Marie-Chantal Fortin, Delphine Roigt, and Hubert Doucet, "What Should We Do with Patients Who Buy a Kidney Overseas?" *The Journal of Clinical Ethics* 18, no. 1 (Spring 2007): 23-34.

What Should We Do with Patients Who Buy a Kidney Overseas?

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INTRODUCTION

Worldwide, there is a growing discrepancy between the demand and supply of kidneys for transplantation. Canada is no exception to this rule. As a result of this shortage, waiting lists and times to transplant are becoming longer:[1] in Toronto, for example, the average waiting time for a cadaveric transplant was seven years in 2005.[2] Considering that time spent on dialysis may decrease patients' chances for survival and make them unsuitable for transplantation, some feel compelled to seek other alternatives.[3] One of these is to go overseas, buy a kidney, have it transplanted, and then come home for long-term follow-up care. Experts estimate that every year, 30 to 50 Canadians buy kidneys abroad — between 3 percent and 5 percent of all renal transplants performed.[4] Over the past few years, the media have made public many cases of "transplant tourism." For example, Canadian newspapers published articles on a Chinese website advertising transplant opportunities for foreigners, as well as a Canadian firm offering help to Canadians wanting to buy a kidney from living donors in Pakistan.[5] Although buying kidneys abroad is not yet a widespread practice, there are indicators suggesting it will become increasingly so. This raises a number of issues that can be encapsulated in the question: "What should we — as nephrologists, hospital staff, and the transplant community — do with Canadian patients who buy a kidney overseas?"

In recent years, nephrologists at the Centre Hospitalier de l'Université de Montréal (CHUM) have been confronted with cases of transplant tourism. Some of their end-stage renal disease (ERSD) patients have gone to Pakistan, India, China, or to countries in the Middle East for a renal transplant, while others are seriously considering it. Even though, as in Canada, the sale of organs is prohibited in these countries, there is still a black market for kidneys. The CHUM transplant team felt ethically uncomfortable with these patients' actions.

Searching for guidelines in this difficult matter, the CHUM team submitted the case to their Clinical Ethics Committee (CEC). One of the main issues raised revolves around the fact that the doctors felt they were colluding in an illegal and immoral act, which made them uncomfortable and called into question their doctor-patient relationship. The other principal concern was the acceptability of the sale and traffic of organs. The questions brought to the CEC may be summarized as follows:

1. How can/should one react toward patients who have probably committed an act that is considered illegal in Canada?
2. How can one reconcile a physician's duty to ensure the follow-up care of these patients with his or her uneasiness regarding the sale of organs?
3. What is the appropriate attitude to adopt with patients suspected of buying organs, when we have no tangible evidence?
4. Can we refuse to monitor these patients?
5. Can the doctor or the institution do something to prevent this practice?

The CEC conducted an extensive review of the literature on the subject. The only recommendation found was issued by the ethical committee of the Établissements français des greffes in 2003. It stated that even though selling and purchasing an organ in France or overseas is illegal, the transplant physician cannot refuse to treat and monitor patients who return to France with such a transplant.[6] Surprisingly, no national or international ethical or clinical recommendations were found on the issue of follow-up care for patients who have bought and have been transplanted with a kidney overseas. Before offering recommendations on appropriate attitudes to adopt, the CEC had to summarize the ethical issues at stake, review the arguments regarding the selling and trafficking of organs, and propose an ethical framework. This article describes the reasoning of the CEC and its resulting conclusions.

ETHICAL FRAMEWORK

Before making any recommendations on this issue, it was important for the CEC to understand the complexity of the sale and trafficking of organs, and its meaning in the Québec medical context. To do so, legal arguments, medical data, cultural issues, and ethical arguments and values were studied.

