews took place.

Whereas the majority found out that their patients had had a kidney transplant abroad after it had taken place, a minority reported that they knew beforehand that their patients were going abroad. Unaware of their patients' plans, professionals stated that their

patients left unannounced and unexpectedly returned with a strange implanted kidney in need of aftercare. The following statement captures the limited control and knowledge of the respondents regarding their patients' transplant ventures:

A woman suddenly appeared in our ward and said, 'Hello, I was in Afghanistan and I got very sick and needed a kidney and then my nephew in Pakistan donated his kidney.' I never discovered how she had arranged it. I had many questions that she didn't answer. It was a bizarre story. (NP24)

Respondents described their experiences with recipients of suspected kidney purchases as an unwelcome issue that they were unwillingly confronted with and had no control over. Furthermore, their knowledge and information about the suspected purchases were limited. One reason is that the documentation that patients bring back from abroad is often incomplete or absent. If available, only a few details about the medications and post-operative outcome are provided. In addition, patients and their (suspected) kidney purchases are not reported or registered. Consequently, professionals could not rely on a registry of cases or on comprehensive documentation. Rather, with the unusual and suspect nature of these cases 'stuck' in their memories, they based their accounts on their recollections. Sharing an experience about a patient who returned from a transplant in China, a nephrologist recalled:

He merely said, 'it had been arranged'. We asked whether the donor had been someone from the death list and if he had bought the kidney but he didn't want to tell us. He didn't answer. There was an awful silence. I remember that. Yes, that was quite extraordinary. (N29)

The participants generally associated their patients' transplants abroad with the organ trade, especially those obtained in countries such as India, Pakistan and China. In the absence of verifiable information about their patients' donors, respondents often imagined them to be the impoverished kidney sellers or executed prisoners whom they had seen, heard or read about in the media.

Patients' silence about how they had organized their transplants often confirmed the professionals' suspicions. The professionals explained that, when they asked their patients how and where they obtained the grafts, patients acted 'vaguely and suspiciously', avoided answering questions or 'mumbled' that it 'had been taken care of' for them. Others told their caregivers that they had received the kidney from a relative. Because participants could not verify this on the basis of the available documentation, these statements were often met with suspicion and doubt. Only on rare occasions did patients tell their caregivers that they had purchased the kidney.

Their limited knowledge about their patients' transplantations was also reported by professionals who knew beforehand that their patients were going abroad. In these cases, patients did not say they were getting a transplant but told their doctors that they were going 'on holiday' and returned with an implanted kidney whose origin was unknown.

In their accounts, the participants predominantly spoke about the medical aspects, emphasizing the complex treatment that the patients required owing to their post-operative complaints. Patients who obtain transplants abroad are significantly more likely to contract infections than those receiving domestic kidney transplants (Anker and Feeley,

2012; Sajjad et al., 2008). These recipients also report significantly lower patient- and graft-survival rates (Albugami et al., 2017; Ivanovski et al., 2011). Many of the complications reported in the literature were also found in the underlying study. Respondents spoke about patients, in particular those who went to Asia and the Middle East, who returned with infections (such as hepatitis, tuberculosis, paratyphus), acute graft rejection and/or graft loss. One patient died in Pakistan after a transplant. A few others passed away upon their return. The complications constituted a source of frustration and worry amongst professionals because these patients required more time-consuming treatment than domestic transplant recipients.

Notably, these reports require some nuance, as there were also patients who returned without infections and with properly functioning grafts. Moreover, respondents remarked that post-transplant complications are common in The Netherlands as well. Overall, however, professionals did not have a high regard for the quality of care that patients received in Asia and the Middle East. They assumed that the complications resulted from old-fashioned treatment or overdoses of immunosuppressant drugs, and presumed that the transplantations had been performed in unhygienic or 'shady' circumstances.

Ethnic ties in cross-border kidney purchases

Patients who travelled abroad for transplantation commonly had the nationality of the destination country, had lived or worked there in the past, and/or had family and friends living there who supported them by organizing the transplants. Patients' ties to countries with an 'organ trade reputation' were another reason for respondents to assume that the kidneys had been bought. They speculated that it was easier and cheaper for them to buy kidneys abroad than it was for native Dutch patients.

