
Foreword

Living donor kidney transplantation was first performed in Paris in 1953 by Jean Hamburger and his team. The development of renal transplantation as a clinical field over the next 20 years was highly dependent on the use of live donor kidneys. During most of these two decades, organs from deceased donors could be obtained only after cessation of heartbeat and respiration. Consequently, observations in recipients of the ischemically compromised deceased donor grafts were so variable that definitive conclusions about immunosuppression and tissue typing were reached primarily by studies of live donor kidney recipients.

Live kidney donation was no secret and aroused surprisingly little negative reaction from the public. It was, however, a divisive issue within the medical profession because live donation potentially placed healthy people in harm's way and therefore appeared to violate the deep-rooted tradition of *primum non nocere* (first do no harm). It was essential to develop agreement within the medical profession on the probity of the practice. A kidney-specific consensus about living donor transplantation was reached by the early 1970s following a series of ethical-medical conferences and publications.

A seminal question from the beginning was 'what conceivable benefit was there for the previously healthy live donor?' A defensible way out was found at the ethics conferences and in law courts with the argument that the fullness of the donor's emotional life and welfare was often dependent on that of the recipient. Under these circumstances, the long-term benefits to the donor could be viewed in many cases as equivalent to those of the recipient. This was most frequently obvious when the transplantation was between family members. In addition, it began to be

argued by the mid-1980s that live kidney donation had to be considered in the context of society's needs.

In the social context, emerging pivotal problems had been caused by a rapidly growing but unmet need for transplantable kidneys; a long list of transplant candidates on long-term dialysis were waiting in vain for organs. At an administrative level, the fiscal viability of transplant centres frequently depended on a supply of live donor organs. It was feared that closure of the handmaiden transplant programmes would inhibit the homogeneous diffusion of end-stage renal disease care into national health care systems. From the perspective of 'group ethics', it was argued by some that the death of one volunteer per 2000 donations was a statistical non-event in relation to the life years saved.

In more recent times, the use of live donor kidneys has increased dramatically, while the concept of volunteer donation has extended to the liver and other non-renal organs. Support for live-donor liver transplantation (LDLT) was built on the same ethical-social base as kidney transplantation by regulatory and oversight committees at the University of Chicago. Publication of the Chicago LDLT proposal in a 1989 issue of the *New England Journal of Medicine* helped launch LDLT programs that revolutionised the treatment of children with biliary atresia and other hepatic disorders.

At first, LDLT was employed mainly in Asian centres, where deceased donation did not exist, and was used almost entirely for the treatment of children. By the mid-1990s, however, LDLT for adults was begun. Worldwide experience in various liver donor operations rapidly accumulated until it was recognised that the donor mortality was many times greater than that of kidney donations, and that the highest donor risk was with right lobar LDLTs. Inevitably, other kinds of non-renal living donor transplantation have emerged: pancreas, lung and intestine.

It is apparent that non-renal live donor organ transplantation is on the same developmental path as that of blood transfusion in the first half of the 20th century, and kidney and stem cell transplantation in the last half. With the kidney and the non-renal organ procedures, the principal concern has been the physical and emotional health risk to the live donor. The risk-benefit ratio, as this applies to both donors and recipients, has

yet to be finalised for living donor liver, lung, pancreas (or islet) and intestinal transplantation.

In this text, the editors have compiled a series of chapters about all these procedures. Because the chapters were written by pioneer proponents of the different kinds of transplantation, the resulting slender book has the weight of authority, and will be a valuable resource to anyone interested in developing a global view of the ethics and practice of transplantation.

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