FACTS AND ARGUMENTS ABOUT THE SALE OF ORGANS

Legal arguments. There seems to be an international consensus on the prohibition of any form of commodification of organs, as witnessed by statements issued by the World Medical Association, the World Health Organization, and the American Society of Transplantation.[7] In Québec and Canada, the sale or purchase of organs is illegal. Sections 3, 10, 19, and 25 of the Civil Code of Québec proclaim the right of all persons to the inviolability and integrity of their body, the requirement of free and enlightened consent for any interference with their body, and, more specifically, the gratuitousness of any alienation of a part or product of their body.[8] The Québec Charter of Human Rights and Freedoms also enforces the principle of non-commodification of the human body by proclaiming the right of every person to dignity. No matter how universal these principles may seem, however, they are only enforceable if the sale of an organ is conducted in Québec. There is apparently no sanction if the sale and transplantation are performed in another country, where they are legal. There would have to be an international agreement strictly prohibiting the sale of human organs to enforce extraterritorial sanctions. Recently in Canada, Bill C-49, An Act to Amend the Criminal Code (Trafficking in Persons) came into effect, making it a criminal offense to force or threaten a person to have an organ or piece of tissue removed, as well as to offer financial or other material rewards in the knowledge that this would result in the trafficking of the person. It also states that the victim's consent to trafficking is never a valid defense.[9] Since the amendment is recent, its interpretation and application in transplant cases will need to be followed.

In the United States, since 1984, the National Organ Transplant Act states that the sale of body parts is illegal and constitutes a criminal offense.[10] The validity of this prohibition is often called into question.[11] Nevertheless, nothing is stipulated about buying organs outside the U.S. Recently, the United Network for Organ Sharing (UNOS) Ethics Committee endorsed a statement that condemns "transplant tourism" and encourages the transplant community to adopt "ethically defensible" policies.[12] However, UNOS did not clarify what it meant by "ethically defensible" policies.

In 2003, the Council of Europe was the first to make a recommendation about organ trafficking. In its report, it encourages countries to struggle against this practice. The council states that it should be considered criminal to be involved in any way in the trafficking of organs. It would therefore be legitimate for countries to take legal action against a patient who illegally buys an organ, or against a doctor who provides information on how to purchase an organ or who agrees to provide follow-up care to a patient who has purchased an organ. Moreover, the council invites countries receiving organs, that is, countries whose citizens have gone abroad to buy an organ, to refuse to reimburse the illegal transplantation and pay for follow-up care, except in cases of emergency.[13] In 2004, the United Kingdom passed the Human Tissue Act, which was fully implemented in September 2006. This law prohibits commercial dealings in human material for transplantation, and states that a person commits an offense if she or he is involved in any way with organ traffic (purchasing, selling, or advertising).[14]

To this day, Iran is the only country to have made public its experience with a legalized and institutionalized market for organs. It is important to note that this institutionalized market does not allow transplant tourism. In fact, organs are procured from Iranians and given exclusively to Iranians. It is impossible for foreigners to receive a kidney from living unrelated Iranian donors.[15]

Position of the World Health Organization. In its most recent resolution on "Human Organ and Tissue Transplantation" (2004), WHO urged its members to take measures to protect vulnerable populations from transplant tourism. It also requested the WHO Director General to provide support to countries that are trying to prevent organ trafficking and transplant tourism.[16] However, it does not suggest any practical means to achieve this goal. In a previous report (2003), WHO members suggested, as a possible solution, assigning organ trafficking the same legal status as pedophilia.[17]

Medical context. Living-donor nephrectomy is associated with low mortality (0.03 percent) and morbidity rates, and it is not connected with an increased risk of ESRD or mortality compared to the general population.[18] It is important to keep in mind that these data are from developed countries. Transplant teams who are participating in organ trafficking are not reporting their complications. Moreover, in countries known for organ trafficking, donors do not receive any follow-up care, so the incidence of ESRD remains unknown.[19]

