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The Bellagio Task Force Report on Transplantation, Bodily Integrity, and the International Traffic in Organs

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RECOGNIZING the need to define ethical standards for the international practice of organ donation, especially in light of abuses that undermine both the bodily integrity of socially disadvantaged members of society and the trust that must be integral to donation, a task force composed of transplant surgeons, organ procurement specialists, human rights activists, and social scientists met at the Rockefeller Conference Center at Bellagio, Italy. The Task Force examined the ethical, social, and medical ramifications of these problems and evaluated strategies to ameliorate them. The report and recommendations that follow represent the Task Force's effort to promote public trust in organ donation and to protect the well-being of all participants.

I. THE PROBLEM DEFINED

Over the past 30 years, organ transplantation has been transformed from an experimental procedure performed in a handful of tertiary medical centers in highly developed western countries to a therapeutic intervention carried out in hospitals and clinics worldwide. Kidney transplantation is now conducted in the United States, in most major European and Asian countries, as well as in at least 9 Middle Eastern, 6 South American, 2 North African, and 2 African countries. Over the next decade heart, liver, and heart–lung transplantation procedures are also likely to become standard in medical care.

Although 1-year survival rates for the graft vary by country and by the source of the organ (whether from a living person or a cadaver), 75% of the procedures are generally successful. To be sure, morbidity rates (from infection and hepatitis) are considerably higher in countries such as India and China (which generally use organs from living persons).[1] Despite such problems, transplantation is saving lives around the globe. Nevertheless, the extent and rapidity of the spread of the technology have intensified several critical concerns. First, supply has not kept pace with demand. Over the past 5 years the shortfall has become worse. With a few exceptions (most notably Belgium, Austria, and Spain), no country has sufficient organs to satisfy its citizens' needs. The scarcity affects countries west and east as well as north and south. The United States, despite a well-organized national distribution system, a succession of carefully crafted publicity campaigns, and a law requiring hospitals to request donation of organs from next of kin, still has 37,800 people on organ waiting lists. Annually, almost 10% of patients awaiting a heart transplant die because no organ is available.[2]

The gap between demand and supply is even more acute in countries where religious or cultural considerations inhibit organ donation. In the Middle East, religious precepts discourage and in places prohibit cadaveric organ donation. Islamic teachings emphasize the need to maintain the integrity of the body at burial, and although many religious leaders have sanctioned organ donation as a gift of life, others continue to object to the practice.[3] So too, some orthodox Jewish rabbis sanction cadaveric donation on the grounds of "pekuach nefesh," the need to save a life. However, others reject the principle of brain death (equating it with murder), thereby making organ retrieval almost impossible.

Asian concepts of bodily integrity, the respect due elders, and objections to a standard of brain death, practically eliminate cadaveric organ donation in such countries as Japan.[4] Despite an embrace of most medical technologies and deeply ingrained habits of gift-giving, transplantation from cadaveric sources is rare. Heart transplantation is not

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performed at all and the limited number of kidneys donated come from living related persons.[5]

Cultural barriers to donation are no less significant in western countries. In the United States, for example, 53% of families (in one recent study) refused to allow their dead kin to become organ donors. Taboos against dismembering a dead body are far more widely shared than commonly appreciated.

The shortfall in available organs has generated a desperate search for them. Many patients are prepared to travel national or international routes to secure a transplant. And they are so single-minded in their quest, that some of them are ready to put aside questions about how the organ was obtained.

This very scarcity has provided incentives to physicians, hospital administrators, and government officials in a number of countries to pursue ethically dubious strategies for obtaining organs. They are motivated less by a desire to meet the need of their country's patients than to secure payments from foreign nationals. Specifically, the world wide shortage has encouraged the sale of organs, nowhere more conspicuously than in India.[6]* It has also stimulated the use of organs from executed prisoners, nowhere more systematically than in China.[7] Thus, residents of Gulf States (eg, Kuwait, Saudi Arabia, Bahrain, Oman, United Arab Emirates) and other Asian countries (eg, Malaysia, Singapore) frequently travel to India to obtain a kidney.[8] Residents of Taiwan, Hong Kong, Korea, and Singapore go to mainland China.

