At least three people died today in the United Kingdom because they couldn’t get a kidney transplant. Several thousand more will attend dialysis units. There are increasing numbers of patients, usually young, whose doctors would like to give them “pre-emptive” kidney transplants instead of starting dialysis, which is harsh on the patient and expensive for NHS resources. A transplanted kidney will “pay for itself” within 18 months. Although kidneys obtained within minutes of cardiac death or during the process of “neurological death” are usable and a boon to recipients, those from living kidney donors give the recipient a better and longer lease of life.

The increase in diabetes and hypertension in the community puts further pressure on the need for kidney transplantation. But the rate of donors has never kept pace with the need, and has plateaued at about 2000 a year in the UK. At present we have a reimbursement model whereby donors’ costs are covered for several weeks by the NHS, insurers (who well know the cost savings), and employers. Kidney donation is about equivalent to an elective caesarean section in terms of its immediate and long term health risks for the patient.

But there are other models that it’s time we looked at. We have the wage payment model, for services supplied by participants in medical research, often are admitted to hospital for a fortnight or more and undergo unpleasant, sometimes risky procedures. We have compensation models, for criminal, worker, and military injuries, which have agreed tariffs, such as £2500 for a fractured coccyx and £22 500 for the loss of one kidney.

It would not be such a big step to move towards regulated paid provision for live donors’ kidneys. This would be far different from the illegal organ market that exists now in several countries, and we must not make the mistake of ruling out a properly regulated system because of the depredations of the current illegal market. The standards of care before and after operation would be as good as they are now for kidney donors in the UK. The kidneys would be allocated in the same fair way as they are now.

One reservation that many people express about such a proposal is that it might exploit poor people in the same way the illegal market does now. But if the standard payment were equivalent to the average annual income in the UK, currently about £28 000, it would be an incentive across most income levels for those who wanted to do a kind deed and make enough money to, for instance, pay off university loans.

We have recently moved to allowing donation of strangers’ live kidneys, in which an individual decides to give to someone whom they will never meet and with whom they have no emotional or genetic relationship. That is a huge shift from the approach of last century, when it was largely assumed that genetically related members of families would want to donate among themselves. It isn’t always as straightforward as that. As one potential donor told me, “When my brother was diagnosed my mother went ape because he is her favourite child. She dragged us all down to the hospital to get tested, and I am the only one who is compatible. One day I will get the call and have to do it.”

If the standard payment were equivalent to the average annual income in the UK, currently about £28 000, it would be an incentive across most income levels.

When I served as a non-medical member on the Unrelated Live Transplants Regulatory Authority we had to look at the motivation to donate of spouses and friends. They were asked to write statements about “what was in it for them.” Many said that giving the kidney would improve the quality of family life, reinvigorate a marriage, or make possible the retirement travel plans they had made together. If we couldn’t see sufficient incentive in this form we had to consider the possibility that the person was being persuaded, or coerced, into giving the kidney. Yet we shy away from other forms of social good, which can be manifested in monetary payments, as incentives for live kidney donation.

Oddly enough, it is not clear in law who owns our body parts even while we are using them. But a 2009 Court of Appeal decision by the Lord Chief Justice in favour of two men whose sperm had perished while it was in the care of an NHS trust could have important parallels for the legal issues around our rights to be paid for the supply of a kidney. Transplant chains, in which matches are found for two or more patients by virtue of donors “exchanging” their kidneys in simultaneous operations, can be viewed as a version of payment.

So it’s time to begin to explore how to pilot paid provision of live kidneys in the UK under strict rules of access and equity. We need to extend our thinking beyond opt-in and opt-out to looking at how we can make it possible for those who wish to do so to express their autonomy in the same way as current donors are encouraged to do by making available a healthy kidney for a fee that is not exploitative.

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doc2doc.bmj.com
Would you donate a kidney to a stranger?
http://bit.ly/d8kJHi
The wrong way to highlight problems in maternity care

BBC’s Panorama suggests the NHS in London is failing to deliver safe maternity care, but James Owen Drife thinks the programme may alienate clinicians, and asks why the report on which it is based was not published before transmission.

