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Stateless Crimes, Legitimacy, and International Criminal Law: The Case of Organ Trafficking

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Organ trafficking—coercion for the purpose of removal of organs (United Nations 2000; GTZ 2004)—is recognized as a significant international problem. Yet unlike sex trafficking or trafficking in children, it is largely left out of international criminal law regimes and to some extent of domestic criminal law regimes as well. It does not come within the jurisdiction of the ICC, except in very special cases such as when it is conducted in a manner that conforms to the definitions of genocide or crimes against humanity. Although the United States Code characterizes trafficking as "a transnational crime with national implications," (22 U.S.C. § 7101(b)(24) (2010)), it is rarely prosecuted in domestic courts. It has thus functioned in practice largely as what might be judged a "stateless" offense, out of the purview of both international and national courts. Yet organ trafficking remains widespread—and devastating to those who are its victims.

In this article, we begin by describing what is known about the extent of organ trafficking. We then critically evaluate how and why such trafficking has remained largely unaddressed by both international and domestic criminal law regimes. This state of affairs, we argue, presents a missed chance for the legitimacy of international criminal law and an illustration of how far current international legal institutions remain from ideal justice.

Organ transplantation, transplant tourism, and organ trafficking

Organ transplantation is recognized as an effective therapy for end-stage organ failure. Its use is widespread across the globe; according to the World Health Organization (WHO),

kidney transplants are carried out in 91 countries. (Shimazono 2007) Currently, about 100,000 solid organ transplantations are performed yearly worldwide; in 2007, there were 68,250 kidney transplantations, 19,850 liver transplantations, 5179 heart transplantations, 3245 lung transplantations, and 2797 pancreas transplantations. (Matesanz 2009) In the United States, according to the latest data available in February 2010, 26,095 transplants were performed in the first 11 months of 2009 (OPTN 2010). In China, 164 medical institutions have licenses to perform organ transplants; up until 2009, China had carried out over 86,500 kidney transplants, over 14,500 liver transplants, nearly 900 heart and lung transplants, and more than 220 transplants of other organs.

At present, the demand for organs far outstrips the supply. In 2007, only 21,489 deceased donors were reported to the Global Database on Donation and Transplantation. (Matesanz 2009) In United States, as of the end of February 2010, 105,966 patients were on waiting lists for transplantation. (OPTN 2010). In the United Kingdom, an estimated 9,000 patients need an organ transplant at any given time but only 3500 transplantations were carried out in 2008. In July 2009, the UK announced plans to ban private patients from paying for organ transplants in order to address concerns about fairness of the allocation system—and to allay complaints that patients from abroad were coming to the UK to receive transplants as private pay patients. (Weaver 2009) In the European Union, according to a 2007 Communication from the European Commission, there were 40,000 people on the waiting list for transplants; an estimated 10 people in the EU die every day waiting for an organ. (Shimazono 2007) Although it is estimated that 1.5 million Chinese patients need organ transplants, only approximately 10,000 operations take place annually because of the severe shortage of organ donors. (Paddock 2009) With the aging of

populations worldwide, increased affluence, and growth in burdens of disease such as diabetes, demand for transplantation is increasing exponentially. (Jafar 2009)

Transplantation of organs is thus a life-prolonging, last resort therapy for many; but there is a grave mismatch between supply and demand. Donation rates vary widely; for example, within the EU, Spain has a donation rate of 34.6/million and Romania a donation rate of 0.5/million. (Europa 2008) Many countries are only now instituting regularized systems for organ donation and allocation. Proposals to increase the supply of organs include adoption elsewhere of the presumption of consent in effect in Spain. They also include strategies of paired donation, in which patients with willing donors who are not matches for them can link up with other likewise unmatched pairs to trade for matches, and the use of biobanks to identify possible matches for patients. (Forsberg, Eriksson, and Hansson 2010) Proposals to allow sale of organs (Hippen, Ross & Sade, 2009; Satel 2008) are more controversial for many reasons, including increased risks of trafficking. (Rothman & Rothman, 2006) Under these circumstances, it is understandable that patients engage in strategies to obtain organs from outside of their home jurisdictions, including both medical tourism and the purchase of organs.

