Where There Is Smoke There Is Fire: The Iranian System of Paid Donation

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Received 01 August 2013, revised and accepted for publication 28 August 2013

Nearly 30 years after its introduction, the Iranian model remains an enigma to the Western transplant community. Established in 1988, the government-funded, compensated living unrelated kidney donor program was Iran’s answer for its urgent transplantation needs. The modest fixed sum (currently about $400 US dollars) provided by the government was intended as a reward rather than as a payment for the donated kidney. The real incentive for those who have submitted to nephrectomy was a supplementary payment negotiated directly between the recipient and living donor (typically in the amount of $10 000 US dollars). Putative oversight by a not-for-profit organization maintains a buyer’s market by providing a back-up donor in the event that a recipient and potential donor cannot agree on a price. The government pays for all transplant-related expenses and provides the donor with medical coverage for 1 year after the nephrectomy. It is worth noting that such depictions of the Iranian model have been contested as disingenuous by members of the Iranian transplant community (1). Accordingly, one must interpret any analyses of the Iranian model with caution.

Predictably, critics of commercialization have opposed the program primarily out of concerns of exploitation and disrespect for human integrity (2,3). Aside from such opposition, the model fails to meet many of the proposed standards for a regulated system of organ sales, including nondirected donations, provisions to ensure long-term donor follow-up, and access to health care (4). Despite the facilitation of tens of thousands of transplants, the lack of public reporting and transparency have precluded acceptance of the Iranian model as a solution to the organ shortage internationally, and have fueled questions about the integrity of the program.

The report by Fallahzadeh et al (5) in this issue of the journal provides a novel glimpse into the Iranian model. The study shares many of the limitations of other studies from Iran, including a small and selected study sample. However, their identification of a difference in microalbuminuria postnephrectomy between paid and unpaid donors fuels concerns that the clinical evaluation of donors may be compromised when donor payments are allowed. Although the absence of prenephrectomy information precludes definitive conclusions, the short time since donation suggests that abnormalities may have been present prior to nephrectomy and accordingly, that the donor clinical evaluation may not have been as thorough as necessary. The potential presence of predonation abnormalities is worth considering given the ethical ramifications. A scrupulous pretransplant evaluation and conservative approach to donor acceptance may be particularly important for paid donors who may be vulnerable to adverse health outcomes for other reasons. Subjecting paid donors to unnecessary harms without sufficient safeguards in place during the evaluation process tips the delicate risk–benefit balance against living donation.

The most plausible alternative explanation for the findings is that the proteinuria was in some way related to the higher level of poverty in the paid donors. There is limited research to suggest a link between poverty and development of proteinuria in living donors. In a cross-sectional study of living related donors from Hyderabad, India, 40% of the 50 donors studied developed microalbuminuria, and 14% developed overt proteinuria (>300 mg/day) after an average of 63 months postdonation (6). Irrespective of the basis for the observed difference, it is not clear that the Iranian system will financially support the authors’ recommendation for long-term follow-up of the individuals who developed microalbuminuria in the study.

Sadly, the risk factors for and clinical significance of proteinuria in living kidney donors remain unclear. The existing literature on this subject is hampered by use of nonstandardized definitions, a paucity of controlled studies, and virtually no information regarding progression over time. Therefore, although it is tempting to criticize the lack of organized donor follow-up in the Iranian model, to do so...
would be hypocritical (7). The findings of this study therefore serve as a reminder of our collective responsibility to better understand the long-term consequences of living kidney donation.

The findings of Fallahzadeh et al (5) add to the accumulating literature that there are problems with the existing Iranian model and that the program must evolve. It is clear that the majority of paid donors are poor males, whose quality of life after nephrectomy is lower than that of the general Iranian population, and who are frequently dissatisfied with their decision to undergo nephrectomy (8). Further, the program has been a contributing factor limiting the advancement of deceased donation and living related donation in Iran. For these reasons, a program that was once justified on the basis of need, may now be a barrier to the advancement of transplantation in Iran. How much harm to living donors’ health and quality of life should Iranian transplant centers tolerate? As transplant centers are responsible for ethically sound clinical care, all potential living donors must be assured a high standard of clinical and psychosocial evaluation before the Iranian model can publicize its success.

As Fallahzadeh et al (5) point out, studies have found that few paid unrelated donors undergo follow-up care due to insufficient finances to pay for care, and donors lack knowledge about living donor complications or the need for follow-up care (9,10). Accordingly, transplant centers operating within the Iranian model should take extra care to optimally inform donors about the short- and long-term complications of living donation, as well as inform, encourage and enable living donors, particularly donors most at risk—paid unrelated donors—to undergo long-term follow-up care. The government’s provision of health insurance to living donors for 1 year is a start toward removing some of the disincentives to donation; however, the recognition of paid donors as a particularly vulnerable group behooves the government to provide long-term follow-up care.

Disclosure

The authors of this manuscript have no conflicts of interest to disclose as described by the American Journal of Transplantation.

References