Perhaps, only in a few Scandinavian countries as Norway or Iceland, repeatedly ranked as the two highest HDI, it would be not much daring to try to implement such polemic strategy to increase organ supply.

For the moment, the universal rule has to remain as always preached and proposed by the US and other developed countries: a strong condemnation of organ commerce and endorsement to incentives aiming to increase organ supply from deceased donations.

Drs EA Friedman and AL Friedman end their review suggesting that the debate in which they endorse the strategy of organ commerce ‘is better than doing nothing more productive than complaining’. As well stated by Dr FL Delmonico ‘… endorsement of payment for organs could propel other countries to sanction an unethical and unjust standard of immense proportions….’. We are quite convinced that before embarking in this polemic and dangerous adventure of legitimate organ commerce, it is necessary to recognize the fragility of our ‘strategies’ when applied into a world where socioeconomic inequalities prevail and poverty does not respect boundaries.

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Response to ‘Payment for donor kidneys: Only cons’


Abbud-Filho et al. 1 present their argument that payment for donor kidneys whether to a deceased donor’s family or a living donor must be viewed negatively as exploitation of vulnerable people. Terming the case for legitimizing and regulating kidney sales ‘naive’ and ‘simplistic’, Abbud-Filho et al. omit mention of the 17 Americans who die each day, while waiting for as long as 10 years, with 91 851 others (as of 2 April 2006), for a deceased donor organ transplant.

Translating accomplishments in Brazil, with a population of 296 million would yield 2368 deceased donors, whereas in 2005, the United Network for Organ Sharing reported that a total of 7593 deceased kidney donors were actually utilized in the United States. From another perspective, despite nationwide public education campaigns and adding willingness to be an organ donor to several state driver’s licenses, resulting in a deceased donor rate that is three times that of Brazil, the United States continues to experience a progressive increase in kidney wait times with 7478 dialysis patients on a waiting list for 5 or more years as of 24 March 2006. 2

Certainly, we regret the ‘consequences of poverty and illiteracy’ that force more than 2 billion people to exist on less than 1 dollar per day. Nevertheless, life today is more than the dismal contest between ‘haves’ and ‘have nots’ portrayed by Abbud-Filho et al. Indeed, according to the United Nations in February 2005, global life expectancy at birth, increased from 46 years in 1950–1955 to 65 years in 2000–2005, and is expected to reach 75 years in 2045–2050. 3

In the least developed countries, where life expectancy today is just under 50 years, it is expected to be 66 years in 2045–2050. Rather than devoting total emotional energy to squelching a dissenting point of view, it is in the best interests of intellectual inquiry to encourage the presentation and examination of the purported benefits of a regulated market to waiting recipients, potential paid donors, and society. In at least one country where ‘official’ governmental policy sanctions the selling of kidneys from both living and deceased donors, there is no longer a waiting list for potential recipients. 4


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The transplant donor payment debate


To the Editor: We applaud Kidney International for the publication of the exchange of views on payments to organ donors. Although we appreciate Dr Delmonico’s lifetime of efforts on behalf of transplant patients and we realize that this
has been a contentious subject for years, three specific statements of his give us concern.

First, his statement that Congress recently rejected donor payments is inaccurate. Congress never voted on the Frist bill, because it was killed in committee. Moreover, Congressional decisions are usually driven by interest group politics, not ethics, economics, or good medicine. Consequently, any action (or inaction) taken by that body fails to support the moral superiority of any policy position.

Secondly, Dr Delmonico’s statement regarding the need for better preventive care is a classical ‘if-then’ fallacy of logic. If we could prevent all kidney failure, then there would be no shortage. That is true, but we cannot prevent all kidney failure. When the antecedent phrase is false, then any consequent phrase can be used to produce a true statement. Clearly, prevention of kidney failure is a laudable goal, but what do we do about the organ shortage until we can?

Thirdly, Dr Delmonico mentions the successes realized by the Organ Donation Collaborative; however, although donations have increased under that program, no one seriously expects it to resolve the organ shortage. Have patients stopped dying owing to the shortage? If not, more needs to be done. And if that ‘more’ means donor payments, we should begin to consider them.

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The transplant donor payment debate


To the Editor: Years ago, Philip Held (for whom I have much personal regard) introduced me to the writings of Dr Kaserman. Thus, knowing of Dr Kaserman’s genuine and long-standing interest in this issue, it is with much respect that I furnish this reply.

My understanding of the Frist bill is that the Organ Donation and Recovery Improvement Act was passed by the Senate. The House had passed similar legislation (HR 399, the Organ Donation Improvement Act of 2003). The Organ Donation and Recovery Improvement Act was signed into law by President George W Bush.

The Organ Donation and Recovery Improvement Act encourages organ donation, permits a reimbursement for living donors for expenses related to organ donation, and calls for a registry to monitor the long-term health of living donors. All good! The bill was not killed in committee as Dr Kaserman suggests. However, up till now, Congress has not appropriated funding for the legislation. Perhaps that is Dr Kaserman’s misunderstanding about this enacted legislation. Nevertheless, the point is that the enacted legislation did not include language that would permit the overturning of the 1984 National Organ Transplant Act that prohibits the buying and selling of organs. That omission was intentional.

An attempt to include language for financial incentives ‘notwithstanding NOTA’ was not brought forward because of objections from Senator Judd Gregg (Republican, NH, USA) at least, but the staffs of Senator Kennedy and Dodd were of similar mindset (Democrats, MA and CT, USA).

As to this bipartisan Congressional perspective, my personal discussions with some of the following Senators, but perhaps just as importantly with the legislative staff of Senators Frist, Kennedy, Dodd, Gregg, Durbin, and DeWine, and with Congressmen Bilirakis and Tauzin, and by my presentation at the Hearings of Congressman Greenwood (which included Democratic Congressmen Dingell, Inslee, and DeGette), are the sources of my confidence that Congress will not adopt a regulated market for organ sales.

Further, I would ask that Dr Kaserman not overlook opposition to his proposal from The Transplantation Society, The American Society of Transplantation, The American Society of Transplant Surgeons (ASTS), the National Kidney Foundation, the United Network for Organ Sharing (UNOS), and the World Health Organization. Notwithstanding the writings of some prominent members of the ASTS, that Society is on record as recently as last week, and that it is opposed to the buying and selling of organs. These organizations bring a powerful testimony to the debate that will be persuasive, were that declaration necessary in Congressional hearings. However, any further Congressional review of this issue is clearly not contemplated at this time. What Congress is currently attempting to resolve is the possibility of sanctioned paired live organ donation.

As to Dr Kaserman’s admonition that we cannot prevent all kidney failure, I am not suggesting that we can. But I am asking him to consider the following: it would be much less expensive for society to prevent the renal failure associated with hypertension, atherosclerosis, obesity, and type II diabetes than to have an expectation that we will resolve those medical problems at the corner kidney vendor store. That recommendation has international support. As to the ethical challenge, this recommendation is made for a patient population that is mainly uninsured and constitutes a substantial portion of the list (and a sizeable portion of those who do not get access to the list).

Which takes me to Dr Kaserman’s third point about the list, and for me to inquire: does Dr Kaserman know of the profile of the kidney patients who are dying on the list? Has Dr Kaserman evaluated the profile of patients who have died in the immediate post-transplant period with a functioning transplant? These data must shape the debate as well. The