So-called "organ transplant tourism" occurs when potential organ recipients cross national borders to undergo organ transplantation. Medical tourism generally occurs for many reasons, including the comparative quality of care at home and abroad, unavailability or unacceptable waiting times for care at home, and relative costs of care. Growing rates of medical tourism raise concerns about justice to patients in both home jurisdictions and jurisdictions in which the care is provided, about the ability of home jurisdictions to maintain cost and quality control over the care patients receive, and about the adequacy of informed consent across borders. Bioethicists in countries such as India voice concerns about internal

brain drains and diversion of resources. (Gupta 2008) Yet medical tourism seems only likely to grow. Uninsured patients in the United States may seek care abroad because it is far less expensive; although Medicare generally does not cover care received outside of the United States, some U.S. insurance programs now offer patients incentives to seek out cheaper care providers abroad. (Cohen 2010) The Joint Commission on the Accreditation of Healthcare Organizations has an international division, and many facilities in countries such as Brazil, China, India, Malaysia, the Philippines, Saudi Arabia, Singapore, Thailand, and Turkey feature such JCI accreditation. (JCI 2010) Countries such as India openly encourage medical tourism (Gupta 2008), and the global availability of medical services is widely advertised across the web.

Tourism for the purposes of organ transplantation raises particular concerns, however, especially when the organ donor does not come from the patient's home country. Patients seeking transplants abroad may encounter poorer quality of care and greater risks of infection including Hepatitis B, HIV, Aspergillus, and fungal sepsis. Such very sick patients require extensive care when they return home, in addition to the lifelong anti-rejection regime faced by all transplant recipients, and may encounter obstacles to the availability of this care. (Bramstedt and Xu 2007) Transplant physicians in the United States reportedly express greater moral doubts about continuing to treat patients who received their organs abroad, especially because of ethical concerns about procurement practices (Biggins et al. 2009) but also because of the possibility that antibiotic resistant infections acquired abroad may pose risks to other patients (Bramstedt and Xu 2007). Uninsured patients who can afford transplantation abroad may be unable to finance their requirements for ongoing care when they return home. (Bramstedt and Xu 2007) Richer patients from abroad may divert organs from less-well-off domestic patients and utilize hospital resources that might otherwise have been available domestically. (Gupta 2008)

Although some transplant tourism programs transport recipient-donor pairs identified in their country of origin, others rely on overseas organ supplies. (Bramstedt and Xu 2007)

By far the greatest ethical concern about transplant tourism is the victims of organ procurement itself. Living donors may be the source of kidneys, lungs, corneas, and liver lobes. The WHO estimates that about 10% of the approximately 63,000 kidneys transplanted annually from living donors have been trafficked. (Tao 2009) For many years, Nancy Scheper-Hughes, Organ Watch, Francis Delmonico, Michelle Goodwin, David and Sheila Rothman, and others have documented organ trafficking and attempted to call it to public attention. (Budiani-Saberi & Delmonico 2008; Scheper-Hughes 2008; Bakdash & Scheper-Hughes 2006; Goodwin 2006; Rothman & Rothman 2006; Lawless 2004) Donors are coerced, lied to, paid little, and all-too-frequently left with permanent disabilities and without treatment. (Budiani-Saberi & Delmonico 2008; Goodwin 2006) A recent study of kidney vendors in impoverished regions of Pakistan documents the grievous consequences for their health and lives. (Naqvi, Ali, Mazhar, Zafar & Rizvi 2007; Delmonico 2007) The consequences for entire communities in the Punjab reportedly have been dire. (Mozam, Zaman, & Jafarey 2009) Lainie Ross has held up to criticism the image of bodies of the world's poor being harvested as natural resources—and left as waste, just as their lands and other natural resources also have been. (Hippen, Ross, & Sade 2009) Michele Goodwin's (2006) documentation of a "black" market in organs reveals both the exploitation and racism implicit in underground sale of organs. Reportedly, 11,000 transplants from executed prisoners were performed in China in 2006, although in 2007 China banned commercialized organ procurement and procurement from prisoners. (Budiani-Saberi & Delmonico, 2009)

