

Paying for organs: a shifting discourse

■ When successful organ transplantation was established in the 1980s, international ethical consensus was against a trade in human organs from living or dead persons. By 1989, 21 countries had laws against paying for organs. The World Health Organization and international medical associations on transplantation had declarations on the subject.

However, a massive organ shortage in the US encouraged rethinking of these objections. In 1996, a speaker at the meeting of the US Department of Health and Human Services Division of Transplantation urged a reconsideration of the "ethical objections and legal impediments to financial incentives for organ donation". Another offered a panel presentation on a futures market in cadaver organs. Persons and organisations that once condemned mixing money with organ donation now suggest more aggressive moves: the Council on Ethical and Judicial Affairs of the American Medical Association proposed a futures market in cadaver organs, and members of the International Forum for Transplant Ethics recommended lifting the ban on kidney sales from living donors pending better justifications for prohibiting such transactions.

In 1999 the US state of Pennsylvania considered a plan to pay a "stipend" to organ donors' families to defray funeral costs. The programme would be monitored to see if it increased donations. While some called the Pennsylvania plan "very dangerous", and "a step away from altruism toward commerce...", the National Kidney Foundation felt it should be tested: "If a small financial incentive increases the number of organs available to save lives, good will have been accomplished."

A strong rejection of uncompensated donation is being replaced by a debate on the use of financial rewards.

How did this ethical shift come about?

The author identifies various techniques used to shape the debate on financial compensation for donors. "These strategies tell us a great deal about the role of the medical profession in shaping ethical debates at the high technology end of medicine."

Public opinion surveys have been presented in a way that supports paid donation. A 1990 survey of public attitudes to donor compensation presents only the positive responses: "an illustration of how surveys may be used to support the ethical preferences of the transplantation profession, and how they might be used not just to assess, but to sway, public opinion."

• Extreme proposals — such as soliciting motorcycle gangs 'organ sale contracts' because they're more likely to brain-dead after accidents — enable the entry of the more 'moderate' Pennsylvania proposal.

• New language such as 'rewarded gifting' sanitises the terms of the debate.

• Public relations strategies are used to introduce the notion cautiously; if the Pennsylvania plan increases organ supply, it will be promoted more aggressively.

• Inviting public input on committees' recommendations

desensitises the public to the issue. Also, negative responses permit fine-tuning of proposals, positive responses become a reservoir of evidence.

The author could have reflected on two related issues: what are 'legitimate' and 'illegitimate' ways of changing public policy? Second, why do other options to increase organ availability not get discussed?

Joralemon D: Shifting ethics: debating the incentive question in organ transplantation *J Med Ethics* 2001; 27:30-35

Black is white, and day is night

■ An illustration of how things get done in India is given in this column by Dr M K Mani who quotes, without comment, the minutes of the authorisation committee which gives permission for non-related transplants. The first set of minutes refuses permission because the donor is "not motivated, too young, unmarried and not aware of the complications." The second set of minutes, less than three weeks later, approves the same donor for the same recipient -- stating that both parties have apologised for giving wrong information about the donor's age.

Mani MK: Letter from Chennai *Natl Med J India* 2000; 13: 271-3.

A one in 10 chance of an 'adverse event'

■ This retrospective review of 1,014 medical and nursing records at two acute hospitals in London found that 10.8 per cent of patients experienced an adverse event, with an overall rate of adverse events of 11.7% when multiple adverse events were included. About half of these events were judged preventable with ordinary standards of care. A third of adverse events led to moderate or greater disability or death. While some adverse events are serious and are traumatic for both staff and patients, others are frequent, minor events that go unnoticed in routine clinical care and yet together have massive economic consequences.

Vincent C et al: Adverse events in British hospitals: preliminary retrospective record review *BMJ* 2000; 321: 890-892

Drug companies and doctors -1

■ This description of the physician-pharmaceutical industry relationship and its impact on physicians' knowledge, attitudes and behaviour is based on analysing the results of internet searches and through interviews with key informants. The author concludes that the doctor-pharmaceutical representatives relationship is an accepted one, it begins in medical school and is maintained through regular meetings. These meetings influence physicians' prescribing practices and get them to add the company's drugs to the hospital formulary. "Attending sponsored CME events and accepting funding for travel or lodging for educational symposia were associated with increased prescription rates of the sponsor's medication. Attending

presentations given by pharmaceutical representative speakers was also associated with irrational prescribing.” The author concludes: “The present extent of physician-industry interactions appears to affect prescribing and professional behaviour and should be further addressed at the level of policy and education.” Surely this is an even more severe problem in India.