While the complications for the sellers of kidneys are unknown, there have been reports of complications for patients who buy organs. For instance, there have been documented cases of HIV and hepatitis among patients who bought a kidney in India.[20] In Toronto, where 20 Canadian patients went overseas to buy kidneys, a higher rate of complications than usual was observed, with worse outcomes in terms of graft survival compared to patients receiving transplants from living donors at home. These complications included infections with antibiotic-multiresistant bacteria, disseminated fungemia, and tuberculosis.[21] The transplant team of the University of Minnesota reported similar results in 2006 from 10 patients who underwent renal transplantation in Pakistan, China, and Iran. Complications occurred in six out of 10 patients. In this report, graft and patient survival were good (one graft loss and no patient deaths).[22] An Australian study reported similar results in patient survival and complications following a renal transplantation performed abroad.[23] It is of concern that when the complications are infections, it becomes a public health issue: the introduction of new pathogens, such as a new strain of antibiotic-multiresistant bacterium, represents not only a threat to the transplanted patient, but also to the entire community, in terms of costs, resources, et cetera.

Cultural context. *India.* In India, renal transplantation is very often the only solution to ESRD. For the majority of ESRD patients, dialysis is too expensive and unavailable. Though most renal transplantations are conducted using kidneys bought from living donors, organ sale remains controversial.[24] Some authors disagree with Western condemnation of the existence of an organ market in India, saying that ethics are context-based and that the Western position is paternalistic and ethnocentric.[25]

The Indian Transplantation of Human Organs Act was adopted in 1995 by most state governments. The bill was passed in the context of a police investigation into organized organ trade. In terms of prison sentences and fines, the law makes the purchasing of organs punishable.[26] Despite the legislation, there is still a market for organs.[27]

A 2002 study interviewing Indians who had sold a kidney reported the following.

- Brokers are almost always involved in the transactions,
- Poverty is the principal motivation for selling an organ (96 percent of organs are sold to pay off debts),
- Women comprise the majority of the sellers,
- The amount the seller received was less than promised,
- The sellers' socio-economic status did not improve after the sale (in fact, it was often worse than before the transaction),
- Of the sellers interviewed, 79 percent said that they would never recommend the practice of selling a kidney to someone else.[28]

Iran. As stated previously, Iran is the only known country where organ selling is legal. In Iran, procuring organs from a brain-dead patient was not permitted until 2001; renal transplantation could only be done from living donors.[29] A governmental organization acts as a broker between seller and buyer. Since the legalization of organ selling, there have been no more waiting lists for renal transplantation.[30]

A study interviewing Iranian kidney sellers showed similar results to the Indian study cited previously.

- Poverty is the principal reason for selling kidneys,
- Most sellers were not able to reimburse their debts from the moneys from the sale,
- Of the sellers interviewed, 76 percent would agree to a prohibition on paid organ donation.[31]

The studies in these two countries indicate that current modes of organ selling are not an effective way to fight exploitation or to alleviate poverty among people in Third World countries.[32]

Canada. In Canada and Québec, organ donation has always been considered solely altruistic.[33] The Canadian healthcare system is based on solidarity, which might explain why organ donation is associated with virtues of altruism, generosity, and charity. The metaphor of the "gift of life" prevails. However, no public debate exists on the subject. In its recent report (2004), the Québec Commission de l'éthique de la science et de la technologie suggests that accepting paid organ donation could lead the population to distrust transplantation professionals and could adversely affect other organ donation programs (living and cadaveric). It also argues that any form of compensation or retribution would constitute an infringement of the law as well as an unacceptable practice from an ethical perspective.[34]

Considering the way healthcare and services are reimbursed in Canada, transplant tourism raises other questions: Should the public health insurance system reimburse patients who buy a kidney overseas, since it is presumably economically advantageous for the system to have more patients transplanted? However, if patients who come back need to be hospitalized for complications resulting from transplantation, is it really cheaper for the system in the long run? Would it be legally and ethically defensible for the healthcare system to refuse to pay for the follow-up care of patients who have committed illegal acts abroad? Would this be a means to dissuade patients from going abroad? Is it nonsensical to ask these questions in the context of the Canadian healthcare system? Does the notion of reimbursing anything related to transplant tourism not negate the philosophy underlying the healthcare system? These questions are all highly relevant to this topical debate. In 2005, a decision handed down by the Supreme Court of Canada authorized the use of private health insurance in instances when the public system is unable to deliver care in a reasonable time frame (the *Chaoulli* decision).[35] With this decision, the Supreme Court sent a very strong message to provincial governments to rapidly strengthen their healthcare systems and improve their management of waiting lists and times. Despite the fact that the Supreme Court decision applies only in Québec, on 17 August 2005, the Canadian Medical Association adopted a resolution supporting it.[36] Could this decision have an impact on the transplant situation? For now, the response of the Québec government outlines three specific measures:

