The Challenges of Organ Transplantation in Egypt:  
A Religious, Medical, Ethical, and Legal Perspective

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Abstract:

Every 27 minutes someone in the world receives an organ transplant, while at the same time another patient dies while waiting for an organ to become available. Organ transplantation is a unique area of medicine because it involves more than just one individual patient, it involves three: i.e, the patient who is to receive the donated organ, the patient who will die as a result of not receiving a donor, and the organ donor. If this is not complicated enough there has been increasing concern expressed about the growing number of reports about medical personnel participating in the transplantation of human organs or tissues taken from the cadavers of executed prisoners; handicapped individuals; or, of poor individuals who have agreed to part with their organs for commercial purposes. Such behavior has been universally considered as ethically and morally reprehensible, yet the practice continues to flourish. The concept of justice demands that every person have an equal right to life. To protect this right, society has an obligation to ensure that every person, whether rich or poor, has equal access to medical care. Regrettably, the need for donor organs continues to outstrip availability. This market of organs for sale has subverted the medical ideal and resulted in economic factors being the primary factor in determining the use of a scarce societal resource. In other words, increasingly it’s the ability to pay that determines who receives a donor organ and economic need determining who would be motivated to sell their organs. As social workers and physicians it is important that we advocate on behalf of all patients, potential recipients, donors, and for those who are left out and not likely to receive a donor organ in an economic based system. A review of the current issues associated with this debate in Egypt will be discussed.
Introduction:

The number of patients throughout the world waiting for a donor organ is continuously increasing (Crowe, 2007). Although this may be due, in part, to the ongoing improvement in the medical management and longevity of patients with end-stage organ disease, the reality is that the waiting lists get longer while more patients die while awaiting a donor. Yet, there has been only marginal improvement in the availability of donor organs for transplant in either the United States or Europe. The latest numbers available from the International Society for Heart and Lung Transplantation suggest that the actual number of heart transplant procedures has declined in 9 of the last 10 years (1995-2005) because of the limited availability of needed cadaveric organs (Taylor et al., 2007). Regrettably, the same has also been reported for liver and kidney patients. Even though those individuals have the potential to benefit from both living or cadaveric donors, the number needing transplants far exceed their availability (Beholz & Kipke, 2007).

Although the US and European organ procurement systems are highly organized and legally sanctioned by their governments, they use different approaches in the securing of cadaveric donors and each face a similar shortage of organs. The US system is based on an “opt in” process whereby an individual must express their preference in writing to actually donate a donor organ on either a drivers license or through a document known as a living will. This compares with the European system which uses the concept of “presumed consent” or “opt out” (Gimbel, Strosberg, Lehrman, Gefenas & Taft, 2003). A process by which the organ procurement organization can “presume” that someone is willing to donate in the absence of a written declaration of refusal or “opt out.” Although the extent to which this is actually practiced may be open to debate, the differential approaches used by both the US and European organ procurement systems for cadaveric harvesting has not met the need for donor organs.

The process for the securing of organs becomes less clear when one considers the issue of living donor donation. The organ procurement systems do not control their use and few published studies exist clearly indicating the selection and use of living unrelated donors (Wright & Caan, 2003). This may be due to a unique aspect of living donation, in that, physicians must risk the life of a healthy person to save or improve the life of a patient with end-stage organ
disease (Truog, 2005). As a result wide variations exist in practice between centers which use living donors. It has been reported that the use of living donors has doubled the availability of certain organs, yet there remains a shortfall in every region of the world (Beholz & Kipke, 2007). In simple terms, a shortage of donor organs is the major limitation for any type of transplantation of patients with end-stage organ disease.