Countries allegedly facilitating organ trafficking include Egypt, India, Iran, Pakistan, and the Philippines. (Budiani-Saberi & Delmonico, 2009) Brokers reportedly flourish in Israel and

in South Africa. India recently announced breaking up a ring of illegal organ procurement that had involved 500 illegal transplants; "donors" were paid up to $2,500 for kidneys, and some were forced to donate at gunpoint. (Tao 2009) The arrest of an alleged organ broker in the U.S. in the summer of 2009, Levy-Izhak Rosenbaum, garnered extensive publicity; Rosenbaum was accused of enticing the vulnerable to sell organs for $10,000 which he then sold for $160,000. (Halbfinger 2009)

Trafficking reportedly persists, despite the multiple international and domestic efforts at prevention and outright prohibition that we detail in the following section. The difficulties of deterring the practice are clear, given the incentives that support it. (Jafar 2009) Professionals in countries where organs are procured have financial incentives to encourage the practice, as do the countries themselves. It was transplant professionals who (unsuccessfully) brought a legal challenge to Pakistan's recent ban on commercial transplantation and on donations to foreigners from unrelated Pakistani donors. The challenge, recently rejected by the federal shariat court of Pakistan, rested on the claim that the prohibitions made saving lives more difficult. (Noel & Martin 2009) But the commercial appeal of trafficking remains. In India, for example, the 2002 National Health Policy seeks to capitalize on attracting medical tourists by deeming services paid for in foreign exchange as export earnings. (Gupta 2008) Impoverished "donors" are desperate. And the demand from wealthier patients is unrelenting, especially in countries such as Japan or Israel where there may continue to be reluctance to donate for cultural reasons. In Japan, for example, "brain death" is not recognized (WHO 2006), so deceased donor supplies are limited. In Israel, some orthodox Jews oppose organ donation; Israel has recently adopted a controversial preference in organ allocation to people with donor cards that will be implemented in 2011. (Brimelow 2009)

International condemnation of organ trafficking

International efforts to combat organ trafficking have been extensive, with the WHO in the lead. In 1991, the World Health Assembly approved the WHO guiding principles on organ transplantation. Intended "to provide an orderly, ethical, and acceptable framework for regulating the acquisition and transplantation of human organs for therapeutic purposes," these principles emphasized protection of donors through informed consent, prohibition on conflicts of interests by transplant physicians, and preferences for deceased or related donors. The guidelines explicitly prohibited the sale of organs and organ trafficking, but left methods of enforcement up to individual jurisdictions. (WHO 1991) In 2004, the World Health Assembly enacted an amended version of the principles in light of global increases in organ transplantation and organ shortages. This resolution urged member states to implement effective oversight regimes and to cooperate in the harmonization of global practices. It also encouraged extending the use of living kidney donors where possible. It requested the Director-General of WHO to provide support for member states to prevent organ trafficking and to draw up guidelines to protect vulnerable groups from the practice. Finally, it urged member states to act against transplant tourism and international organ trafficking. (WHA 2004)

The WHO has continued to monitor and support efforts to combat trafficking. An illustration of these efforts was the consultation meeting held with national health authorities in the western Pacific region in 2005 in Manila, a known center of trafficking. (WHO 2006) The report from the meeting urged transparency about transplantation practices—including data about the country of origin of donors and recipients—as necessary for "accountability and traceability." Although resoundingly condemning the commercial sale of organs, the report

permitted payment of expenses to donors, including health care and lost income, and "modest nonmonetary assistance." Any support, however, was to be transparent and according to host country regulation. Recipients of organs were to be held responsible for knowing whether their organs came from legitimate sources—and their countries of origin were to take measures to prevent exploitation of donors from other countries or breaches of other countries' organ donation rules.

In 2000, the United Nations issued a protocol to prevent, suppress, and punish trafficking in persons as a supplement to the Convention against Transnational Organized Crime. (United Nations 2000) The Protocol's definition of trafficking in persons explicitly includes removal of organs and explicitly rejects consent of the victim to exploitation as irrelevant. States parties are urged to protect victims of trafficking to the extent permissible under domestic law and are required to establish comprehensive policies to prevent and combat trafficking. As of February 2010, there were 117 signatories to the protocol, including Egypt, India, Israel, the Philippines, and the United States, but not either Iran or Pakistan. Notably, the United States explicitly reserved the right to assume obligations under the Protocol in a manner consisted with federalist principles.

