Don't single out private colleges

I take strong exception to your statement in the editorial (1). You have written, "As medical education became commercialised, the alliance between corrupt medical council members and politician owners of capitation fee-based private medical colleges destroyed the profession's ethical fabric."

This sort of generalisation and lumping of all private medical colleges under one wide umbrella is distasteful. While I accept that many private colleges have a lot of scope for improvement and leave a lot to be desired, there are other private colleges who are making genuine efforts to maintain standards, and it is not fair to tar them with the same brush. And what about government colleges? Are they above corrupt practices?

To me, the decline of self-regulation started a long time ago, in the fair city of Mumbai, where the cut-practice racket started, spreading to other cities and towns. The decline started when specialists began treating patients according to the dictates of the referring general practitioner. It continued when unnecessary admissions and operations began to be done because "If I don't do it someone else will." With so much turmoil within us it is not fair to single out private colleges for censure.

Having been a surgeon, a teacher and having spent some time on the State Medical Council as a university representative, I have seen how ineffective our internal policing is.

The practice of medicine is no longer a profession but a commercial venture, with most practitioners, either singly or in groups, investing in costly diagnostic/therapeutic equipment and trying to recoup the investment by fair means or foul.

The 'because it is there' syndrome is a major ailment affecting our profession. Remove the appendix because it is there. The USG shows a simple ovarian cyst, take it out. CT/MRI facilities are available, use them to impress the patient. Who is bothered about medical justification and patient safety?

There are many more problems which have to be faced and rooted out. Unless like-minded people get together and form a strong and effective lobby the trend will not change. It is encouraging to see some new entrants into the profession, who want to practise ethically. Maybe it is up to them to cleanse the profession and bring back the dignity and prestige that was once associated with the words 'medical doctor'.

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Political economy of human organ selling

The debate on trade in kidneys for economic gain (1, 2, 3, 4) has become polarised between those who do not view this as different from any other economic gain (those not attaching any moral value to any economic transaction), and those who view this in the context of human realities, like poverty, that drive people to make a forced 'choice' of selling an organ for an economic consideration.

In this globalised and market-oriented world, there is a tendency to commodify everything and this includes human organs. Everything must be viewed in a detached and 'objective' manner and should not be adulterated with any values.

Unfortunately human life and living does not work that way, and more so in our part of the world. In the real world things are not black and white but there are many shades of grey. One example with which we have had experience for a number of years is blood donation. Professional blood donation was permitted and had become quite messy but it took the HIV/AIDS scare to put a stop to it, at least officially. Voluntary blood donation is encouraged and whenever a patient needs blood, relatives and friends must contribute without any monetary compensation.

Why can't we follow the same principle for kidney donation? Encourage people to donate their kidneys on death to a public 'kidney bank'. Anyone needing a transplant must get a relative or friend to pledge their kidneys on death. The option of a live donation from a compatible relative may also be kept open as an exception, but this should be subject to an ethical review to assure that no undue advantage is taken, or any payment made. And of course this should be only in the public domain. (By public domain I do not necessarily mean the government, it could also be an association of the concerned profession.)

This is not very different from the question of the misuse of amniocentesis. Just because the technology is misused, we cannot ban it since it also serves a useful purpose. There has to be control over the use of the technology by the profession. We know that legislation in the case of amniocentesis has not worked effectively. It can only work if the medical profession becomes ethical in its use and any misuse is dealt with severely by professional bodies. For example, the Federation of Obstetric and Gynaecological Societies of India (FOGSI) should take a lead and pressurise its fraternity to stop sex-determination tests. The fact that FOGSI has not done this shows the lack of ethical concern within the association. On the positive side, there has been a report from Bhuj that prescriptions and other stationery used by obstetricians and gynaecologists in that region carries a slogan that sex-determination is a crime. FOGSI must use such examples to advantage and get its members and other related specialists to become concerned about and bring about a change in practice.