The cost of the procedure in these countries is substantially below that of western medical centers (ranging from $15,000 to $20,000 for a kidney transplant, rather than $40,000 to $70,000). From the patients' perspective, the savings may not be nearly as important as the availability of the organ. But from the perspective of an Indian or Chinese health facility, the income that is earned through this traffic is substantial. (Indeed, foreign nationals travel to wherever there are organs available, including Europe and the United States, and make their payments directly to the hospitals.) Finally, the shortage has stimulated allegations, particularly in South America, of babies and children kidnapped and murdered for their organs. Many journalists as well as individuals are convinced that the ready market for organs has stimulated these abuses.[9] However incredible the charges may seem, they must be addressed in an overall effort to analyze and prevent abuses associated with trafficking in organs.

*The recently introduced transplant law in India declares the sale of organs illegal. It has been ratified in some states but not all. The law, however, has several critical loopholes, especially concerning live donors and it remains to be seen whether the legislative change will alter practice. ("Business as Usual," *India Today*, March 15, 1995, 176.)

II. THE SALE OF ORGANS

The purchase of organs from living persons or the provision of economic incentives to the kin of deceased donors, has been opposed by many international medical and human rights organizations.† In 1985, 1987, and again in 1994, the World Medical Association resolved: "The purchase and sale of human organs for transplantation is [sic] condemned."[10] The World Health Organization has found the sale of organs to violate the Universal Declaration of Human Rights as well as its own constitution: "The human body and its parts cannot be the subject of commercial transactions. Accordingly, giving or receiving payment- . . . for organs should be prohibited." The WHO enjoins physicians not to transplant organs "if they have reason to believe that the organs concerned have been the subject of commercial transactions."[11] The Council of Europe in 1987 also declared: "A human organ must not be offered for profit by any organ exchange organisation, organ banking centre or by any other organisation or individual whatsoever."[12] And the International Council of the Transplantation Society unequivocally insists: "No transplant surgeon/team shall be involved directly or indirectly in the buying or selling of organs/tissues or in any transplant activity aimed at commercial gain."[13]

Despite the unanimity that commercialization is unethical, the international proclamations do not address several pivotal concerns. First, they fail to provide a rationale for their position. The declarations are put forward in one or two terse sentences with no supporting arguments.[14] Second, they contain no provisions for enforcement, no consideration of how these policies should be implemented or what penalties ought to be imposed for violations. The World Medical Association, for example, "calls on the governments of all countries to take effective steps to prevent the commercial use of human organs."[15] The WHO states: "The method of prohibition, including sanctions, will be determined independently by each jurisdiction." The Transplantation Society does declare that violating its guidelines on commercialization "may be cause for expulsion from the Society." However, its language is discretionary ("may be" not "shall be" cause), and fails to establish a process for investigation and discipline.

To the framers of the resolutions condemning organ sale, the practices seemed so corrupt and demeaning, the commercialism so rampant, that the reasons for a blanket prohibition appeared self-evident. To judge by the preamble to the World Medical Association 1985 resolution, for example, its authors were dismayed by news stories, emanating mainly from India, describing the abuses to which lower class and lower caste populations were exposed. Brokers were bringing together potential donors and recipients, arranging payments, taking large commissions, and

†Persons who sell their organs are commonly described as "living donors," but of course, they are not donating their body parts but selling them.

bilking the poor of the sums due them.[16] Opponents also feared that commercialization would promote substandard medical care, through the incompetence of the physicians or the poor quality of the organs.[17]

The grounds for condemning the commercialization of body parts are not as obvious as these declarations imply. One question is whether a system of sale which is both regulated and transparent is also unethical; in the words of one Task Force member, can one find room for "rewarded giving," wherein the act retains something of the quality of a gift although money does change hands.[18] Accordingly, the Task Force considered whether a distinction should be made between acceptable and unacceptable forms of payment, and if so, where the line should be drawn. Second, the Task Force asked whether the failure to honor a contract of sale or the commercialism itself violates social values. Third, is the distinction between payment for an organ to live unrelated persons or to families who agree to the procedure for a deceased kin ethically meaningful? Should sale be banned in the first case but some modest economic rewards allowed in the second? Finally, would commercialism put the poor at still greater disadvantage because they would be unable to afford the market price for an organ?

