Editorial Comments

The development of the Declaration of Istanbul on Organ Trafficking and Transplant Tourism

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In this issue of *Nephrology Dialysis and Transplantation*, the Declaration of Istanbul on Organ Trafficking and Transplant Tourism is presented from a multicultural representation of the international community as a resolve to combat unethical practices that have been long standing. Organ trafficking, transplant tourism and transplant commercialism, which threaten to undermine the nobility of transplantation worldwide, became the subject of a summit convened in Istanbul from 30 April to 1 May 2008 by The Transplantation Society (TTS) and the International Society of Nephrology (ISN). The result of these deliberations was the *Istanbul Declaration on Organ Trafficking and Transplant Tourism*. The initial text of the Declaration was prepared by a multicultural Steering Committee, which issued the invitations to medical and scientific professionals, representatives of governmental and social agencies, social scientists, legal scholars and ethicist to participate. None of the 152 participants from 78 countries was polled with respect to his or her opinion, practice or philosophy prior to selection. The consensus achieved at the Istanbul Summit was remarkable.

The development of the Istanbul Summit and Declaration was derived from a direction by the World Health Assembly in 2004 when it adopted resolution WHA57.18 urging member states: ‘to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs’. As a consequence of the widespread shortage of organs and the increasing ease of internet communication, organ trafficking and transplant tourism have become global problems accounting for ~10% of organ transplants that are performed annually around the world. Vulnerable populations (such as illiterate and impoverished persons, undocumented immigrants, prisoners and political or economic refugees) in resource-poor countries have been a major source of organs for rich patient-tourists who are prepared to travel and can afford to purchase organs.

Although the WHA 2004 resolution was unambiguous in its objection to trafficking and transplant tourism, a comprehensive description of these unethical practices was still needed. Organ trafficking, transplant tourism and transplant commercialism are now comprehensively defined by the Declaration and it provides principles of practice based on those definitions. For example with regard to transplant tourism, not all recipients travel to a foreign country to undergo transplantation is unethical. Transplant tourism may be ethical if the following conditions are fulfilled.

*For transplantation from a live donor:*

- if the recipient has a dual citizenship (in the country of residence and also in the destination country) and wishes to undergo transplantation from a live donor that is a family member in the destination country of citizenship that is not their residence;
- if the donor and recipient are genetically or emotionally related and wish to undergo donation and transplantation in a country not of their residence to gain access to better health services.

*For transplantation from a deceased donor:*

- if official regulated bilateral or multilateral organ sharing programs exist between or among jurisdictions (countries) that are based on a reciprocated organ sharing programs between or among the jurisdictions.

The Istanbul Declaration notes the following: travel for transplantation is the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes *transplant tourism* if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centres) devoted to providing transplants to patients from outside a country undermine the country’s ability to provide transplant services for its own population.

The Istanbul participants emphasized that organ trafficking and transplant tourism should be prohibited because they violate the principles of equity, justice and respect for human dignity. The Declaration is also clear regarding the consequences of transplant commercialism. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should also be prohibited. To be effective, these prohibitions must include bans on all types of advertising (electronic and print), soliciting or brokering for the purpose of transplant commercialism.

At this time, most of the countries from which transplant tourists originate, as well as those destinations to which

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they travel to obtain transplants, are just beginning to address their responsibilities to protect their people from exploitation and to develop national self-sufficiency in organ donation. The medical leaders who played major roles in the promulgation of laws and regulations within the past 2 years in China, Pakistan and Philippines were participants in the Istanbul Summit meeting. The Declaration describes universal approaches to providing care for the living donor and also emphasizes the need for effective practices that support deceased organ donation.

The implications of the Istanbul Declaration definitions, principles and recommendations are profound. They call for a legal and professional framework in each country to govern organ donation and transplantation activities. They call for a transparent regulatory oversight system that ensures donor and recipient safety and enforces the prohibitions of unethical practices. Governments should ensure that the provision of care and follow-up of living donors be no less than the care and attention provided for transplant recipients. Professional societies should not continue to enable membership status for those individuals that violate the principles of the Declaration. Pharmaceutical companies and public and private funding agencies must affirm the Declaration in their consideration of clinical research support.

The Istanbul Declaration preserves the goodness of the act of organ donation without victimizing the poor of the world to be the targeted source of organs for the rich.

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Editorial comment with reply:
The continuing salt war: the final battle?

Salt intake and cardiovascular disease

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McCarron, in his review on salt [1], makes some serious and misleading mistakes. For example, he claimed that, in two of our own randomized double-blind crossover trials of modest salt restriction [2,3], we restricted potassium intake. This is incorrect and can be ascertained from a superficial reading of both papers. The average potassium intake on the individuals’ usual diet, as measured by 24-h urinary potassium excretion, was the same as that for the UK population. Secondly, there was no significant change in 24-h urinary potassium with a reduction in salt intake during the run-in period while individuals were on a reduced salt diet. Thirdly, not like McCarron implied, participants did not change their diet during the randomized crossover phase of the studies. Instead they took slow sodium and placebo tablets in a randomized double-blind crossover manner to achieve a difference in salt intake. There was no significant change in 24-h urinary potassium excretion throughout the studies. These results can be clearly seen in the table on page 353 of the first paper [2] and the table on page 1245 of the second paper [3]. Our studies, therefore, contrary to McCarron’s claims, clearly document that a modest reduction in salt intake lowers blood pressure in hypertensive individuals without any change in potassium intake.

Our results are strongly supported by the Dietary Approaches to Stop Hypertension (DASH)-Sodium study that is a similar well-controlled, but open, feeding trial where a reduced salt intake has a significant effect on blood pressure, not only on the usual American diet with no change in potassium intake but also on the DASH diet that is rich in fruits, vegetables and low-fat dairy products [4]. Our results are also supported by the Cochrane review of all of the longer term modest salt reduction trials, which demonstrates significant reductions in blood pressure both in hypertensive and normotensive individuals. Additionally, there is a clear dose–response relationship. A reduction of 6 g/day of salt intake would lower blood pressure