One approach to this shortfall which has received considerable international attention is the practice of harvesting the heart, lungs, or liver of executed criminals. It is believed that Confucianism and the dominant cultural ideal of returning to the ancestors with one’s own body intact led to the widespread refusal of the Chinese to harvest the organs from the cadavers of recently deceased relatives. There have been numerous reports from the press and scientific community about the Chinese use of organs from executed criminals (Smith, 2001; Gorman, 1998; Eckholm, 1995; Diffo, 2004; Becker, 1999). The British Transplantation Society reportedly believes that the majority of donor organs for British citizens who recently went to China for an organ donor continue to be harvested from executed criminals (Boseley, 2006). More recently, China has been reported to be a “Global Centre for Organ Transplant” (Clear Harmony, 2006). Although the veracity of the claims made by this source are sketchy at best, there remains concern regarding the exact source of donor organs in China (Beholz & Kipke, 2007).

China is not the only country who has been accused of what has been referred to as “transplant tourism”, terminology applied to any practice where patients with end-stage organ disease will travel to another country for the specific purpose of receiving a transplant. For 20 years multiple countries have been linked to both the securing and distribution of donor organs under such questionable circumstances (i.e., Brazil, Columbia, Pakistan, India, Bolivia, Turkey, Egypt, etc…) (Shimazono, 2007; Nagral, 2005; Kyriazi, 2001; Ram, 2002; Andre & Velasquez, 1988; Scheper-Hughes, nd; WHO, 2007). The US has not been immune from similar accusations. Cheney (2006) reported that as a result of a loophole in the Uniform Anatomical Gift Act of 1968 bones, tissues, joints, limbs, and even heads can and have been sold for profit.

Although rather cursory in its review, the above information gives the reader some hint about the complexity of the factors associated internationally with organ procurement and
According to the World Health Organization (WHO) (2007) there are three major issues which must be addressed by international organizations and governments when considering the issue of organ transplantation: “…the fundamental morality of functional body parts, the ethics of organ procurement, and the ethics of allocation. All of these issues involve social and moral controversy. In order to approach the establishment of ethical and health standards for organ transplant, one must consider several points. The morality of giving and/or receiving an organ is determined by each person’s religious beliefs and elicits a range of opinion concerning whether or not this exchange is ethical.” They went on to suggest that “procurement of organs broaches a border between moral duty with society and individual rights within society.” They also recognized that, “…the most sensitive issue of this conflict is allocation of organs which involves an indifferent distribution while maximizing the probabilities of graft survival.”

Using the WHO suggestions as a guide it is the purpose of this paper to review the existing literature regarding the current state of affairs within Egypt regarding the morality of the use of body parts, ethics of organ procurement, and ethics of allocation of donor organs. The authors hope that this work will serve as the basis for an ongoing collaborative effort which involves the religious, medical, academic, clinical, and political systems to help develop an organ procurement and distribution system that is ethically and morally appropriate to the Egyptian religious, medical, and social culture.

Current Egyptian Practice:

A Cairo paper recently reported the transferring of the case of two unemployed Egyptian men to the Religious Supreme Authority for the approval of their capital punishment verdict after having been found guilty of murder. They had solicited a kidney from a young man for 15,000 LE ($3,000 US) and after the organ had been harvested he was paid, but later they took him to the desert, stole the money and left him where he later died (Personal communication from Hussein Soliman, PhD, January 15, 2008). Regrettably, this is an all too frequent occurrence in Egypt. Bassoul (2008) has reported that numerous factors have indirectly supported a new form of “mafia” that is prospering in Egypt and turning the country into the regional hub for the human organs trade. He believed there were numerous factors (i.e., dire poverty, legal shortcomings,
and a plurality of religious interpretations regarding Islam’s support for transplantation) which were contributing to its existence. Even though there were no official statistics to support this claim, it was suggested that the absence of laws criminalizing the actions of “go betweens” who solicit and or traffic the organ has played a major part. Compared to the US and Europe where the buying and selling of organs is a criminal offense with fines of up to $50,000 and 5 years in jail, in Egypt, the worst a physician can expect is to lose their license, a license which some have regained through judicial means. The “go betweens” or broker’s actions are not considered to be illegal in most cases (Budiani, 2007).

