Personal Opinion

Paid transplants in India: the grim reality

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Keywords: India; kidney donation; paid transplants; transplant tourists; unrelated donors

Commercial transplants are performed in several countries, but a combination of trained transplant personnel, large impoverished population and lack of any law governing organ transplantation made India the hub of this activity in the late 1980s. Reports of large-scale transplants using kidneys bought from economically deprived living donors under questionable circumstances from different parts of the country attracted worldwide condemnation. After a lot of media criticism, the Indian Parliament passed an act in 1995 banning payment for organ donation. The practice, however, has continued, and paid transplants are still being performed in several parts of the country [1,2].

A gradual change has been observed over the last few years in the attitude of western transplant professionals towards unrelated transplants. Concerns about the continuing organ shortage have prompted calls for legalizing transplants using organs donated by strangers [2]. The excellent outcome of genetically unmatched kidney transplants from living unrelated donors done in the west [3,4] provides support to this argument. Short-term survival figures are better than cadaver transplants, and approach one-haplotype matched living transplants. The risk to donor is low [5] and advocates of such transplants are increasing in number.

At first sight, this seems to be a solution to please all concerned. However, the published literature suggests that the outcome of commercial transplants performed under less than optimal conditions, and with donors of dubious backgrounds, is inferior to those that are carried out under rigorous medical scrutiny [6]. A high rate of transmission of infections including HIV, fungi and hepatitis viruses, and high short-term mortality was documented by Salahudeen et al. [7] in 1990. In a recent publication in this journal, Higgins et al. [8] report almost similar findings, suggesting little change in the situation over the last 13 years. They draw attention to the poor donor and recipient selection, and how several of the problems were related to transplantation of organs that would be rejected in standard transplant programmes.

It can be argued that these reports are not representative of the outcome of all such transplants. It is telling, however, that few centres that have performed thousands of such transplants have published their results [9]. The reasons for this could be one or more of the following: (i) these transplants are performed as a commercial activity, and these hospitals are not interested in publications; (ii) the legal status of this activity has been largely dubious, and publication could draw the attention of law enforcement agencies; (iii) the majority of the recipients are ‘transplant tourists’, who travel to these cities from far off places (including foreign countries), get the organ and then go back, making follow-up impossible; and (iv) if the results are indeed as poor as the existing reports suggest, publications will be self-defeating. Any person or group who can collect outcome data on such recipients will do a great service to the transplant community, and provide a valuable database/reference point for physicians. Indeed, if the results turn out to be similar to the results of non-related transplants done in the west, it would strongly enhance the acceptability of this practice. The lay public, including the patients and lawmakers also need to know this data so that they can make a proper informed choice.

Some transplant ethicists have strongly argued that as paid transplants benefit both the recipient and the donor, they should be permitted in a regulated manner [10–13]. It has been suggested that setting up a commission responsible for donor and recipient screening and overseeing the financial transaction will remove the unsavoury practices associated with this act. However, a major assumption behind this argument is that the western standards of justice and fair play would apply to the developing societies and that...
such regulatory bodies would do their jobs fairly. We need to examine if this premise is true.

Almost all the countries where paid transplants are performed score poorly on the Corruption Perception Index (the degree to which corruption is perceived to exist among public officials and politicians) compiled by Transparency International. Out of 102 countries ranked on a scale of 0–10, with 10 being the cleanest score, India scored 2.7 and was ranked joint 71st in the 2002 report [14]. Corruption pervades all sections of the society and it would be naïve to assume that the regulators of paid transplants would remain untouched by this menace. The role of ‘Authorization Committees’ set up by the Union and State governments under the Indian Organ Transplant Act provides interesting insights. This act has a provision that allows unrelated transplants on altruistic grounds provided there is no financial transaction. Authorization Committees composed of persons holding respectable public offices such as bureaucrats, academicians and physicians were constituted to examine all such requests and ensure no commercial transaction was involved. In some states, Committees approved thousands of paid donor transplants after getting affidavits from donors stating that the donations were being made on the grounds of ‘love and affection’ for the recipients. It can be nobody’s case that so many poor, illiterate, out of work strangers developed enough affection for rich recipients from far off places whom they have either never met or just seen a couple of times to be able to donate an organ for them. A charitable view could be that the members permitted these transplants out of a sense of pity for the recipients. However, there is a suspicion that some of the members were bribed by the middlemen, and a few have even been arrested by the investigative agencies [15].

That the donors do not receive the money that is promised, and the medical care is poor is common knowledge amongst transplant professionals [7]. In fact, after the surgery, donors are strongly discouraged from returning to the hospitals. Recent reports [2] have documented a high rate of mortality and morbidity amongst the donors. Clinching evidence was recently provided by a group of independent American researchers, who tracked down over 300 individuals who had sold a kidney in Chennai, India [16]. Their findings were as follows: (i) the donors received far less money than what had been promised to them during the process of initial bargaining; (ii) instead of improving, the family income declined by about one-third after donation, and the number of participants living below the poverty line increased by ~20%; (iii) ~75% of the participants whose motive for selling the kidney was payment of debts, continued to be in debt; (iv) over 95% of the sellers admitted that desire to help a gravely ill patient with kidney disease was not a factor in their decision; (v) close to 90% of participants reported significant deterioration in their health status; and (vi) wives had been forced to donate against their wishes to because the husbands needed money. When asked what advice they would give to others contemplating selling a kidney, over 80% said that they would not recommend such a step. The authors concluded that the Authorization Committee failed in its duty and exploded the myth that the money earned by selling an organ helps the donor(s) to improve their financial standard and get a fresh start in life. Zargooshi [17] found similar results in a survey of paid donors in Iran.

An interesting phenomenon has been the fluctuation in the numbers of these transplants in different cities over time. India is a large country with several administrative units or states. As the law-enforcement authorities in one state become aware of this activity and take steps to curb it, the numbers increase in another geographic area where the authorities are not yet sensitized to this practice. Publicity is usually by word of mouth, and after a brief period of confusion, patients reach the right place.

The ponderous pace of the judicial system has prevented the conclusion of most cases investigated under the Organ Transplant Act [18]. As time goes by, the witnesses disappear or change their minds, and securing a conviction becomes difficult. The medical profession, including licensing Council and professional societies, has also been strangely indifferent to the practice, and none of the professional organizations have issued any guidelines.

By providing an easy way out for both patients and the transplant community, paid transplants negatively affect the living related and cadaver transplant activities in developing countries [7,19]. In our experience, those who can afford to pay, opt for a paid organ rather than subject a loved one to the risk of donor nephrectomy. In no way can this be considered a healthy sign. Also, if the option of buying organs were not available, the pressure on the health care administrators to breathe some life into the cadaver transplant programme would increase.

In conclusion, while the transplant community strives to improve the outcomes of the ESRD patients, it should be in a socially responsible manner. Increase in organ supply will certainly help, but the community needs to look at several difficult social issues before modifying its well reasoned and principled stand on commercial transplants. It could be argued that these could be allowed in countries where the social system is mature enough to handle the problems that will be encountered. But, as and when the argument for opening paid transplants is accepted, the biggest market for them will be, as it is now, in the developing nations with the vast impoverished populations. Once accepted in any country, there will be tremendous pressure by the interested parties on the lawmakers in developing countries to allow it. We should be careful in not starting a process that cannot be controlled.

Conflict of interest statement. None declared.
References

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