International medical associations have been active as well in condemning organ trafficking. A 2008 summit convened by the Transplantation Society and the International Society of Nephrology in Turkey (notably another location identified with trafficking) resulted in the Declaration of Istanbul. The Declaration condemns organ trafficking and transplant tourism as violations of the principles of equity, justice, and respect for human dignity and recommends that they be prohibited. In the judgment of the Declaration, practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants,

prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism, and transplant commercialism. Countries were urged to implement programs to reduce rates of organ failure and to increase legitimate methods of donation. (Declaration of Istanbul 2008)

These efforts—of the WHO, the United Nations, and international societies—lack direct enforcement mechanisms. They remain hortatory at best. As we shall now see, they have been met with limited implementation success at both domestic and international levels.

Domestic enforcement: limited implementation of bans on organ trafficking

Within Europe, legal instruments such as the European Charter on Fundamental Rights (article 3) and the 1997 Oviedo Treaty on Human Rights and Biomedicine (article 21) condemn organ trafficking. (Europa 2009) Presumably, suit could be brought in the European Court of Human Rights alleging organ trafficking as a violation of the Charter, but there are no reported decisions to this effect. A recent United Nations report describes the "slow evolution" of Europe's criminal justice response to the UN Trafficking Protocol. Although it analyzes patterns of sex and labor trafficking both to and within Europe, and identifies Central Europe and the Balkans as origins for trafficking victims (Bulgaria and Romania are described as "hotspots"), the report does not even consider the issue of organ trafficking. In March 2009, in light of these concerns that Europe was lagging in enforcing the UN Trafficking Protocol, the European Commission issued a framework decision for combating trafficking generally, but without mentioning organ trafficking specifically.

At present, Europe faces severe organ shortages, wide variations in donation rates and in cultural views about donation, as well as ongoing efforts to understand the application of the

principle of free movement of goods and services within the EU. As a result, in 2007 the European Commission recommended further action to the Council of Europe and the European Parliament, including development of a legal instrument for authorization of transplantation centers, the establishment of conditions of procurement and systems of traceability, largely for safety reasons but indirectly as a method to combat trafficking. (Europa 2009) In April, 2008, the European Parliament adopted the resolution, which included efforts to improve the supply and distribution of organs. The resolution also called on member states to "fight" against organ trafficking with measures such as punishment of health care providers who participate in trafficking and "making every effort to discourage potential recipients from seeking trafficked organs and tissues." With regard to the latter, the resolution "stresses that that consideration should be given to making EU citizens criminally liable for purchasing organs inside or outside the EU." Finally, the resolution expresses regret "that Europol did not come up with a survey on organ selling and trafficking because it claims that there are no documented cases," despite United Nations evidence to the contrary. (European Parliament 2008)

In the United States, the National Organ Transplant Act of 1984, Pub. L. 98-507, forbids any sale of organs that affects interstate commerce; the penalty is 5 years imprisonment and/or a $50,000 fine. The Trafficking Victims Protection Act, Pub. L. 106-386, first passed in 2000 and last reauthorized in 2008, applies to slavery, sex trading and forced labor; organ trafficking is not specifically included in this definition. (22 U.S.C. § 7102(8) (2010)) Instead, the Act's primary focus is the illicit trade in sex and in illegal immigration. This gap means that the benefits extended in the United States to victims of severe forms of trafficking generally, including Medicaid, would not be available to victims of organ trafficking in the United States. (22 U.S.C. § 7105(b)(1)(A) (2010)) It also means that the measures required of foreign governments who

receive non-humanitarian foreign aid to eliminate severe forms of trafficking are not explicitly extended to trafficking in organs. (22 U.S.C. §7106 (2010)) Nor is the authorization for the President to use emergency powers to punish traffickers. (22 U.S.C. § 7108 (2010) Sex tourism abroad with children is also explicitly criminalized for persons residing in the United States. (18 U.S.C. § 2423(c) (2010))

A single arrest for an attempt to sell an organ in New York in the summer of 2009 drew significant publicity in the United States. (Halbfinger 2009) However, the difference between domestic enforcement regimes for sex trafficking against children and for labor trafficking of illegal immigrants, and the enforcement regime for international organ trafficking remains noteworthy. Perhaps the explanation is that people who engage in illicit sex with children abroad and people who use coercion to bring illegal immigrants into the U.S. are not themselves sympathetic victims. In comparison, people who purchase organs abroad and who return to the U.S. as transplant recipients may be viewed as desperate victims themselves, taking any steps they could to save their own lives.