The more deeply the Task Force examined the sale of organs, the more complex the issue became. For example the sale of body parts is already so widespread that it is not self-evident why solid organs should be excluded. In many countries, blood, sperm, and ova may be sold. So too, an international trade exists in cadaveric body parts for medical education and research and pharmaceutical companies purchase large quantities of tissue for commercial purposes. Other companies openly purchase and sell tissue such as dura matter and fascia lata.[19]

The counter-argument that unlike solid organs, blood and sperm are self-renewing body parts is not telling, for if the risk to health in selling one kidney is truly minimal (which it is, at least in developed countries[20]), then much of the relevance of the distinction disappears. By the same token, on what grounds may blood or bone be traded on the open market but not cadaveric kidneys?

Prohibiting the sale of organs from living persons because of past illegalities does not resolve the question of whether a fair and open commodity exchange system would be ethically acceptable. Would a trade in organs be acceptable if it were government supervised, banned private bidding or black market maneuvering, established set prices for organs, and made certain that sellers or relatives received the compensation due them? Indeed, would a market transaction be more acceptable if the organs purchased were then distributed equitably, based on medical need not the ability to pay? After all, transplantation now is hardly a commerce-free transaction. Hospitals, surgeons, organ retrieval teams, and procurement organizations regularly sell their services. Why should the source of the organ be the only one not financially rewarded?

Note, too, that Belgian and Austrian hospitals do not send available organs abroad but require patients to come to their institutions, in part because they want their hospitals and physicians to receive the fees.[21] Transplantation, in other words, is already a financially rewarding practice.

Moreover, the movement in favor of commercialization is steadily gaining strength, as demonstrated by the number of commentators who argue in favor of organ sale.[22] A committee of the American Medical Association recently approved a proposal to establish a "futures market" in organs from deceased persons.[23] Commercialization is also appearing under the guise of rewards for families that agree to donation.[24] Hospitals, foundations, and private individuals are providing such families with compensation for burial expenses; the state of Pennsylvania recently established a fund to pay families of organ donors $1000 for these expenses.[25] These innovations pose the problem of where and why one draws lines around financial rewards for organ donation.

The Bellagio Task Force weighed all these considerations and found no unarguable ethical principle that would justify a ban on the sale of organs under all circumstances. It also appreciated that a prohibition on sale might well cost would-be recipients their lives and infringe in important ways on the autonomy of would-be sellers. Outsiders may not be in a position to make decisions for those who may have to choose between grinding poverty on the one hand and the sale of a kidney on the other.

To strike a balance among these concerns, the Task Force proposes that, at present, a two-pronged policy prevail. The ban on the sale of solid organs from live unrelated donors should be continued; at the same time, experimentation with (and close evaluation of) programs to reward families of donors of cadaveric organs should proceed. Although some Task Force members have a principled objection to commercialization—believing that a progression from sale of blood to sale of solid organs is inimical to human dignity—the entire Task Force agreed that the abuses of commercial arrangements as they exist today supply the underpinning for its recommendation against organ sale from living donors.[26] In the opinion of the Task Force, present abuses are so grave that the self-determination of would-be sellers of organs must be curtailed to protect the most vulnerable.

The Task Force concluded that existing social and political inequities are such that commercialization would put powerless and deprived people at still graver risk. The physical well-being of disadvantaged populations, especially in developing countries, is already placed in jeopardy by a variety of causes, including the hazards of inadequate nutrition, substandard housing, unclean water, and parasitic infection. In these circumstances, adding organ sale to this roster would be to subject an already vulnerable group to yet another threat to its physical health and bodily integrity.

Because persons selling their organs would be drawn exclusively from the economically deprived, regulation can not prevent fundamental abuses. Transparency and fairness can not be assured. For example, the absence of systematic data on who sells their organs in India reveals how unreg-

ulated and susceptible to manipulation the entire process is. To be sure, a ban on sales might drive the enterprise further underground. But as described below, a permanent monitoring body would counter the effects of such a change.

Even in developed countries, the sale of organs from living persons would lend itself to abuse. One can imagine a revamped social welfare system in which organs are assets that can be sold before a person is eligible for public relief. In all, inequities in political power and social well-being remain so profound and the poverty and deprivation so extreme, that the voluntary character of a sale of an organ remains in doubt. Nor does the fact that economically deprived persons must now accept risks that others may refuse (such as working in dangerous occupations), justify adding yet another danger to those they already confront.