In the first six months of 2010 there were 21 maternal deaths in London—as many as in the whole of the previous year. Seventeen of those 42 deaths, according to an independent report, could have been prevented with better care. This was the startling information that appeared on the BBC website and in newspapers in advance of a Panorama programme investigating the effects of increasing pressure on maternity services.

I wanted to read the independent report before watching the programme, but it was not available. I found that it had been commissioned in September 2010 by NHS London, a strategic health authority, and completed by the Centre for Maternal and Child Enquiries (CMACE), the organisation responsible for the United Kingdom’s national reports on maternal deaths.

NHS London had not published the report, and CMACE no longer exists.

CMACE used to put a media embargo on its national reports until their launch date, when they could be read simultaneously by clinicians, journalists, and the public. NHS London does things differently. It shared this report with managers, commissioners, and the BBC, but it did not publish it on its website until after the Panorama broadcast. The report makes interesting reading. Nowhere does it state that 17 of the 42 deaths could have been prevented by better care, and its foreword reassures us that the rising trend in maternal deaths did not continue after June 2010.

Despite featuring so strongly in the trailers, the report forms a relatively small part of the programme, which begins by pointing out that the number of deliveries in the UK is at its highest for nearly 20 years. There were 723,165 live births in England and Wales in 2010 (hence the programme’s title), a 19.6% increase in the past decade. Viewers are not told that the number of midwives has risen by 17.7% in the same period, but I agree that numbers do not tell the whole story. The midwifery service is substantially overstretched, particularly in London, where the proportions of older and foreign born mothers are more than elsewhere.

It looked as if this would be Panorama’s message.

Suddenly, however, the scene shifts. A couple tells us how, back in 2005, their baby died at the Royal Free Hospital in north London after a midwife failed to call a doctor quickly enough. We are given many details about the case, except one: the mother was a BBC journalist. The couple’s complaint against the midwife has already been widely reported, and the Nursing and Midwifery Council has still to decide what action to take. The mother thinks that the midwife (illustrated by unflattering photographs) should not be allowed to continue to practise. So much, then, for a sympathetic view of overworked professionals.

Other birth stories follow, with less tragic outcomes. A piece of placenta is left in the uterus after a caesarean section in Manchester. Blaming this on midwifery understaffing is perhaps stretching things a bit. The cameras visit small hospitals where the midwives come across well. Television, it seems, is never going to tire of mothers grunting in strange positions and fathers shouting “push” as if from the touchline.

Serious points are made. The president of the Royal College of Midwives thinks the system is not supporting midwives. The college has calculated that nationally 4700 more midwives are required. Increasingly, maternity units are declaring themselves temporarily closed and turning women away. In part, this is a sign of how risk averse we have become: by the time the administrative process of closing your unit has been completed the rush has often subsided and you can embark on reopening.

Returning to maternal deaths in London, we hear that the serious untoward incident (SUI) inquiries conducted by hospitals themselves are, according to the independent panel, often inaccurate and defensive. This is not news. The most recent national CMACE report, published in March 2011, found that SUI reports were “highly variable, with many of dubious or poor quality” (BJOG 2011;118:s1-203). It is hardly surprising, however, that a hospital faced with a rare catastrophe lacks the expertise to investigate itself properly. This skill was painstakingly acquired over many years by CMACE, whose sudden disappearance has attracted little media attention.

London’s maternity services have problems that are different from the rest of the country, and a case needs to be made for tackling these by local measures. Sadly, this programme fails to do so. By attacking an individual practitioner it alienates the midwives it is ostensibly trying to support. By drawing its positive images from distant hospitals it irritates those inside the M25. And by obtaining so called exclusive access to an unpublished report it reveals NHS London’s cosy relationship with the BBC and its cavalier attitude towards its working clinicians. London deserves better.

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Competing interests: The author was a national assessor in obstetrics to the Confidential Enquiries into Maternal Deaths from 1994 to 2011.


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Vitamins in verse

Do we worry too much or too little about our health? I can never quite make up my mind, but it seems to me probable that there is an inverse anxiety law: those with most to worry about do so least, while those with least to worry about do so most.

To treat each meal as a medical procedure, however, is certainly to go too far in the direction of caution, even if a little bit of what we fancy does us harm. The comic poet and member of parliament (a combination of careers difficult to envisage today) A P Herbert, who was born in 1890 and died in 1971, satirised this tendency in his poem The Vitamins, published in 1930 in his collection Ballads for Brodbrows.

