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Human organ sale: the Kerala story

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It has been reported from the Idukki district of Kerala at Poomala tribal settlement that 45 persons sold their kidneys and 30 received advance payment for the same. In Kerala, there are 20–80 renal transplantations per month from live donors, mostly done by private, for-profit hospitals (1).

This issue created a lot of commotion in the media and political and medical field. The Kerala State Health Department closed the chapter after satisfying itself with a cursory enquiry by the police which suggested that 'there is nothing legally wrong in the case records in the hospitals accused'.

In Kerala, 13 hospitals spread over six districts perform renal transplants. Four government and three private hospitals perform only related donor transplants. The remaining six private hospitals do transplants of unrelated as well as related donors. Till October 2002 there were 1,178 renal transplantations carried out in Kerala. Of these, 488 were from unrelated donors. One hundred and thirty-five of 183 transplants performed in the accused hospitals in Kozhikode were from unrelated donors.

Findings of the police enquiry

Sources reveal, on conditions of anonymity, certain conclusions of the 'police enquiry report' which the state government is keeping under tape. Nearly 20 persons, the majority of them poor and uneducated, traded their kidneys for money. Most of them contacted a 'middle man' through whom the transactions were discussed and finalised. They sold the kidney as an option to overcome their immediate financial difficulties. There is evidence to show the involvement of a few doctors. Under the state Act, every transplantation from a live donor who is not a relative of the patient has to be screened by the 'Authorisation Committee' to ensure that there was no payment involved and the donor is acting with altruistic motives. Although all the cases were approved by the Authorisation Committee there was no evidence of the involvement of any of the members of the Committee (2).

As 'kidney trade' was evident in the preliminary committee sitting, the state branch of the Indian Medical Association (IMA) deployed an enquiry committee on this issue. The draft report indicated large-scale kidney rackets operating in Kerala. An important finding was that a woman donor had undergone a medical termination of pregnancy (MTP) conducted by a lady doctor. But the final report published by the IMA State Committee was 'white-washed'. It found nothing irregular about the kidney transplantations. There were protests against this 'correction' from the IMA itself under the leadership of Dr Mohammed Ali who was the chairman of the Ethics Committee and had conducted the enquiry and prepared the draft. The IMA leadership finally expelled the doctor and the issue was in court.

For years India has been known as a 'warehouse for kidneys' and has become one of the largest centres for kidney availability. To curb the unethical trade of human organs and promote legal transplantation, the Indian Parliament adopted the 'Transplantation of Human Organs Act' in July 1994 (3). It was concerned with the removal, storage and transport of human organs. Brainstem death was accepted as death when diagnosed by a skilled person at the bedside without sophisticated instruments. The law mentions people who are competent to certify brain death and removal of human organs and the hospitals registered for removal, storage and transplantation. This allows removal from related or unrelated cadavers, live donation from first-degree relatives and unrelated persons in case of a dire necessity.

In spite of this law, the use of powerful immunosuppressive drugs and new surgical techniques boosted kidney transplant activities in the atmosphere of loose medical ethics. Many have sold their kidneys to build houses, feed their families and wed their daughters. Many 'kidney tours' and 'kidney marriages' have taken place between people. In 1995, a customs officer of Delhi uncovered hundreds of 'kidney tours' to foreign countries. In the same month, it was discovered that commercial trade in kidneys occurred among the residents of a leprosy rehabilitative colony in Chennai. Later, the police uncovered a massive racket in Bangalore in which the kidneys of nearly 1000 unsuspecting people were removed in a lead-

ing city hospital (4).

The organ trade within and outside the country is very difficult to prevent among the rich as there are many loopholes and grey areas in the law, and poverty is all too common (5).

No monitoring

Indian law permits live donation from non-relatives; this is mostly misused for commercial interests. The lacuna in the law was that the screening committee had no mechanism to find out the whereabouts of the donor and whether the donor was truly altruistic. In most cases, the donors were well coached by the middle man before the screening procedure. There is no system in place that can effectively monitor the transplantations. If the organ trade is not controlled, disappearances, especially among street children, violences and baby kidnapping rackets may flourish along with the theft of organs of executed criminals in future. The people may lose trust in the medical community and may suspect their involvement in premature declaration of death on seeing a signed donor card (6).

Donation of an organ is most altruistic, meaning an act in life to help another human being and reliably change the situation of the latter. Even in the UK, 70% of the people favour organ donation, but only 25% hold donor cards (5). Data from the Arab world shows that all the 81 renal transplantations conducted during 2001 were cadaveric donations (7). Selling organs demean human beings; there is always 'the rich who receive and the poor who give' (6).

In India, it is estimated that there are 80,000 people with severe renal failure and 650 dialysis units are available. Our resources are scarce and the needs outstrip these (4).The recurrent annual cost of haemodialysis is Rs 1,00,000 and that of renal transplantation is Rs 75,000–1,00,000. (Dr Pisharody, personal communication, 2002). We have to weigh the risk–benefit, cost–benefit and cost–effectiveness ratio in the management of end-stage renal disease.

A recently published World Health Organization (WHO) document made the following points (8): Changed economic policies leading to foreign competition in the health service market are reducing the access to care for the poor. It appears that health is a luxury in developing countries. The system of forcing individuals to make out-of-pocket payments for health care denies basic care to the poorest members of the society. The above statement is relevant in the Indian context where there is no social security system and very little public expenditure in the health sector.

Studies have shown that 85% of doctors in India have no training in medical ethics (9). Teaching, training, following and practising ethics among doctors in our country is the only solution for the unethical medical problems flourishing in our country amidst poverty. We have to uplift the four big values in bioethics: autonomy, beneficence, non-maleficence and distributive justice.

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