1. Guaranteed waiting periods for certain elective cases (tertiary cardiology and radio oncology, as well as hip, knee, and cataract surgery) should be expanded as resources become available and regulated;
2. Development of "affiliated specialized clinics," run by private partners, to complement public service

offerings, and from which public establishments may purchase certain services already provided in the public system, without cost to patients; and
3. Allowing citizens to purchase private insurance for hip, knee, and cataract surgeries.[37]

If transplantation were to be added to the list of these procedures, however, the availability of the resource would remain problematic. It might then be considered acceptable for the healthcare system to pay for patients to purchase a kidney overseas when the waiting period for receiving a transplant exceeds a certain limit. Considering the social, economic, and political repercussions of these issues, it is beyond the scope of the CEC to find answers. The CEC believes these issues should be publicly debated and addressed at the governmental and legislative levels.

ETHICAL DELIBERATIONS

After looking closely at the facts and data related to organ selling and trafficking, the CEC considered the values, professional ethics, and ethical principles involved.

Values. In any ethical deliberation, the values at stake need to be analyzed. Moreover, facts and values are often closely interlinked. Emotions should also be considered, because they influence judgments and perceptions of moral dilemmas, and are part of doctors' and patients' narratives. Moral action is rarely absolutely rational and principle-based; emotions, common sense, and intuition are also involved.[38] In the following paragraphs, the values of patients and doctors will be examined; however, further studies are needed on such narratives around the issue of transplant tourism.

Patients waiting for a transplant. Waiting times for renal transplants for ESRD patients are growing. Some patients die while waiting (6 percent in the U.S. and 2 percent in Québec).[39] Dialysis is associated with much suffering. Some patients are so exhausted from dialysis that they are driven to seek other alternatives, such as buying a kidney. Some patients told the transplant team that buying a kidney abroad is a "win-win" situation: they will be free from the constraints of dialysis and they believe the transaction will help someone who is poor. The transplant team felt that most of the patients were not adequately informed of the legal status of the transaction, the conditions of the purchase, the associated medical risks, and the potential consequences for themselves and the sellers. If patients who plan to buy a kidney abroad are not properly informed of the risks and the consequences of their action, can they really be held accountable?

Transplant physicians. During the meetings with the CEC, some members of the CHUM transplant team expressed distaste for organ buying, and saw it as an exploitation of poor and vulnerable people who thought they would benefit from selling their kidney — a situation that team members did not want to encourage. Since trust is a cornerstone of the doctor-patient relationship, some doctors felt deceived by those patients who did not tell them about their plans to buy a kidney. Some of them also felt betrayed when a patient went ahead with the purchase, despite their advice to the contrary. Nevertheless, members of the transplant team said they would not want to act as whistle-blowers. On the other hand, transplant physicians understood the suffering and exasperation of some of their patients on dialysis. Perhaps if they were in the same position, they would look into all the options, including buying an organ. However, the transplant team also knows that transplantation is not a panacea, and that it should be done in proper conditions with full knowledge of the associated risks.