Wazana A: Physicians and the pharmaceutical industry: is a gift ever just a gift? *JAMA* 2000;283:373-380

Drug companies and doctors -2

■ This essay refers to various studies documenting the physician-pharmaceutical industry nexus, and its influence on prescribing behaviour as well as public perceptions of the sponsor's drugs. The industry directs medical research, it exerts pressure on medical journal to prevent the publication of unfavourable results, it uses the internet to provide mis-information. What we need is documentation of such practices in the Indian context.

Anand AC: The pharmaceutical industry: our ‘silent partner in the practice of medicine *Natl Med J India* 2000; 13: 319-21.

How managed care manages

■ Do health plans affect the kind of care their subscribers get? This US study compared the use of coronary angiography after acute myocardial infarction among Medicare beneficiaries (over 65?) who had traditional fee-for-service coverage with the use among Medicare beneficiaries enrolled in managed-care plans, studying a total of more than 50,000 people, adjusting for differences in patients' demographic and clinical characteristics for hospitals' characteristics. Care was evaluated according to guidelines proposed by the American College of Cardiology and the American Heart Association.

Among the 44 percent of patients in both groups who had class I indications (for which angiography is useful and effective), more fee-for-service beneficiaries than managed-care enrollees underwent angiography. Interestingly, rates of use among patients with class I indications are fairly low in both groups, suggesting that there is room for improving the care of elderly patients with myocardial infarction.

Guadagnoli E et al.: Appropriateness of coronary angiography after myocardial infarction among Medicare beneficiaries: managed care versus fee for service *N Engl J Med* 2000; 343: 1460-6. r service *N Engl J Med* 2000; 343: 1460-6.

Giving parents prenatal test results

■ A prenatal test result showing chromosomal abnormalities leaves women and their partners with an agonising decision on whether or not to continue the pregnancy. How can healthcare providers help them? There is little research on pre-test counselling, the communication of abnormal results, their impact on parents' decision making, or the long-term outcomes of such decisions. Such as situation poses even more challenges to Indian health

care providers.

This editorial writer comments on a UK-based pilot study on how parents are told that the foetus has a sex chromosome abnormality. The findings: little or inaccurate information is provided; healthcare providers know little about such abnormalities; and the literature is often out of date and conflicting. However, even accurate information may not tell one how a particular child will be affected.

Reproductive decisions are complex, influenced by women's values and beliefs and their hopes for the future baby, attitudes toward abortion, desires for biological children, religious beliefs, attitudes toward disability and human variation, social norms about prenatal testing outcomes, practical issues such as money and social support... Healthcare providers must understand what the information **means** to women and their partners, to **enable** decision making. If they cannot, they must refer patients to someone who can help.

Women learning of an abnormal prenatal diagnosis deserve accurate information and healthcare providers who convey respect, honesty, and compassion, not ill-informed suggestions about whether or not to continue the pregnancy.

Biesecker B: Prenatal diagnoses of sex chromosome conditions: Parents need more than just accurate information Editorial *BMJ* 2001;322:441-442.

Is there an ‘Asian bioethics’?

■ Is today's bioethics transplanting Western concepts to Asia? Can Asians develop a concept of bioethics based on their traditional cultures? This article argues that Asian bioethicists must develop a bioethics responding to their own cultural contexts. If Western principles are adopted, then they must be re-interpreted and even modified, if necessary, in light of Asian beliefs.

Asian interest in medical ethics dates back centuries before the West. In the first century AD the Caraka Samhita laid down standards of behaviour for physicians: they should endeavour to relieve patients, should not desert or injure them and should never cause another's death; they should be committed to helping their patients, but should not to tell patients of their terminal illness. The Susruta Samhita refers to the atharvan, a medicine man in a domestic setting, who helped alleviate personal and family crises.

Western biomedical ethics literature has identified autonomy, non-maleficence, beneficence, and justice as the four basic principles of medical ethics. These principles will have different applications — especially with the principles of autonomy and justice — in cultural settings where the family or community carry a greater weight than the individual does.

To give a concrete example, the rule of informed consent extends to consulting the patient's family before an action is taken. By the same token, justice cannot be defined as straightforward fairness. A person's responsibility to look after his own health should also be considered.

Cheng-tek T, Seng Lin C: Developing a culturally relevant bioethics for Asian people *J Med Ethics* 2001; 27:51-54