Vitamins were a comparatively new thing when he wrote, but Herbert was nevertheless behind the times, biochemically speaking, and was not always quite accurate: “Vitamin ‘A’ / Keeps the rickets away / And succours the meagre and very .. .”

Then he improves slightly: “‘B’”s what you lack / If the stomach is slack / And ‘C’ / Is the foe of the scurvy.”

Herbert then satirises the so-called vitamin mania: the then fashionable belief that all diseases were caused by vitamin deficiency: “So when a man dines / Let him murmur these lines, / Or sure he will live to deplore it— / Just ask yourself / What / Disease have I got / And which is the vitamin for it?”

Herbertpublished in Punch and was somewhat put out that his work was not esteemed more highly by the literati. “It has never been clear to us,” he complained, “why light verse, however good, should be regarded as inferior to ‘serious’ poetry, however bad.” He pointed out that, while Homer could nod from time to time, a comic poet could not afford a single dull line that neither scanned nor rhymed. Light a comic poet could not afford a single dull line that neither scanned nor rhymed. Light

“Before you seize and swallow whole
Some luscious bird or fancy sole,
Send for the manager and hiss,
‘Is there a vitamin in this?’”

I, of sterner schools, / Must eat by scientific rules. They made it incumbent upon every responsible citizen to know the value of what he ate: “So do not plunge a hasty fork / Into the pickles or the pork, / But telephone to Harley Street, / ‘Is this a vital thing to eat?’”

Herbert ironically advocates the labelling of food: “Before you order what you want — / Tripe, caviar or crème de menthe — / Before you seize and swallow whole / Some luscious bird or fancy sole, / Send for the manager and hiss, / ‘Is there a vitamin in this?’”

Unhappily, then as now, what was good for us was not always what we most liked: “Well ‘B’ occurs in nuts and peas, / In lentils, beans, and things like these, / In wholemeal rye and wholemeal wheat, / And bread that is not fit to eat, / In roes of fish and some dried fruits, / And milk and yeast and uncooked roots; / And death, as far as I can see, / May be preferred to eating ‘B.’” The solution is close at hand: “I have found a Vitamin / In brandy, burgundy and gin.” Quite right, provided, of course, that it is not overdone; by which I mean, consumption greater than mine.

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BETWEEN THE LINES Theodore Dalrymple

MEDICAL CLASSICS

Longtime Companion

A film directed by Norman René, first released 1990

Longtime Companion is often credited with being the first film to put a human face to the AIDS epidemic. The title derives from the New York Times’s refusal to acknowledge homosexual relationships in its obituaries in the 1980s and its use of the term for the surviving partner in a gay relationship.

The story is told in nine single days in each of the years 1981 to 1989 and follows a group of close friends. The action switches between Manhattan and Fire Island and ends with three of the friends remembering about all those they have lost over the years, all of whom appear to them in a brief imaginary sequence. Longtime Companion does not provide a professional medical perspective, despite the many scenes of doctors dealing with sick patients and trying to communicate to friends and families their ignorance about this terrifying new disease. The portrayal is strictly from the perspective of those affected and their loved ones.

The New York Times’s reporting of the disease through the decade is a continuing thread throughout the film. Initially, the disease is seen mainly as a rare cancer that affects homosexual men. It is then accompanied by Pneumocystis jirovecii pneumonia and toxoplasmosis—all of which affect characters in the film. Later, it transpires that the problem affects patients’ immune systems (and is called “gay related immune disorder”). By the middle of the 1980s it has become clear that the immune deficiency is caused by a virus, albeit one that not everyone might contract (one of the characters likens it to the plague, against which some people also had immunity). At this time, the term AIDS is first mentioned in the film.

Possible causes of AIDS hypothesised by the characters include amyl nitrate use, exercising too much, too much sun exposure, herpes, hepatitis B, giardiasis, LSD, and a mindset focused only on drugs and sex. Initially AIDS was not thought to be contagious, and some of the characters even assume that the new skin cancer is the result of a conspiracy by the FBI.