At the same time, the Task Force is persuaded that some incentives should be in place for families of deceased organ donors. For one, a firm line can be maintained, between cadaveric and live donation, reducing the likelihood of moving down a slippery slope. For another, payments for cadaveric organs do not promote the same potential abuses; although the poor would still feel greater pressure to seek these benefits, families from all social classes might be prepared to accept them. There is the risk that families might be more willing to agree to terminate treatment because of the prospect of a financial return. But the fact that termination decisions generally occur in the context of a hospital with the participation of a number of health care providers reduces the risk.

Thus, the Task Force favors the design and implementation of incentive programs to learn whether they generate higher percentages of agreements to donate and are free of abuse. The arrangements must be scrupulously regulated and supervised to guarantee that the sums are kept relatively modest (more of a reward than a bribe), and that no undue pressure is exerted on the families. In this way we will learn whether rewards to the next of kin can increase rates of donation and not bring adverse cultural and social consequences.

III. ORGANS FROM EXECUTED PRISONERS

The use of organs from executed prisoners, like the sale of organs, raises profound concerns about the vulnerability of socially disadvantaged members of society (who constitute the majority of persons so punished). The practice is not followed in the United States and western European countries, but the reasons for not using these organs have not been made explicit.

Existing international declarations demonstrate notable inconsistencies. The World Medical Association in 1994 noted "the increasing number of reports of physicians participating in the transplantation of human organs or tissue taken from the bodies of prisoners executed in application of a death sentence without previously obtaining their consent or giving them the opportunity to refuse." It condemned the practice and called upon national medical associations to "severely discipline the physicians involved."[27] But its resolution left open the possibility of using organs from executed prisoners if informed consent had been obtained, without any discussion of whether death row prisoners were in a position to give informed consent. The WMA failed to consider whether consent in the shadow of an execution chamber was meaningful.

So too, the June 1977 Protocol One Additional to the Geneva Conventions of 1974–1977, bans the use of organs from prisoners of war. "The physical or mental health and integrity of persons who are in the power of the adverse Party . . . shall not be endangered by any unjustified act . . . . It is prohibited to subject the persons described . . . to any medical procedure which is not indicated by the state of health of the person concerned." Specifically, the Protocol declares: "It is, in particular, prohibited to carry out on such persons, even with their consent . . . removal of tissue or organs for transplantation."[28] But the Protocol allows two exceptions, namely, "the case of blood for transfusion or of skin for grafting, provided that they are given voluntarily and without any coercion or inducement."

The apparent rationale for the exceptions is that under conditions of war, making blood and tissue available from captured soldiers would enable medical officers to transfuse and perform skin grafts on the wounded. But in carving out these two exceptions, the Protocol accepts the premise that prisoners of war are capable of giving consent—which then raises the question of why they may consent for fluid and blood but not for solid organs? What makes kidney donation different? Is it a concern for the future health of the donor, or the invasiveness of the procedure, or the potential for abuse? The Protocol also fails to address policies toward mortally wounded prisoners of war. May they consent to the use of their organs after death? Undoubtedly, the Protocol overlooked these issues because in 1977 transplantation was still highly experimental and such questions seemed too speculative. Now, almost 20 years later, they must be explored.

In light of the acute shortage of organs, it is not difficult to marshall arguments in favor of using executed prisoners (or mortally wounded combatants) as donors. Since the execution and death will occur anyway, why "waste" the kidneys and heart? Since the state has the legal right to execute the prisoner, surely it may remove organs for so socially constructive a purpose. Moreover, donation can provide recompense for past misdeeds. The criminal has the opportunity to redeem himself through this act.

Nevertheless, the Task Force concludes that objections outweigh benefits. First, securing organs from executed prisoners entails a process that is hidden and, therefore, subject to gross abuse. Conditions intrinsic to incarceration (the difficulty of penetrating behind closed walls), make this exceptionally difficult to accomplish. The situation in many jurisdictions may not be as extreme as that in China, but the problems that arise there speak clearly to the larger concerns.