Professional ethics. When physicians in Québec are faced with any type of ethical dilemma, one of the first documents they should consult is the Québec Code of Ethics of Physicians.[40] The Code of Ethics of Physicians was adopted by the Collège des médecins du Québec and the Québec legislature. The Collège des médecins du Québec is the medical professional corporation constituted by the Medical Act.[41] This act states, "All the physicians qualified to practise the medical profession in Québec constitute a professional order called the 'Collège des médecins du Québec' . . . ."[42] According to the act, the corporation and its members shall be governed by the Professional Code, which is the provincial regulation authorizing professional corporations to adopt a code of ethics and to oversee its application.[43] The mission of the Collège des médecins du Québec is to promote quality medicine and to protect lay persons, as well as supervise the

practice of medicine by its members. It is also in charge of granting the exclusive right to practice medicine, ensuring that its members are suitably trained and qualified.[44]

The regulations of the Code of Ethics of Physicians are legally binding, unlike the American Medical Association Code of Medical Ethics, for instance, which is an ethical guide, rather than a law. The Québec Code of Ethics of Physicians is subject to periodic review to ensure that it reflects social, cultural, and political changes in Québec society. A physician may not exempt him- or herself (even indirectly) from a duty or obligation contained in the Code of Ethics. However, the code might not be as helpful in regulating the doctor-patient relationship when the patient is on a waiting list for a transplant. In the Québec context, it appears that the actual therapeutic contract or agreement between a transplant physician and a patient begins only after the transplant has been performed. Before the procedure, the transplant medical team assesses the patient and decides whether or not she or he is a suitable candidate. There seems to be a tacit agreement between the medical team and the patient on the waiting list as to their respective obligations; for example, the transplant team commits to the agreement for as long as the patient remains a suitable candidate for transplantation. Therefore, the transplant doctor is not the treating doctor while the patient is on the waiting list; the treating doctor is the nephrologist in the referral center.

The code allows for conscientious objection on the part of a physician, but it does not present clear guidelines as to how or when this right may be exercised. In fact, if a doctor is feeling uncomfortable, based on moral or ethical grounds, to provide some form of treatment or procedure to the patient, she or he is allowed, under certain circumstances, to end the relationship and refer the patient to another physician. For example, a Roman Catholic physician who wants to refuse to perform an abortion has the professional and legal obligation to refer the patient and help her find another physician. In the meantime, the physician must assume responsibility for the patient until a new physician is found. Such conscientious objection must not be related to the nature of the patient's illness or to his or her standards of behavior. A physician may not, for instance, refuse to examine or treat a patient based on criteria that would be considered discriminatory such as race, sexual orientation, or political views. Physicians must also inform patients of their personal views and advise the latter of the consequences of not receiving professional care, when such care may be appropriate. In cases of emergency, however, physicians must provide assistance and care, regardless of their personal views.[45] If conscientious objection involves declining a treatment that the patient is entitled to receive — based on the physician's moral, ethical, or religious beliefs[46] — one might question whether a refusal to follow up on patients who purchased an organ abroad actually constitutes such a case. Is a patient entitled to receive elective follow-up care, considering that the commodification of bodies is illegal in Canada? The question is debatable.

That being said, one must realize the difficult situation that transplant doctors may find themselves in: on the one hand, they have the individual right to refuse to treat a patient based on their belief that buying an organ overseas is immoral, provided they inform the patient and help him or her to find another physician; on the other hand, they are obliged to treat in emergency situations — even though the patient may have made a deliberate choice to purchase an organ, with full knowledge of the risks involved. One may wonder, too, about the definition of "emergency": is this an acute rejection, an infection, or other life-threatening disease, such as a stroke or myocardial infarction? At what point does a health condition cease to be an emergency? What, if anything, becomes of a doctor's duties toward a patient from then on? Referring solely to the Québec Code of Ethics of Physicians remains an unsatisfactory method to resolve these quandaries and effectively support a doctor's natural response: to provide care and assistance to people who are suffering. *This response is a key imperative of the medical profession.*

