Transplanting best practices

Heart transplantation has always been in the public eye right from the time Christiaan Barnard performed the first successful human heart transplant in 1967, in Cape Town, Africa. Therefore, controversy in India over a large percentage of foreign nationals receiving cardiac transplants from deceased donors in India is not surprising. This follows a report published by *The Hindu* (June 12, 2018) based on a leaked WhatsApp message from the head of the National Organ and Tissue Transplant Organisation. However, the debate around it is vital because it is a marker of the fault lines in transplantation policy in India that need immediate correction.

The senior surgeon, Mohamed Rela, wrote an article last week on the need for transparency in the organ allocation process (*The Hindu*, Editorial page, “Heart of the matter”, June 19). He is right in saying that Tamil Nadu’s deceased donor programme is one of the best in the country and that public credibility is key to its continuing success. But it is also important to address certain key drivers behind foreigners getting cardiac transplants.

It may be pertinent to note that one of the first cardiac transplants in the world was attempted back in 1968 at Mumbai’s King Edward Memorial Hospital by P.K. Sen (the world’s fifth and sixth heart transplants). What is relevant to the debate is that Dr. Sen’s transplants as well as India’s first successful cardiac transplant in 1994 (by P. Venugopal at the All India Institute of Medical Sciences, Delhi) were performed in public institutions.

Along the way, organ transplantation in India (this includes Tamil Nadu) largely became a private sector activity. Hence while the act of donation is a public act and the organs a public good, from that point onwards whatever happens is largely under the private sector. The rules of market medicine thus dictate who the organs go to. And hospitals that invest large sums in transplantation programmes which include huge payouts to surgeons look for returns.

Unlike the liver and kidneys, a heart transplant cannot be performed with a living donor. Incidentally, around 20% of living donor liver transplants performed in some of the large centres in India are also on foreigners. So patients with advanced heart failure from certain countries which do not have a deceased donor programme have no option but to try their luck in India. As these are largely performed in corporate hospitals, the costs in India are well beyond a large majority of the local population. This is where foreigner nationals who are often able to pay such sums fit in.

Cardiovascular practice in India is largely dominated by bypass and stenting for ischemic heart disease partly because this is a cash cow. Treatment of ailments such as valve problems and advanced cardiac failure has been sidelined. For example, in Mumbai city while there are at least 30 cardiac centres with advanced expertise, only one hospital has chosen to start and support cardiac transplantation. As one who has been associated closely with deceased donation in Mumbai (especially the first few years) I often saw perfect hearts of young deceased donors remaining unutilised for the lack of recipients. Cardiac surgeons with training in transplantation who were appointed for this purpose did not have enough referrals and chose to leave or focus their attention on bypass. As has been pointed out, this may change in the future.

While ensuring the credibility of the process in the public eye lies at the heart of deceased organ donation, we need to go beyond just general calls for transparency. We will have to demonstrate that organs will go to those who need them the most rather than to those who can pay for them. This will mean considering hard policy changes that include strengthening the capacity of the public sector, subsidising transplantation and perhaps enabling affirmative action in the allocation process in favour of public hospitals. Thus every fifth or sixth organ could be mandatorily allotted to a public hospital or the private centre can be asked to perform a certain proportion of

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transplants free.

As Tamil Nadu has led the way in deceased donation and also has a good record of public medicine, it could lead the way here. One of the secrets behind Europe's high donation rates is public trust in their respective nationalised health schemes.

While India has enthusiastically embraced the idea of a liberalised economy and immediately applied it to health care, many countries have insulated their health-care systems from the ravages of the market. This too is at the heart of this matter.

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