The (ethnic) affinity of patients with their destination countries is reported in almost all studies on the topic. Analysing waiting list removal data in the USA of 373 foreign transplants, researchers found that Asian race and non-resident alien status were significantly and independently associated with foreign transplants, with most transplants having been performed in East Asia and the Pacific (Merion et al., 2008). In the UK, data on 323 foreign transplants were analysed, and it was found that recipients transplanted overseas (that is, in Pakistan and India) were predominantly of South Asian ethnicity (Cronin et al., 2011). Similar findings have been reported in studies amongst patients who travelled from Australia (Kennedy et al., 2005), The Netherlands (Van Balen et al., 2016), Canada (Prasad et al., 2006) and Sweden (Berglund and Lundin, 2012). The authors explain that patients went abroad because of a greater familiarity with and trust in the destination country's health care system. Patients themselves have also stated that they felt more comfortable having the transplant in their native country because they knew the language and the culture, and they had family and friends abroad who helped them organize their transplants (Berglund and Lundin, 2012; Van Balen et al., 2016).

The importance of ethnic ties as an explanation for cross-border kidney purchases may, however, be somewhat overstated. Not all patients in the underlying study were affiliated to their destination country. Furthermore, ethnic affiliation with the destination country did not always guarantee a successful transplant; some patients travelled to their country of origin for transplantation but returned 'empty handed'.

The walls of secrecy and silence surrounding kidney purchase

Patients' reluctance to share information about their kidney purchase with their caregiver is not the only reason that there is limited knowledge about the organ trade. A recurring pattern throughout the study was transplant professionals' avoidance of the issue. They were reluctant to ask patients how they had obtained the kidney and consistently referred to their professional duties to explain that they did not need to know about their patients' presumed purchases. As one respondent explained:

My patient came back with a need for care that I provided. Whether it was an ethically condemnable transplantation or not, has nothing to do with my duty of care. For that reason, I didn't pay attention to whether the donor was paid or not. We don't need to know everything. (N14)

Medical professionals are bound by a duty of medical care and an oath of secrecy. The oath of secrecy serves to maintain confidentiality between patients and physicians (Mappes and DeGrazia, 2001; Rieder et al., 2016). Its underlying rationale is its protective function, which allows patients to speak freely about delicate issues, including wrongdoings they might have committed (Mappes and DeGrazia, 2001). The reasoning is that doctors cannot give proper medical care if patients withhold certain information from them out of fear of disclosure (Duijst-Heesters, 2007). The oath of secrecy therefore grants doctors the right of nondisclosure, which releases doctors from the obligation to testify in court (General Medical Council, 2009). The oath of secrecy exists in conjunction with the patient's right to privacy and serves to protect the patient's autonomy and the accessibility of care. Accessibility of care entails that patients have the right to receive care in all circumstances, even after they have committed a crime (Duijst-Heesters, 2007).

Simmel (1906) has demonstrated how secrecy guarantees trust in relationships and creates the conditions for people to talk freely about sensitive issues. Indeed, the oath of secrecy has become a universal duty, laid not only upon doctors but also on notaries and lawyers, that allows their clients to speak in trust about sensitive topics (Mann, 1985; Mappes and DeGrazia, 2001).

The results of the underlying study not only reveal the importance that transplant professionals attach to the fulfilment of their duties, but also demonstrate professionals' reluctance to know the truth behind their patients' alleged kidney purchases. They rationalized their avoidance of the issue:

The kidney was purchased outside our institution. We deliberately don't ask, because we don't want to know. We don't want to hear that he bought the kidney from a poor person who sold his kidney in order to provide shelter for his family. We want to protect ourselves from such sad stories. (N31)

Avoiding guilt or uncomfortable truths is a common neutralization technique. Sykes and Matza (1957) identified five techniques of neutralization: denial of responsibility (offenders claim their behaviour was not in their control), denial of injury (offenders minimize or negate the extent of the harm caused), denial of victim (offenders argue that,

although people got hurt, they deserved it), condemnation of the condemners (others' rights to pass judgement is negated) and appeal to higher loyalties (offenders argue that their loyalties lie with others). Whereas Sykes and Matza presented these neutralizations as justifications for deviance, Cohen (2001) illustrated that these rationalizations can also apply to bystanders. He added two rationalizations to the list: moral indifference (absence of appeals to conventional morality) and denial of knowledge (offenders or bystanders profess not to know what they and others around them did). Distinguishing three categories of denial, Cohen explained that, first, there are those who really do not know what was going on and therefore can justifiably claim to have seen nothing. The second category consists of people who are aware of a situation but deny that they knew anything about it (that is, they are lying). The largest category involves those who are in denial, that is, who find themselves between knowing and not knowing. It is the attitude of aloofness – of looking away – that is characteristic of people who find themselves confronted by uncomfortable situations they do not want to face (Cohen, 2001).