Islamic bioethics derives from a combination of principles, duties and rights, and to a certain extent, a call to virtue (Daar et al., 2001). In large part ethical standards are an interpretation of the teachings of the Prophet Muhammad, and thus the interpretation of Islamic Law. Although Islam shares many foundational values with Judaism and Christianity, it too cannot be directly attributed to have one overriding belief or teaching. This helps explain how, according to Tober and Budiani (2007) there is a plurality of Muslim beliefs about the use of new technologies. “Unlike the role of the Vatican plays in the Catholic Church, there is no central authority in Islam. Rather, both national and local Muslim scholars interpret Islamic principles to establish sharia (Islamic law) and formulate fatawa (Islamic guidelines or opinions) based on these interpretations.” (pg. 4).

Organ transplantation is practiced in almost all Muslim countries (Daar, Khitamy & Binsumeit, 2001). Death is considered to have occurred when the soul has left the body, but the exact moment this occurs cannot be known with certainty. Death is therefore diagnosed by its physical signs. The concept of brain death was first accepted by a majority of middle eastern scholars and jurists at the Third International Conference of Islamic Jurists, in Amman, Jordan, in October 1986. Most, but not all, Muslim countries now accept brain death criteria. Egypt continues to be an exception and has no laws clarifying the use of this criteria in the diagnosis of death.

Until 1988 Islamic strictures within Egypt banned the donation of organs upon one’s death (Jehl, 1997). The announcement by the Grand Sheik of Al Azhar, Mohammed Sayed
Tantawi of his willingness to donate his organs to needy patients was the first recognition by a religious authority in Egypt of a Moslem’s faith allowing the act of organ donation after death (Budiani, 2007). Although receiving less attention, his initial edict left the medical community to decide the definition of what constitutes death. Hassaballah (1996) suggested that because of a lack of consensus about medical opinion regarding brain death the Egyptian Parliament had been reluctant to approve the necessary laws codifying acceptance of the concept of brain death in the 1990’s. Therein lies the problem because the debate continues in Egypt today about the use of brain death as criteria to harvest donor organs for transplantation. Although reportedly gaining momentum, there remains an absence of federal policies that address living donorship, religious authority, and the national Medical/Doctors’ Syndicate to provide the framework for the procurement and distribution of donor organs (Budiani, 2007).

Outside of Egypt those of the Muslim faith are more likely to accept the concept of brain death and do not see it as a prohibition based on their interpretation of the writings of the Prophet Muhammed. An example of this is the brochure which is published by the National Health Service in Britain declares that, “Muslim scholars of the most prestigious academies are unanimous in declaring that organ donation is an act of merit and in certain circumstances can be an obligation.” (NHS, 2003). It then gives the individuals phone numbers and weblinks to help get further information or help with the donation process. The most recent evidence suggests that the assertion of the NHS is more right than wrong, because brain death criteria has been legally sanctioned in the Republic of Iran and Kingdom of Saudi Arabia and most of the rest of the middle east.

Consistent with the experience of other countries, the Egyptian health care system there is a vast public-private dichotomy in the quality and types of services (Boydiani, 2007). This means that increasingly the availability of advanced medical procedures such as transplantation exists within a system where the majority of Egyptians struggle to receive adequate care. From a political perspective it seems that there are two schools of thought about whether or not organ transplantation is economically effective. From a cost-benefit perspective advocates for organ transplantation often emphasize their cost-effectiveness compared to the treatment of end-stage
organ disease. Such an approach was also used very successfully in the early 1980’s in the US to justify getting public and private insurance carriers to pay for organ transplantation (Paris, 1990). Also those physicians who support transplantation on the basis of the “economics” of the procedure tend to dismiss concerns over the exploitation of the poor and vulnerable as a source of organs within the current system and often put forth the notion that the establishment of a cadaveric transplant program is the key solution to the problem of marketed organs (Boudiani, 2007). The critics of this approach challenge the notion that transplant procedures are economically feasible on the grounds that such comparisons do not account for the life-long requirements of expensive drugs, follow-up treatments, and resulting medical complications.