Coming back to the kidney trade, this is also the concern of inadequate access to dialysis facilities for affected patients. With increasing privatisation the situation is becoming worse. Access to such care for the poor, who are the majority in this country, is becoming increasingly out of reach. If we are concerned about equity — and we ought to be given that we are a society with an exceptionally large population with insufficient access to basic needs including health care — then we ought to be concerned

about the increasing commodification of health care. Public investment is declining and the private sector is booming. It was not very long ago that specialist care was largely in the public domain but today even that is being monopolised by the private sector. If things continue in the same vein then arguments in favour of allowing free trade in human organs will gain momentum.

Thus we must view the human organ trade in the context of this overall political economy of health care. If we allow the organ trade we will be favouring a small class of people who can buy out the desperate poor. It will also create its own economy of middlemen who will facilitate this trade. Experience teaches us that whenever such middlemen take over, the beneficiary is neither the buyer nor the seller.

In this case there is a third loser – the medical profession which is fast losing its credibility because of the large number of unethical practices which increasingly characterise it. We are fortunate that a large majority of the medical profession world wide is either against the human organ trade or at best ambivalent.

So we do have a hope that the *banias* can be prevented from taking over control of human organs. However, this will depend entirely on the ethical standards medical professionals set for themselves.

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Kidney transplants: some realities

I read with much interest the discussion on kidney transplant and whether the sale of kidneys should be legally permissible (1,2,3,4), and narrate two of my experiences as a social worker, for the readers of *IME* to think about.

A young man coming from a middle-class Amritsar family needed a kidney transplant. He was admitted in a government hospital in Chandigarh. The donor was the patient's mother. It did not work. He was advised another transplant. He got admitted in a private hospital where the kidney transplant specialist and his colleagues enjoyed a very high reputation. There was no suitable donor in his family now. The kidney had to be purchased. The hospital had a network for the purpose — legal at the time. The donor was a poor Bengali from Delhi. He was paid only a small part of what was charged, and the rest went to the doctors' network.

The patient died. The father alleged that the donor had not been tested for AIDS and that he most likely had the disease. There was no post-mortem. An enquiry ordered after much agitation held that no kidney donor had been tested for AIDS in this hospital. A police case was registered. The doctor concerned got anticipatory bail from the high court. The father too went to the high court only to find that the file on the case had been 'misplaced'. The father was reportedly offered a large sum of money for dropping the matter but refused saying he would not sell his dead son. Ultimately, however, the costs of the litigation forced him to give up the fight.

The kidney trade continued to flourish in the same hospital, even after the practice was declared illegal. Poor people would sell their kidneys and the rich would buy them to save their lives. I was told that magistrates would attest affidavits in which a donor said (for instance) that he was a long-time domestic help of the patient (without actually having been one even for a day) and was donating a kidney out of affection for his employer. Members of the committee which clears donations from non-relatives would plead helplessness in the face of an affidavit attested by a magistrate.

Ram Nath (not his real name) is a worker in a woolen mill in Amritsar. He is poor but is insured under the employees' state insurance scheme towards which deductions are made from his wages. His wife needed a kidney transplant. The case was referred to the Post Graduate Institute, Chandigarh. No one in the husband's family could become a donor though willing because of different blood groups. From the wife's family one could, but the person was not willing.

Ram Nath was desperate to save his wife. He was in debt up to his neck because reimbursement of the medical bills would take very long. Still, he somehow managed a suitable kidney for his wife, from a poor man like himself, by paying a price which I believe was much smaller than in the 'normal' kidney black market. The post kidney transplant expenses have accumulated to more than Rs 60,000. Ram Nath does not know what to do because all our pressure on the Punjab government to release money have not borne results so far. Despite all odds, he is hopeful that his wife will live because there is his trade union to help him, the kidney problem having been overcome.

Commenting on another matter, Arun Bal in his editorial (5) rightly differentiates a profession from commerce, and goes on to say that in a profession, including the medical profession, "profit is a secondary motive." I feel that even as a secondary motive, it will result in many unethical practices. The idea of profit should be divorced altogether from the medical profession, in fact from all services of this type. Government doctors should have reasonably good salaries and private doctors should aim at earning more or less equivalent amounts as salaries of corresponding categories of government doctors.

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