In 1984, immediately after the appearance of cyclospo-

rine, China enacted "Rules Concerning the Utilization of Corpses or Organs from the Corpses of Executed Prisoners." It provided that corpses or organs of executed prisoners could be harvested if no one claimed the body, if the executed prisoner volunteered to have his corpse so used, or if the family consented. In the latter case, officials were to discuss "the scope of the use of the corpse, method and cost of disposition after use, and financial compensation," the two issues here joined. The 1984 law then stipulates:

> The use of the corpses or organs of executed criminals must be kept strictly secret, and attention must be paid to avoiding negative repercussions . . . . A surgical vehicle from the health department may be permitted to drive onto the execution grounds to remove the organs, but it is not permitted to use a vehicle bearing health department insignia or to wear white clothing. Guards must remain posted around the execution grounds while the operation for organ removals is going on.
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> In Han regions the corpses and organs of executed criminals of minority nationality shall in principle not be used. In regions where there is a concentration of minority nationalities, the funerary customs of minority nationalities should be respected when implementing these rules.[29]

The two paragraphs suggest that even to its framers, the procedure lacks an ethical basis. That the provisions must be kept secret, that no white clothing is allowed, that guards must remain on duty, and that minorities are exempted may well reflect the fact that such a policy violates fundamental cultural principles. Indeed, Chinese officials have not publicly professed to the practice and interviews with Chinese transplant surgeons invariably bring denials of any knowledge.[30]

Why then was the 1984 law enacted? Probably because the returns are great, not in terms of the health of the population but in bringing foreign capital to local hospitals and officials.[31] The precise number of prisoners executed in China is not known, but some 2000 executions are reported in the country's newspapers and organizations such as Amnesty International believe that the total may be four to five times greater. With thousands of organs available (almost on demand), Chinese hospitals are able to schedule procedures for citizens coming from surrounding countries, and reap the financial rewards.[32]

The covert character of the activities belies the claim that the voluntary consent of the prisoner is obtained. The notion that someone on death row can give meaningful consent to a procedure—particularly when death row is a miserable hovel in a local jail and the prisoner is kept shackled—is in itself very difficult to accept; add to that the exceptional secrecy that envelops the process, and the claims for consent become still weaker. Were consent meaningful, there would be no need to set forth elaborate procedures for concealment or to exempt minorities from the law.

Using executed prisoners for donors also subverts the ethical integrity of the medical profession. Although eyewitness accounts of executions and organ retrieval in China are not available, the process may well duplicate that followed in Taiwan between 1987 and 1994 (when the practice was banned). In both cases, execution is by gunshot and the need to protect and preserve the organ, critical. Accordingly, in Taiwan the physician sedated and intubated the prisoner and inserted an intravenous line prior to execution. Immediately after the prisoner was shot (in the head), the physician stemmed the blood flow, put the prisoner on the respirator, and injected compounds to raise blood pressure and cardiac output so as to keep the organs perfused. In this way, the physician became an intimate participant in the execution process, functioning not to preserve life but to manipulate death in the service of transplantation.[33] However acute the need for organs, physicians should not become accessories to the executioners.

The ethical objections to using prisoners for donors are present everywhere. In the United States, for example, condemned prisoners would have to calculate whether agreeing to donate would help persuade a governor to grant clemency, on the grounds of good character, or hurt their petition, because the governor would be eager to make their organs available. Where capital punishment is invoked more sparingly than in China, the possibility arises of juries convicting for the sake of organs. For all these reasons, the Task Force rejects the use of organs from executed prisoners.

IV. ALLEGATIONS OF KIDNAP AND MURDER FOR ORGANS

Rumors of trafficking in organs from murdered children have been circulating for some ten years, with incidents allegedly having occurred in Honduras, Guatemala, Argentina, and Brazil. The allegations have been put forward not only by newspaper and video journalists but by a wide variety of national and international public officials. The rapporteur for a committee of the European Parliament recently charged: "Organized trafficking in organs exists in the same way as trafficking in drugs . . . . It involved killing people to remove organs which can be sold at a profit. To deny the existence of such trafficking is comparable to denying the existence of the ovens and gas chambers during the last war."[34] So, too, the United Nations special rapporteur "On the Sale of Children . . . " is so certain the practice is widespread that his 1992 "Questionnaire Relating to the Sale of Children's Organs," asked governments: "The sale of children is mainly carried out for the purposes of organ transplantation. To what extent, and in what ways and forms, do these violations of children's rights exist in your country? Please describe."[35]

The Task Force finds no reliable evidence to substantiate these contentions. Not one documented case exists of murder or kidnap or sale of children for their organs. Indeed, each purported case, including that presented "Baby Parts", produced under BBC auspices, has been effectively rebutted.