In some of the countries that have notoriously been centers of organ trafficking, recent bans have been enacted. Egypt, for example, has recently prohibited the sale of organs, enacted punishment for trafficking, and established a procedure for organ donation. According to WHO (2010), it is hoped that these measures will reduce incentives for trafficking in a jurisdiction that has been a hub. Pakistan's law banning organ sales was recently upheld in the shariat court, despite a challenge from transplantation professionals (Noel & Martin 2009). Japan has investigated alleged tourism to China for organ transplantation. (Jafar 2009) A ban on organ sales has also been enacted in the Philippines. (Noel & Martin 2009) Moves to increase organ

donation in countries such as Israel that have been trafficking hubs have also been cited as strategies that may reduce demand. (Noel & Martin 2009)

Nonetheless, incentives for both purchase and sale remain in both affluent and impoverished areas of the world. The growing demand of individuals seeking organs from wealthy states places pressure on less well off countries that seek to restrict their own citizens from selling organs. Ironically, prohibitions on the sale of organs within wealthy nations such as the United States may only increase these pressures by contributing to the disparity between demand and local supply. Domestic regulatory restrictions are thus likely to remain uneven and weakly enforced given the combination of foreign need and money involved in organ trafficking.

Thus international efforts at prevention are prescriptive but lack an enforcement regime. Individual countries remain ambivalent about enforcement; this is not surprising, given the incentives supporting trafficking that we have documented. Moreover, trafficking is difficult to control within any single jurisdiction. Trafficking is truly a transboundary activity, potentially involving multiple jurisdictions: the location of organ procurement, the location of the recipient, the place where actual transplantation occurs, and the location of any organ broker. (Shimazono 2007) To date, despite international appeals, its punishment has remained largely stateless. It seems reasonable, therefore, to entertain the possibility of subjecting the international trade in organs to an international criminal law regime.

The jurisdiction of the International Criminal Court and organ trafficking

The jurisdiction of the International Criminal Court is limited at present to three crimes: genocide, crimes against humanity, and war crimes. While the conditions for any of these three

might be met in a case of organ trafficking, as allegations in the former Yugoslavia contended (Del Ponte & Sudetic 2008), it is unlikely.

The crime of genocide requires the intent to destroy, in whole or in part, a "national, ethnical, racial or religious group." (Statute of Rome 2002, Art. 6) The destructive actions may include killing, causing bodily harm, and forcible transfer—an actus reus condition that organ trafficking clearly could meet. The mens rea required for the crime of genocide, however, is the intention of group destruction, a requirement unlikely to be met when organ trafficking simply preys on impoverished victims without regard to their group status. There have been, however, allegations of genocidal organ trafficking in the former Yugoslavia; former prosecutor Carla Del Ponte has charged that 300 ethnic Serbs and Roma were trafficked to Albania for their organs. (Del Ponte & Sudetic, 2008) Notably, the crime of genocide does not require that the actions in question cross national boundaries or occur in more than one nation; genocide need not, therefore, be a crime of international proportion in order to come within the jurisdiction of the ICC.

Under the Statute of Rome, crimes against humanity include many types of actions that could be represented by organ trafficking: killing, extermination, enslavement, forcible transfer, or other similar inhumane acts intentionally causing great suffering or serious injury. These acts, however, must be part of a widespread or systematic attack against a civilian population—and must be performed with knowledge of the attack. (Statute of Rome, Art. 7) Organ trafficking as a series of individual black market transactions is unlikely to fall within these conditions. Although crimes against humanity must be widespread, like genocide they need not be cross national borders. War crimes under the Statute of Rome are defined in terms of the Geneva Convention. (Statute of Rome, Art. 8)