In the 1980s AIDS inevitably ended in death. The physical horror of wasting away, blindness, and neurological symptoms is well portrayed, but the film makers do not show Kaposi’s sarcoma even though some of the characters discover it. Ronald Reagan is mentioned several times, but Longtime Companion does not reflect on what was being done to identify and contain the epidemic. Problems with health insurance that affect some of the characters are not explored further either—again the focus is on individuals.

By the end, the prevailing mood is one of vague hope: “buddying,” a system in which healthy volunteers look after patients with AIDS, creates a new community spirit, and rather than facing imminent and inevitable death, patients may go on “living with AIDS.”

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FROM THE FRONTLINE
Margaret McCartney

The governing bodies of medicine and nursing have taken note of their tweeting membership and their Facebook friends. The Royal College of Nursing says that you should “keep your personal and professional life separate as far as possible” and “do not discuss work related issues online.”

The BMA has issued guidance saying that although “medical professionals should be free to take advantage” of social media, “it is important that they are aware of the potential risks involved.” And of course it would be unprofessional, stupid, and rude to relate stories containing any identifiable, or potentially identifiable, information about patients online (or indeed elsewhere).

Yet there are hazards in doctors being too afraid to have an online presence. Having doctors online is a good antidote to nonsense science, erroneous media health scares, and David Cameron claiming that GPs who attend dinner parties offer rich friends extra medical services. Write under your own name, and you are ensuring transparency as well as a conscious check of willingness to stand by what you’ve written. Social media enable doctors to stand up for good medicine, democratically and instantly.

This is why I’d humbly suggest that more doctors might like Twitter. I hardly knew what it was three months ago, but after encouragement by @cebmblog (Carl Heneghan, at Oxford’s Centre for Evidence Based Medicine) and @amcunningham (Anne Marie Cunningham, a general practitioner and medical educationalist), I dipped a tentative toe and found Twitter encouraging by @cebmblog (Carl Heneghan, at Oxford’s Centre for Evidence Based Medicine) and @amcunningham (Anne Marie Cunningham, a general practitioner and medical educationalist), I dipped a tentative toe and found Twitter.

THE BEST MEDICINE
Liam Farrell

“I have a list,” he said. As inflammatory opening gambits go, it’s hard to beat.

Osler advised equanimity as the second most important medical virtue, next to sarcasm. So over many years I have cultivated a tranquil demeanour, which the casual observer might misinterpret as apathy. I sat back in my chair, closed my eyes, counted to ten, let peace come dropping slow upon linnet’s wings; a mote of dust floated down. Accordingly, my response was a study in restraint.

“Take your list and get out of here,” I said. “What do you think this is? A supermarket?”

“Calm down, calm down,” he said, in what I had to grudgingly admit was a passable imitation of Harry Enfield; the needle of humour can puncture and deflate even the most promising argument.

“I have only two items,” he explained, “Firstly, I want to be detoxified; my body is a temple.” Yeah, I thought, a big fat hairy temple.

“Words are plastic,” I said. “Terrorists become insurgents; innocent victims become civilian casualties before morphing into collateral damage; Bono is an international philanthropist rather than a greedy tax dodger; and detoxification is no longer the process by which toxins are changed into less toxic or more readily excretable substances but instead a callous pseudoscience that allows the fleecing of vulnerable punters by avaricious charlatans.

“There you are,” I continued, googling “detoxification” and skipping over the inevitable pages of celebrities. “Detox diets, detox recipes, detox tea, detox footpads (for those of us who wish to excrete urea through our feet), and detox plutonium. Apparently any old rubbish can be flogged simply by putting the word ‘detox’ in front of it. It’s the timeless pas de deux of gullibility and greed.”

“OK, OK, it’s a crock, I get it,” he said. “Only a complete idiot would fall for it.”

“You’d have to be a real sucker,” I agreed, secretly astounded that logic had, for once, proved to be helpful during a consultation. “And your second item?”

“I added you as a friend on Facebook,” he accused, “and you haven’t answered.” Social media are perilous; becoming overly chummy may corrode our mystique and degrade our relationship with lay people.

“Let’s think about detox again,” I said.

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Des Spence is away.

Want a friend? Get a dog

“We shouldn’t fear Facebook and Twitter

bmj.com/archive

The other Twitter revolution: how social media are helping to monitor the NHS reforms (BMJ 2011;342:d948)

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