Numerous cases are known of offenders and bystanders who rationalized wrongdoings or justified their ignorance of malpractices. Examples include bid-rigging in the Dutch construction industry (Van de Bunt, 2010), the Enron scandal (Friedrichs, 2009), the use of doping by sportspeople, and sexual abuse in the Catholic Church (Siegel, 2011). Mann (1985) found that lawyers do not want to know harmful information about their clients. They have no interest in knowing too much because this knowledge could affect the quality of their work and damage their reputation. Our study reveals that medical professionals can be added to the list of those who make claims and rationalizations in turning a blind eye to practices that they would rather not know about, in this case the (presumed) illegal purchase of kidneys by their patients.

Appeals to a hierarchy of duties

First of all, the transplant professionals consistently appealed to their duties (that is, their duties of care and secrecy) vis-à-vis their patients. Repeatedly, they emphasized that their loyalties lie with their patients. In doing so, they relied on a hierarchy of rights and duties in which secrecy, care and trust in the relationship with their patients prevailed over other principles or concerns such as preventing kidney purchases and protecting donors from (possible) harm. Highlighting the demarcation of duties between doctors on the one hand and those of police, detectives and judges on the other, participants added that it was not their 'job' or 'business' to prove or know about kidney purchase:

I'm not Sherlock Holmes. I'm not going to try to find out whether they purchased the kidney. I'm just not going to do that. I don't care. Why should I care? (N30)

Underlining the importance of trust in the relationships with their patients, professionals frequently pointed out that enquiring after and 'interrogating' patients about the origin of their kidney would give patients the impression that they were being accused of organ purchase. This, in turn, would harm their relationship and hamper their duty of care. Their duties (and their privilege of nondisclosure) served as a veil that helped them avoid the issue:

It's easy for a doctor to say, 'I am his doctor. I'll do everything for my patient. I shall keep my mouth shut. I shall not notify the police. I will treat him and that's that.' In a way, we can hide behind that. (N3)

Professionals explained that there was no need to delve into – or know about – the purchases, because they are not allowed to report their patients. Respondents pointed out that, given their privilege of nondisclosure, there was little point in knowing about the (presumed) purchases.

Denial of responsibility

Professionals also regarded cross-border kidney purchases as links in the illegal transplant chain that they could not (wholly) prevent and that occurred beyond their control. Hence, they did not consider preventing kidney purchases as part of their responsibility:

I don't feel that I take part in the crime. I'm not the treating physician over there. I don't perform the operation. The patient is with me until a certain moment. Then he leaves and comes back. In my opinion, I don't carry responsibility for what happened in the meantime. (N14)

Participants highlighted that there are limitations to their duties and they emphasized their patients' own autonomy in the matter. They pointed out that all they could do was discourage patients from leaving by emphasizing the risks of acquiring transplants abroad and by informing them about domestic transplant solutions:

At a certain point, my duty ends. I can't lie in front of the plane's wheels to stop the patient from going. Besides, we already have enough other problems to worry about. (N6)

Another frequently cited reason was that asking their patients would take up too much of their time, or they simply were not interested in knowing:

I had the impression that he wanted to tell me all about it, but I wasn't interested in sitting by his bedside to listen to his story. (N27)

Because most professionals did not find out about the (suspected) purchase until months or even years later, they considered the act a 'fait accompli' and explained that 'there's no use in crying over spilled milk'.