The ICC was conceived in light of the history of the Nuremberg trials and the use of international criminal tribunals to deal with widespread atrocities in failed states. It is thus not surprising that these were the crimes included within its jurisdiction. Nonetheless, it remains unclear whether the ICC will be a successful model for the development of international criminal law regimes. It has experienced difficulty in bringing alleged offenders before the Court, in finding witnesses, and in bringing prosecutions to completion. As a flagship for the development of a jurisprudence of international criminal law, the ICC is at best problematic. (Francis & Francis 2009)

The Assembly of States Parties has convened a Review Conference for the Court in June of 2010. Plans for the Conference include "stocktaking." (ICC 2009) A number of amendments to the Rome Statute have been proposed for discussion. One that has been proposed, but that may only be referred to a working group or for further study, is including international drug trafficking within the jurisdiction of the ICC. The proposers of the amendment, Trinidad and Tobago and Belize, argue that drug trafficking is a crime that "is transboundary in character" but that places "inordinate burden on the judicial and law enforcement" of many states. (ICC 2009a) Although organ trafficking as we have argued would appear strikingly similar, neither it nor other forms of human trafficking were included in the proposal.

Organ trafficking and international criminal law

Organ trafficking thus illustrates a failure of both international and domestic criminal law. This is thus an area that might be regarded as one of imperfect or "partial compliance" justice. As Buchanan (2004) has argued, in such contexts there may be no clear ideal solution, but the need to build institutions before justice can be improved. Unfortunately, the ICC appears

to have been in some ways an effort to impose a model of the requirements of ideal justice in the most devastating of non-ideal circumstances. (Francis & Francis 2009) Another strategy might have been to consider whether international courts—either new courts on the regional or global level or the ICC itself—might have been constructed to address transboundary crimes that avoid intra-national enforcement such as organ trafficking. Several arguments might be offered in support of this strategy.

Consider, first, the salience of court decisions. Transnational injustices such as organ trafficking cause harm to people in many countries every year. Yet these persistent injustices remain in the penumbra of both international and domestic law as they are constructed today. If an international court—either the ICC itself or an international court established specifically to address trafficking—were to focus international judicial attention on this black market by calling effective judicial attention to a problem that can only be addressed effectively by international action, then the court could enhance the salience of the issue.

Or consider the efficacy of enforcement regimes. Well meant declarations such as the efforts of the WHO or the Declaration of Istanbul are very much exhortations rather than carrying the imprimatur of an international judicial body. States with vulnerable populations have taken action to protect their citizens from groups that prey on the poor to secure organs. But the better off states have chronic and serious imbalances between seriously insufficient local supplies and expanding demands from an aging population. Their failure to monitor, develop, or enforce trafficking restrictions—except the sale of organs between their own residents—threatens to undermine nascent efforts in donor nations to restrict trafficking. The establishment of an effective international enforcement regime might help to counter these pressures.

Consider, finally, how the legitimacy of a regime of international criminal law might be affected by the development of a system to address transboundary offenses such as organ trafficking. Gaining legitimacy has been a persistent difficulty for the ICC, perhaps because of the quite limited range of offenses and offenders that it addresses. Development of an international enforcement regime that deals with more ubiquitous harms in a manner that enhances efficacy and salience might help to address this legitimacy problem. Salience and efficacy, in short, can help to bolster needed legitimacy.

To be sure, progress towards justice could be achieved in other ways as well. At the national level or even international level, problems in the supply of organs might be addressed, although scarcity appears ineluctable at present. Appropriate regulatory regimes might be established to effectively discourage or restrict citizens from leaving their own countries in search of transplantable organ elsewhere. But, as we have seen above, in the states that "export" individuals in search of organs there is a reluctance to condemn individuals or to criminalize what they have done even if it contributes to a practice that inflicts great harm.

To be sure, whether it is practical to expect the development of such a global enforcement regime remains unclear. The pressures on domestic legal regimes may simply be too great. What is clear, however, is that there is general agreement that organ trafficking is a grave international problem that remains under-addressed by both the exhortations of international organizations such as the WHO and by the domestic laws of individual states. It is truly a transboundary offense and, as such, currently represents a missed opportunity for the development of support for international criminal law.

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