Bioethics Panel Debates a Market in Human Organs

BY TODD ZWILLICH
Contributing Writer

WASHINGTON — A report from the Institute of Medicine has helped fuel debate on what can be done to stem the nation's increasing shortage of donated organs.

The report, written by a panel of respected experts, suggested intensified efforts to boost Americans' flagging altruistic instincts and called for research into how to improve the organ donation system.

Institute of Medicine (IOM) advisers also called for revised resuscitation standards to increase the chances that organs of brain-dead trauma victims could be preserved for transplant. They also encouraged authorities to experiment with a new cardiac standard of death, in the hopes that it could roughly double the number of available grafts culled from patients who donate after being declared brain-dead.

Such a standard could allow up to 22,000 donations per year from patients in permanent vegetative states or comas, said James F. Childress, Ph.D., a professor of medical ethics at the University of Virginia and chair of the IOM panel.

But for some ethicists, the report was more noteworthy for what it did not recommend. The IOM panel recommended against what some members of the President's Council support: Allowing the buying and selling of human organs from live donors, in the hopes that market forces move supply nearer to demand.

Some ethicists acknowledge that allowing an organ market is a radical solution, fraught with the ethical pitfalls inherent in commodifying body parts. But they see the benefit as outweighing the risk of death for the 92,400 Americans on the United Network for Organ Sharing (UNOS) waiting list. The number of Americans with end-stage renal disease is expected to double to nearly 650,000 by 2015.

Free-market advocates see it differently. Dr. Benjamin Hippen, a nephrologist at Carolinas Medical Center in Charlotte, N.C., argues that a regulated market in human organs would boost the supply of viable kidneys, while doing away with a dangerous international black market.

Dr. Hippen, an at-large member of the UNOS board, rejects the idea that a legal organ market is a necessary evil. "Mine is not an argument that the ends justify the means, mine is an argument that the means themselves to not warrant legal prohibition," he told the bioethics council.

Meanwhile, others continue to caution that financial incentives would exploit low-income individuals desperate to sell organs out of economic need.

"We simply can't ignore the fact that the sellers are going to be the poor, predominantly. Most well-off people are not going to sell their organs as a way to buy a third car," said Eric Cohen of the Ethics and Public Policy Center, a conservative think tank in Washington.

The President's Council on Bioethics is not expected to issue its recommendations for organ donation until the fall. ■

Kidney Swaps Could Expand Living Donor Transplantation Options

BY KERRI WACHTER
Senior Writer

For patients on the waiting list for kidney transplants, there are few certainties other than the fact that transplant is better than dialysis and a living donor is better than a deceased one.

Kidney swapping—or paired donation—is one option that is helping more patients get transplants from living donors.

In a two-way kidney swap, patient A is incompatible with donor A—because of blood type and/or human leukocyte antigen (HLA) profile—and patient B is incompatible with donor B. However, donor A is a match for recipient B and vice versa. In a four-way surgery session, kidneys are removed from donors A and B and transplanted into their compatible recipients.

"The kidney swap is part of a broader, more comprehensive program for incompatible transplants, where people have live donors but are incompatible with them," said Dr. Lloyd Ratner, who has performed several such procedures.

In 2001, surgeons at Johns Hopkins University in Baltimore performed the first paired kidney exchange in the United States. In 2003, a larger team at Hopkins performed the world's first three-way kidney swap. To date, 35 patients have received kidney transplants through such exchanges at Hopkins, said Robert A. Montgomery, Ph.D., who led those teams.

It's estimated that more than 6,000 people with willing live donors are still waiting for a kidney transplant because they are incompatible. Kidney swapping allows patients to circumvent the waiting list for a cadaveric kidney, thus shortening time on dialysis. People on dialysis live half as long, on average, as do those who receive transplants, said Dr. Montgomery, director of the incompatible kidney transplant program at Johns Hopkins University.