In the words of Scheper-Hughes (n.d., as quoted in Boudiani, 2007), “The sobering reality of the commercialization of organs is one of the consequences of the context of transplants in Egypt, in which a large underclass is heavily relied upon to supply organs for those who can afford to purchase them. These practices persist, despite stipulations by religious authorities and the Doctors’ Syndicate that prohibit this exploitation, in the absence of federal policies. Some doctors in Egypt are directly involved in elements of commercialized transplants and many profit from the transplant enterprise; most are involved through an awareness of the likelihood of financial gifting to the donor. They generally do not play the role of the broker, nor does their involvement tend to entail criminal acts as locally understood, since each transplant is performed under a license. Passivity, denial, lack of awareness, dismissal of inquiry into processes of exploitation, however, do not avert culpability. Transplants that occur in the absence of a national organs procurement and distribution system, in the context of a lack of state accountability, and of a reasonably equitable and fair health care system, even if practiced by the most responsible of doctors, ‘can only represent an abomination, another form of violence’

Recommendations:

Given the current state of transplantation in Egypt the authors’ have identified three specific areas that they recommend to be addressed: legislative, education, and accountability. First and foremost, there is a need for the passage of brain-death legislation. In a democracy there will never be 100% acceptance of any new idea or proposal. Even in the US where brain
death has been the legal definition of death for many years there is still a segment of the population that does accept that as being true. Given the US organ procurement system has been in existence for 20+ years there are still people who will not donate their organs because they believe they will be harvested before they or their loved ones have died. The fact is that the preponderance of Muslim scholars support the use of cadaveric donation. This does not guarantee that every person will agree to donate, but the absence of legislation regulating the practice of cadaveric donation does not provide an opportunity for those who potentially would agree to do so.

In addition, legislative proposals will need to: 1) setup a system for cadaveric donation and distribution, which also oversees live donation; 2) criminalizing the buying, selling, and brokering of live organ donation; 3) holding any and all medical personnel, hospitals, or clinics accountable for any abuses to which they are a part; 4) placing either a moratorium or limit the number of foreign nationals being allowed to be transplanted in Egypt; and 5) not exporting donor organs to other countries for transplantation.

If enacted, legislative action will help to guarantee the equality of access and to reduce the abuses of the current practices. Only when there is a unified system for the procurement and distribution of donor organs will there be any potential to develop trust in the system. As is, the lack of action by the People’s Assembly guarantees the continued presence of what Egyptian citizens fear the most, a corrupt system that exploits the poorest for the benefit of the wealthy and famous.

The implementation of legislative programs will require significant public education programs before there is any chance for acceptable levels of Egyptian’s support. There must be increased public dialogue and discussion by those in positions of authority. This could be coupled with programs specifically directed through the medical, religious, and legal institutions with content directed to their areas of responsibility.

And finally, whatever system is created must make the provision for and the commitment to make everyone accountable for their actions. The current system does not hold the organ brokers accountable for their activities nor for the most part the physicians. As recent research
indicates, physicians are very aware of the buying and selling of organs used by their colleagues, yet they turn a blind eye to the practice (Boudiani, 2007). Is it any wonder there is such significant skepticism about both the current practice and reluctance to impose an organ donation system given the nature of current practices?

Muslim beliefs clearly teach against the buying and selling of organs. As is, the current system is indirectly being supported when the People’s Assembly refuses to act which guarantees the current immoral system will continue. The reluctance of the Physician’s Associations to be more proactive in addressing support of brain death legislation limits the availability of cadaveric donors which increases the demand for living donation. Although there may be some disagreement about the morality of organ donations, the majority of Muslim scholars have done their part by issuing Fatwas in support of the practice of it. But most importantly, in the absence of criminalization and accountability of the current practices it will be impossible to develop the trust necessary for any voluntary cadaveric or living organ donation system to be effective.
References:


