CORRESPONDENCE

Is it okay to compensate a kidney donor?

Numerous comments have been made about ethical aspects of kidney transplantation practice in Iran, generally referred to the "Iran model of kidney transplantation programme" (1). The compensated programme for using living unrelated donation (LURD) has fired strong opposition as well as support since its introduction in 1988. However, common to most of the attributed comments are the terms used for addressing the experience: "organ selling" or "a market for organ transplant". The major question in most of the papers is whether selling body organs is acceptable. No distinction is made between a "compensated kidney donation" and "selling kidneys". For example, in *Indian Journal of Medical Ethics*, in an editorial, the authors ask: "Is it okay to sell a kidney?" (2). Julian Savulescu in a debate in the *Journal of Medical Ethics* claims, "If we should be allowed to risk damaging our body for pleasure (by smoking or skiing), why not for money which we will use to realize other goods in life?" (3).

Such arguments from those opposed to kidney transplantation from living unrelated donors, and even from supporters of the practice, views what is being done in Iran as of a purely financial nature. However, as a nephrologist deeply involved in kidney transplantation in Iran, I strongly disagree with the terms used for explaining the condition. In a fair number of situations I have asked my (donor) patients: "Would you donate your kidney just for money considering that you cannot do anything else to resolve your monetary problems?" The answer I commonly receive is: "This is not just for money. I am saving a human life and this will not be disregarded by God." Some of them come up with other ways that might resolve their financial problems as well. They claim that they want to do something good for their "eternal life after death"; they look at donation as an endeavour that could concomitantly resolve their monetary problems and make God happy.

Some fear that altruistic living donation may decline in the face of payment for organ transplants. But what exactly is an altruistic donation? In the general understanding, an altruistic donation is a non-paid donation. However, even a pure altruistic donation has its own associated expenses. For example, donors will be out of work during kidney transplantation, they may also lose their job. This is a barrier to altruistic donations by people of lower socio-economic classes who have altruistic intentions. On the other hand, if we tighten the criteria for altruistic donation, there will rarely be available altruistic donations. Just consider a mother who donates her kidney to her child. Even in this case, the mother gets a reward -- saving her child's life, which is a matter of extreme concern to her. Or when a friend donates a kidney, it might be a reimbursement for help earlier given by the recipient. Even in living related donation, some have claimed that because of hidden coercion there could be more ethical problems compared to what exists in LURD. The problem will be greater when we consider suggestions for expanding the living donor pool, like gifting the donor a medal or medical insurance, or priority for public services.

In my understanding, giving gifts to LURD donors does not reduce altruistic living donation; it could even promote it in some way. I do agree that we need to continue improving our donors' conditions and to use cadavers as the most ethical source for organ transplantation in the country.

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Unethical restriction of kidney transplantation

Sixty thousand people in the United States are supposed to die this year because they did not receive a kidney allograft (1). Worldwide, the number could exceed 1 million; In India itself the number of people developing end stage renal disease each year is about 100,000. But with such prohibitive policies, can we prevent the development of a black market worldwide? Numerous reports from all over the world disagree. Laws are violated; some patients, disappointed by the legal routes, take the matter into their own hands by advertising for donors on highway billboards, by consulting websites, by making personal pleas in the media, by listing themselves in multiple registries, and by relocating (2). Paid organ procurement has been documented in the Philippines, Iraq, China, India, South Africa, Turkey, Eastern Europe and elsewhere. You can simply go websites that provide the possibility of finding a living matched donor (such as Matchingdonor.com). Transplant tourism is active, but because of its illegal nature there are numerous problems. An Australian study (3) as well as a Canadian (4) one, surveying a number of patients who had undergone overseas commercial kidney transplantation, found that they had generally poor outcomes compared to a legal procedure. China attracts a lot of people around the world, but reports claimed that up to 90 per cent of these allografts are retrieved from executed prisoners (5).

In a number of countries, health authorities have realised the importance of tackling the increasing gap between supply and demand for organ allograft and have promoted the development of other types of kidney transplantation practices based on their cultural and economic backgrounds. In Korea a programme of paired living donor kidney exchange has been developed, in which living related donors who do not match

with their potential recipient exchange their kidneys with another recipient/related donor pair with the same situation. In Iran since 1988 a regulated programme for compensated kidney transplantation from living unrelated donors has been developed, which has eliminated the waiting list in this country. Spain has dramatically increased its donor pool with implementation of "presumed consent" for all deceased potential donors unless the person has expressly refused permission by signing an opting-out register. In China kidneys procured from executed prisoners used for expanding kidney allograft pool.

Lawmakers in some countries still resist developing a way to expand the donor pool. Attempts to pass opt-out (presumed consent) legislation in the UK have failed. The situation is not such better for the USA, Canada and Australia. The waiting list increases each year and people continue to die. Till what time can such a situation be maintained?

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Inducements in health campaigns

On May 8, 2007, 68 children from the Indira Nagar slums of Nagpur were admitted to hospital with complaints of nausea, vomiting, headache and abdominal pain. All had received oral doses of vitamin A the day before during a mass nutritional campaign organised by the state government, the Nagpur Municipal Corporation and the Rotary Club of Nagpur. The children were diagnosed with hypervitaminosis A. Some became critically ill but fortunately no one died.

The problem occurred because T-shirts and drawing books were distributed to each child who took a dose of Vitamin A so naturally the children went to different booths and took multiple doses in order to collect the "gifts". The local ward member knew of children who had collected eight T-shirts (1, 2).

The programme went awry because of total mismanagement, procedural lapses and the casual approach of the organisers. No permission was obtained from higher regulatory authorities for the involvement of the Rotary Club of Nagpur. It was not planned properly; the staff who administered the doses were not trained; and there were no arrangements to tackle medical emergencies. Even children above 14 years of age were administered vitamin A doses. The children being from slums, had higher risk of protein deficiency, and the doses of vitamin A were administered not through the measure provided in the pack, but in caps. No identification mark was put on the children who received the dose and no record was maintained (1, 2). Inducements were offered for taking the dose, resulting repeated doses being administered to the same children.

Fat-soluble vitamins like vitamin A have cumulative toxicity. Those with protein energy malnutrition will experience toxicity with lower doses (3, 4). Long-term toxicity of hypervitaminosis A includes teratogenecity, irreversible damage to liver, desquamation of skin, hyperostosis and bone malformations.

A committee appointed by the government of Maharashtra found that the use of incentives by the Rotary Club of Nagpur, lack of planning and following the procedural requirements had resulted in the incident that affected 68 children, and called for a ban on incentives in such drives (5).

The Rotary has not publicly apologised for its role in the incident, let alone made arrangements for the future follow-up and management of the affected children.

It is unethical to lure children with "free gifts" and then make them suffer with unscientifically conducted health campaigns and nutritional drives.

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