A hypothetical case has been made for the reality of organ theft, based on the supposition that because a market exists for a commodity in short supply, an illegal trade to satisfy it must also exist. The obvious analogy is to the illicit

drugs trade.[36] But the comparison is not apt for it ignores the countervailing medical realities of organ retrieval and transplantation. To remove a kidney for transplantation requires an operation of several hours in a sterile environment, carried out by skilled specialists; these needs will not be met in rural villages or covert settings. Thus, the technical requirements of transplantation, as well as existing national registries of where organs originate and to whom they go make the charges illusory.

Nevertheless, the Task Force believes that the persistence of the allegations reflects causes that go deeper than a pervasive anxiety about conditions of modern life. More is at stake than what one observer has labelled the persistence of an "urban legend"; rumors of organ theft are not at one with tales of unidentified flying objects or of pets exploding in microwave ovens. Rather, these stories of violations to bodily integrity are, in the words of one Task Force member, "metaphorically true, operating by means of symbolic substitutions."[37] They draw their inspiration, particularly in South America, from a long history of abductions, mutilations, and death under the rule of military regimes. In Argentina, babies and children were frequently kidnapped and passed on to military families. In Brazil, it was (and is) not unusual for street children to be gunned down in a paramilitary action. The bodily integrity of the poor is also threatened in more ordinary situations. Rural villagers quite literally disappear when they enter municipal hospitals, not to be found when their families come to visit. Even burial does not protect the body of the poor. After a year or two, if the family lacks resources, the corpse will be disinterred and consigned to a common pit.

There is also considerable evidence that infants and young children are kidnapped for the adoption market. The allegations about "fattening houses" for children to be adopted from Guatemala and Honduras are compelling—although some of these children may have been sold by desperate parents, not actually kidnapped. At the same time, older girls and boys are sold or kidnapped (again the relative percentages are unknown) for the sex trade. Thus, if children are abducted for adoption or for sexual exploitation, it seems logical to conclude that they are abducted also for their organs. Although this charge has not been proven true, it does contribute to a more general suspicion of organ donation and transplantation.[38]

V. OTHER TASK FORCE RECOMMENDATIONS

In light of these substantive recommendations and the issues raised by the traffic in organs, the Task Force sees a critical need for the establishment of a permanent monitoring body.[‡] In light of real and potential abuses in the process of retrieving organs, the lack of substantive analysis in existing international declarations, and the absence of procedures and mechanisms to implement the declarations, the Task Force recommends the creation of an international human donor surveillance committee to conduct the following activities:

1. To serve as a clearing house for information on organ donation practices.

At the moment, neither the health care profession nor other concerned international bodies (including the media) has a central source for information on organ donation policies and practices. Whether the issue is ethical, legal, or social, no single constituted body has the critical data readily available.

To meet these needs, the surveillance committee would carry out and publish an annual survey of organ donation practices, country by country, so that the facts of the international situation are known and receive full publicity. The survey would rely upon reports from corresponding members in each country to provide factual information on the numbers and types of transplants; the size of the waiting list; mortality on the waiting list; organ donation practices, including changes in the legal basis for donation; the demographics of organ donation, including the social composition of donors; the barriers to organ donation, cultural as well as political, and proposed solutions, so that different countries may learn from each other's policies.

The monitoring body would also produce an annual report on how organ donation practices affect vulnerable populations. The reports would provide information on countries using organs from executed prisoners or countries using donation as a means by which convicted criminals can reduce prison sentences; countries allowing the sale of organs, and the conditions, if any, that they impose; and purported incidents of abuse, including stories of children kidnapped for organs.

2. To produce an annual review of declarations by international transplant and human rights groups on organ donation and examination of emerging ethical issues in donation.

3. To propose recommendations to medical and human rights groups of strategies to gain acceptance, adoption, and enforcement of international standards.

The committee would consider and advise on mechanisms by which national and international bodies might implement their declarations, including appropriate sanctions for countries, medical associations, and individuals who violate them. The committee must be able to offer findings, propose strategies, and monitor compliance free of political pressure.

In sum, an international human donor surveillance committee, by providing ongoing reports on practices, investigating particular incidents, and serving as a clearing house for information, would advance medical needs and human rights. The Task Force is persuaded that this information will affect both national and international policies and the behavior of physicians. The light of publicity will help to

[‡]This proposal was initiated by Task Force member Bernard Cohen, from the Netherlands, who first presented this concept to the August 1994 Meeting at Kyoto of the Ethics Council of the Transplantation Society.

sanitize practices precisely because medicine is international in character and heir to powerful ethical principles.

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