The moral ambiguity surrounding kidney purchases

The organ trade is characterized by its moral complexity. Indeed, the question of whether or not to legalize the trade has been the subject of heated debates since the 1980s (Danovitch and Delmonico, 2008; Matas, 2011). The moral controversy underpinning organ sales was also reflected in professionals' responses. They described the organ trade as an ethically complex and difficult topic. As one nephrologist declared:

The patient is guilty of a crime, but there is also a moral context in that. If he doesn't buy that kidney, he might die If the patient benefited from the transplant, then I'm happy for him. But if you were to ask me to share my opinion before he leaves, I would say that I condemn it and that I don't offer my support. Morally we try to find a way out of this, you see? Because we just don't know how to deal with the issue. (N23)

On the one hand, professionals understood and sympathized with patients who bought organs. They referred to patients' desperation owing to the long wait, their dialysis-related complaints, and the government's inability to procure sufficient donor organs. On the other hand, they condemned the purchase and sale of organs, in particular if these took place in illegal circumstances with an increased risk of exploitation. Some, however, alluded to the financial benefits and the 'win-win situation' that may arise between patients and their donors after the sale of a kidney. Approximately half of the respondents considered a government-regulated policy whereby donors receive a reward such as a life-long health insurance as an acceptable solution to the organ shortage. They pointed out that increasing kidney donations through financial incentives might prevent their patients from buying organs on the black market.

They also mentioned that the 'Western attitude to the organ trade is rather rigid' and that ethical norms can vary across cultures. Respondents stated that, in some cultures, paying for organs is considered normal or condoned and explained that their patients who went abroad often came from cultures 'where everything is for sale, including people and their kidneys'. They found it less condemnable if patients originated from and travelled to countries where kidney purchases are permitted (that is, Iran) or tolerated.

The foregoing reveals the conundrum that transplant professionals are faced with when treating patients who purchase kidneys and shows that professionals rationalize their avoidance of patients' kidney purchases by appealing to a hierarchy of duties (in which those towards patients prevail), by claiming that they do not carry responsibility for what happens to patients or donors abroad and by avoiding (guilty) knowledge (that is, the possible exploitation of donors). Yet, professionals' responses must also be understood in the context of the moral ambiguity that underlies organ trade. Not all of the participants perceive the trade as a harmful or serious crime, in particular when it concerns cross-border kidney purchases that take place in cultures that condone or legalize them.

Understanding transplant professionals' responses to kidney purchases

Despite the fact that all transplant centres were found to have provided care to patients who had presumably bought organs abroad, none of them contacted transplant centres abroad to verify the origins of the acquired kidneys. Doctors do not have an obligation to investigate and prove whether their patients will commit or have committed crimes (Duijst-Heesters, 2007). Nonetheless, the oath of secrecy is not absolute (Rieder et al., 2016). Jurisdictions accept that doctors may disclose confidential information when required by law, when patients agree to the disclosure, when conflicts of duties arise, and/or in the case of overriding interests (American Medical Association, 2012; General

Medical Council, 2009). A conflict of duties arises when a doctor is confronted with a situation needing a solution and in which harm can be prevented by a breach of confidentiality. Accepted reasons for disclosure are child abuse, crimes that may lead to the death of the victim and infectious diseases that threaten public health (American Medical Association, 2012; General Medical Council, 2009).

Given these disclosure criteria and the underlying study's findings, it is unlikely that kidney purchases pass the threshold of reporting legislation. First, the study showed that professionals *suspect* that kidney purchases take place, but are rarely certain. Patients commonly do not tell their doctors that they are going to purchase, or have purchased, an organ. The limited information that patients bring back about their transplants also makes it difficult to determine whether an (illegal) organ purchase occurred. Many doctors questioned whether or not their patients should be punished for buying a kidney abroad,³ and feared legal repercussions if they (illegitimately) reported their patients to law enforcement. More importantly, however, transplant professionals did not consider kidney purchases to be sufficiently harmful to justify a breach of secrecy. Rather, they regarded cross-border kidney purchases as a consequence of an organ shortage that is not their responsibility to deter or prevent.