As mentioned previously, doctors cannot discriminate against a patient, for example, by refusing to treat a murderer. Is refusing to treat a patient who bought an organ abroad discrimination of the same moral order as refusing to treat a murderer? This question was raised during discussions between the transplant team and the CEC. Of course, the situations are comparable, because the patient has done something illegal. However, in the case of the murderer, the doctor is not involved in the illegal act, whereas in the case of the organ buyer, the follow-up care of the transplant physician is directly related to the illegal act. Thus, by providing

care to a patient who has purchased an organ, the transplant team may be perceived as supporting organ trafficking and encouraging disadvantaged individuals to undergo a non-therapeutic intervention.[47] Also, ensuring the donor's safety and welfare is a golden rule in procuring organs from living donors,[48] but when the procurement is performed illegally or without any information or guarantees concerning the donor's condition, care, and safety before and after the procedure, it becomes a concern for the transplant community.

Thus, even though professional regulations offer some guidance, there are still many unanswered questions. For example, if the transplant team disagrees with the buying of organs overseas and informs all the patients on its waiting list, would it be legally and ethically acceptable to refuse to monitor the patient afterwards? Do the nephrologists in the referral centers have a role to play in preventing the purchase of organs overseas? Moreover, since there are not a lot of doctors who are involved in the field of renal transplantation, what happens if all of the doctors refuse to deliver follow-up care? As discussed previously, although these questions require answers, they would be more appropriately addressed through public debate.

Ethical principles. *Injustice and exploitation.* In the context of the physician-patient relationship, some nephrologists might feel uncomfortable with a patient suspected of buying an organ in the Third World, on the basis of the argument of injustice and exploitation of vendors. However, since it is difficult to prove such a suspicion, doctors do not want to play a policing role.

As discussed before, organ trading is considered exploitative in Canadian society[49] and organ trading is often criticized by Western intellectuals on these grounds. Some argue that permitting the sale of organs could help donors by giving them the money necessary to escape exploitation.[50] They also argue that we live in societies that allow economic disparities, so there is no breach of the principle of justice.[51] On the other hand, those opposed to the trafficking and marketing of organs also state that available research does not demonstrate that selling an organ leads to less exploitation (Indian and Iranian studies).[52]

The CEC feels that exploitation is a solid argument for prohibiting selling and trafficking. However, it is essential to better identify the values at stake and to propose a framework that goes beyond the exploitation argument, since this argument cannot serve as the sole basis for a doctor to refuse to treat a patient.

Commodification of the human body. Reification of the human body means viewing the body as a material resource in economic and market terms.[53] Selling and purchasing organs leads to reification of the human body by making human beings fungible and turning them into collections of spare parts.[54] This idea is criticized, mostly by American intellectuals who promote autonomy over all other ethical principles. For them, prohibiting the selling of organs undermines human dignity because it prevents the expression of autonomy. Since it is legal in some countries to sell either blood or ova, why would a kidney be any different?[55] One must then consider the invasiveness, risks, and consequences of a phlebotomy versus a nephrectomy.

The commodification of organs goes against the philosophy and principles of social solidarity underlying the Québec and Canadian healthcare systems, as demonstrated by the legal prohibition of the direct sale of gametes.[56] In addition, organ transplantation in Canada and Québec is based on altruism, not market values; it would thus not be surprising for nephrologists to condemn the purchase of organs and to refuse to be "party" to this act, as the human body should not be for sale.

Some have proposed conditions for an "ethical market" of organs.[57] It is beyond the scope of this article to address this issue, which should be the subject of public and governmental debate.

CEC RECOMMENDATIONS

FOR THE DOCTOR-PATIENT RELATIONSHIP

As the situation has been presented to the CEC, there are two problems to address:

1. The patient who is suspected of purchasing a kidney and undergoing transplantation abroad; and
2. The patient who is planning to do so.

The following recommendations must be understood in their social and cultural context, keeping in mind common understandings of the attributes of a "good" doctor, which include humaneness, diligence, consciousness, empathy, and professionalism. For the first problem, the CEC stated that it could be ethically acceptable for the doctors in CHUM's transplantation team who felt most uncomfortable with those patients to refuse to monitor them in elective clinics if they could confirm that another physician who specializes in renal transplantation would do so. However, in emergency situations, doctors cannot discriminate against patients and must provide care in accordance with the Québec Code of Ethics of Physicians.