Dr. Ratner agreed. "The longer you've been on dialysis, your outcome is still worse than people who have been on it for shorter periods of time." The director of the renal transplant program at New York–Presbyterian Hospital in New York City noted, "If you get a kidney from a deceased donor, there's a 50-50 chance that the kidney will last for 10 years or more. If you get a kidney from a live donor, there's a 50-50 chance that the kidney will last for 20 years or more. … If someone happens to have a perfectly matched brother or sister, there's a 50-50 chance that the kidney will last for over 30 years or more," said Dr. Ratner. ■

POLICY & PRACTICE

P4P Raises Pay in UK

A 3-year experiment in pay for performance boosted gross income for family physicians in the United Kingdom but may have made it too easy for the physicians to earn that extra money, according to a study by Tim Doran of the National Primary Care Research and Development Centre, University of Manchester, England, and colleagues. The $3 billion program was designed to boost family physicians' pay an average of 25% depending on how well they performed on certain quality indicators for 10 chronic diseases, including asthma, coronary heart disease, diabetes, and epilepsy. The physicians attained a median of 97% of the available points for clinical indicators—greatly exceeding predictions of 75%—and boosted their gross income by an average of $40,000. However, "the high levels of achievement might suggest that the targets were too easy to achieve," the authors said, adding that the monetary gains may have been offset by the money physicians spent getting ready for the program, including expenses such as hiring extra staff and installing electronic health records. The article appeared in the July 27, 2006, issue of the New England Journal of Medicine. An accompanying editorial agreed that the targets may have been set too low and raised the possibility that some physicians may have "gamed the system" by excluding patients whose care did not meet the performance criteria.

Bill Aims to Delay Imaging Cuts

Rep. Michael Burgess (R-Tex.), an ob.gyn., has introduced legislation to improve physician reimbursement under Medicare and delay cuts in payments for imaging services. The bill also would establish a system of quality measures to give patients more information about Medicare providers. The American Medical Association called the Medicare Physician Payment Reform Bill and Quality Improvement Act of 2006 an "important step toward replacing the flawed Medicare physician payment formula." The legislation would change formulas to end the "negative feedback loop that constantly creates a deficit in healthcare funding," Rep. Burgess said in a statement. It also includes a 1-year delay for planned cuts in Medicare payments for imaging services and requires the Institute of Medicine to perform a study on the question of whether imaging saves money. The quality measures would help beneficiaries decide whether a particular physician was worth paying a higher copayment to see. "If a patient sees that short waiting times equate to perhaps a $10 increase in their bill, they may decide that the money is worth it," the congressman added.

PAs Eye Specialty Recognition

Physician assistants are considering voluntary recognition for those practicing in specialties to denote their advanced knowledge. A task force organized by the National Commission on Certification of Physician Assistants is studying options after receiving comments on the issue during a forum it held on the topic earlier this summer. PAs find their supervising doctors often lack time to train them, forum participants said. The task force does not have a deadline, and it is only considering recognition—not certification—for specialties, Tiffany Flick, communications manager for NCCPA, said in an interview.

Paying Community Pharmacies

Independent pharmacies are seeking legislative help as they struggle with the increased workload from Medicare Part D. Many are racking up debt under the strain—an average of just under $70,000 per pharmacy, according to a survey of 5,000 members of the National Community Pharmacists Association. The Fair and Speedy Treatment of Claims Act of 2006 would require pharmacy claims submitted electronically to be paid within 14 days. The measure aims "to ensure that pharmacists are not forced out of business by inadequate, slow reimbursement and unclear claims processing," according to its sponsors, Rep. Marion Berry (D-Ark.), and Rep. Walter Jones (R-N.C.). Mark Merritt, president of the Pharmaceutical Care Management Association, responded in a teleconference by noting that pharmacy benefit management companies pay most claims from pharmacies within 30 days—standard in American business. The legislation also includes a $14 payment for filling a generic prescription and sets guidelines for medication therapy management programs offered by drug plans. Such programs aim to promote proper medication use in high-risk seniors. PCMA's analysis found that overall, the bill would cost the Medicare program at least $55 billion over 10 years and beneficiaries $30 billion. The measure had 144 cosponsors as of mid-July.

Poll: Live Unhealthy, Pay the Price

More than half of respondents to a Wall Street Journal/Harris Interactive poll say that people who smoke or choose not to wear seat belts should pay a higher health insurance premium than people who don't engage in those behaviors, but most people did not feel the same way about people who were overweight or didn't exercise enough. Only 27% of the poll's 2,200 respondents thought that overweight people should pay more for insurance than slimmer people; the same percentage favored having people who did not exercise regularly pay more. The amount of education the respondent have affected the responses he or she gave: Those with some college education were more likely to agree that those with unhealthy lifestyles should pay higher premiums, compared with respondents with a high school education or less. The poll had a 3.3% margin of error.

—Nancy Nickell