Encouraging disclosure of suspicious transplantations

Although there are good reasons why doctors do not report their patients, the possible implications of nondisclosure by transplant professionals should not be overlooked. First of all, nondisclosure is likely to allow brokers, medical doctors and other actors to continue performing illegal transplantations. At the time of writing, and despite strengthened legislation, new reports demonstrate that patients continue to travel for risky transplantations, most returning with serious medical complications (Albugami et al., 2017; Ratkovic et al., 2018). Furthermore, research into prosecuted cases demonstrates that police and prosecutors struggle to gather sufficient evidence to secure successful convictions, in particular against brokers and medical doctors (De Jong, 2017). Indeed, prosecutions of those who facilitate illegal transplantations remain rare, and medical doctors in particular are immune to prosecution (De Jong, 2017; Holmes et al., 2016; Scheper-Hughes, 2003).

The underlying results nevertheless suggest that support exists amongst transplant professionals to disclose suspicious transplant activity. First of all, the participants accepted the idea of a reporting tool if patients' identities remain protected and if the legal procedure is clear. Many added that a mandatory tool that guarantees anonymity for doctors and patients would be most effective. They added that legal guidelines on the issue would be helpful. They emphasized, however, that such a code should not harm the relationship with their patients. They reiterated that, whereas it is the responsibility of governments to combat the organ trade, it remains theirs to care for and protect their patients. Thus, to generate a more proactive stance from transplant professionals, changes must be made to the legal framework that governs their rights and duties. More specifically, governments need to loosen the conditions under which professionals can legitimately report suspicious transplant activities (Capron et al., 2016; Caulfield et al., 2016).

Elsewhere, we have proposed the implementation of an anonymous reporting code that can support police and judiciary in investigating, disrupting and prosecuting organ-trafficking networks. Information could include the names of hospitals, clinics, cities and/or hospital staff that are involved in illegal transplant activities. To maintain safety and transparency, the code should, at a minimum, designate a reporting centre, guide professionals through a list of indicators and contain protection mechanisms similar to whistle-blower laws. The identity of patients, doctors and/or their institutions should be protected (Ambagtsheer et al., 2015).

Such a tool could support law enforcement in the criminal investigations of those who facilitate illegal organ transplantations abroad. Professionals could report this information to the same national institutions that receive information on human trafficking, domestic violence and child abuse. After analysing the reported information, the reporting centre could submit the information to the national police, who in turn contact the police forces or liaison officers of the transplant destination country. This national–international reporting method would allow for the information to reach the appropriate authorities and would strengthen cross-border collaboration and enforcement of the crime.

Disclosure of such information may have disadvantages. It may erode the patient–doctor relationship. Patients may provide names of fictitious centres or may even avoid seeking care from their treating physicians upon return. On the other hand, disclosure may have a strong preventative effect, causing illegally operating transplant centres to think twice before performing an illegitimate transplant.

Conclusion

In conclusion, the walls of secrecy and silence amongst transplant professionals and their kidney-purchasing patients do little to curb the organ trade. Transplant professionals' responses to the organ trade contrast with the aforementioned developments in the international transplant community, which demand a proactive approach from transplant doctors who treat patients who buy organs (Council of Europe, 2017; Danovitch et al., 2013). We thus found a discrepancy between what is encouraged from transplant professionals at the international level and their actual attitudes and behaviours towards patients in their day-to-day local practices. Furthermore, not all transplant professionals regard cross-border kidney purchases as a serious crime. Rather, they view it as a morally dubious result of organ scarcity that does not legitimize breach of secrecy.

It is likely that cross-border kidney purchases will persist in the absence of reporting by transplant professionals who suspect that they have taken place. Transplant professionals are important actors in (the fight against) the organ trade and should be considered as such, even if they do not take an active or knowing part in the crime. Governments should consider implementing reporting tools for professionals to enable them to disclose suspicious transplant activities anonymously. At the time of writing (2018), no such tool exists in The Netherlands, or in other countries.

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Notes

1. Whereas surgeons perform the transplant operations, nephrologists specialize in kidney care and treat people with (chronic) kidney disease. Nephrologists traditionally chair the kidney transplant programmes.
2. At the time of study, there were seven transplant centres in The Netherlands.
3. Under the Dutch Law on Organ Donation and the Dutch Criminal Code, a cross-border organ purchase is punishable only if the double criminality principle is fulfilled. This principle requires that the patient be of Dutch nationality and that the destination country prohibits organ purchases. At the time of writing, the legal provisions governing (cross-border) organ purchases have not been applied in court or clarified in case law.

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