For patients who are planning to buy an organ overseas and who inform a transplantation team of their intention, there are still many questions that need to be answered. Nonetheless, the CEC recommends that doctors inform their patients of their personal views on the matter, as well as the legal and medical consequences, for both themselves and the sellers, of buying organs. For the CEC, providing such information is one of the roles of the "good" doctor. It is also a way of ensuring the minimal requirements of informed consent, and could ultimately be a way to dissuade patients from going overseas to buy a kidney. Also, information on the purchase of organs abroad and the position of the transplant team on the issue must be communicated to all ESRD patients waiting for a transplant, thus helping them to make an informed decision.

Furthermore, doctors cannot refuse to treat these patients in emergency situations or in elective clinics, unless another doctor agrees to provide follow-up care, again in accordance with the Québec Code of Ethics of Physicians. Finally, the CEC should help doctors and transplant teams clarify their values and positions on the subject by giving them tools for the analysis of ethical issues.

FOR THE HOSPITAL AND THE TRANSPLANTATION COMMUNITY

For the CEC, it appears of the utmost importance that everyone involved in transplantation promote organ donation. An increase in organ donation will reduce the gap between supply and demand for organs, and the option of purchasing an organ abroad will not seem so attractive. Moreover, it is important that clinicians do not present renal transplantation as a miracle or a panacea to their patients. If patients are well informed of the risks and benefits (not only the benefits) of transplantation, they might not seek alternatives such as buying a kidney overseas.

The CEC also believes that organizations such as Québec Transplant, the Canadian Society of Transplantation, and other professional medical associations should lead the organ traffic debate, particularly regarding the consequences for Canadians who participate in it.

For the CEC, organ sale remains ethically unacceptable in the current context. Some clinicians disagree with this position. They condemn organ trafficking, but are open to an institutionalized organ market as a way to address the shortage. It is beyond the scope of this article to discuss the issue of an ethical organ market.

Finally, as noted previously, many issues raised by transplant tourism are beyond the purview of the CEC, as they require a public debate, with governmental and legislative involvement. The CEC obviously encourages all initiatives in this direction.

CONCLUSION

In conclusion, the question posed by the clinicians to the CEC — "What should we, as nephrologists, hospital staff, and the transplant community, do with Canadian patients who buy a kidney overseas?" — is extremely complex. All angles of this question need to be considered: legal, social, cultural, political, and ethical. However, for the CEC, the way this illicit organ market currently operates is unethical in the Canadian and Québec contexts.

Having offered these recommendations, there are still many questions that need to be answered. The CEC, for one, still needs a better understanding of the values of the doctors, medical teams, and patients waiting for a transplant with regard to organ trafficking and transplant tourism, as well as their perceptions of

the role they play in the situation. As we have seen previously, the CEC position on an organ market seems to differ from that of some clinicians. To better explore the position of clinicians on the issue of organ traffic and an organ market, the CEC or the hospital could encourage research projects aimed at gathering clinicians' narratives.

The CEC also recommends informing ESRD patients about organ trafficking. However, who should provide this information? What kind of information should be given? Is there a risk that such information might encourage patients to buy a kidney? Should the information target some cultural groups, considering the Toronto experience, which indicates that patients who bought organs overseas have a variety of cultural backgrounds? Furthermore, what should the role of CHUM be in this issue? For the CEC, these questions open up very interesting avenues for future research.

Finally, considering the nature of our public health system, and the way that resources are allocated and patients are referred for transplantation in Québec, the legal aspects remain to be detailed as to the different levels of responsibility, depending on whether a doctor is the "treating nephrologist" or the "transplant nephrologist." This might bring us to question the level of independence that physicians really have when they are confronted with the dilemma of treating patients who are involved in illegal acts. Also, the recent *Chaoulli* decision may affect the organization of the system and access to transplantation.

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