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Table of Contents

CUSTOMER RELATIONSHIP MANAGEMENT
SYSTEMS AND EMPLOYEE SELECTION PROCESSES
WITHIN HEALTH CARE ORGANIZATIONS 1
Danilo Alonso, Baptist Health
Ileana Pineiro, Home Health
Evelyn Amador, U.S. Century Bank
Danny L. Anderson, Jackson Memorial Hospital
Shawn M. Carraher, Cameron University

AN ANALYSIS ON CUSTOMER SERVICE
ORIENTATION AND ITS BUILDING FACTORS: HOW
THE VARIABLES OF PERSONNEL SELECTION AND
PERSONALITY TYPES, PERFORMANCE METRICS
AND DELIVERED QUALITY VERSUS CUSTOMER
EXPECTATIONS MAKE IT OR BREAK IT IN
HEALTH CARE 7
Jonathan Delgado, Marvin's Air Conditioning Corp
Janine De Veer, Boehringer Ingelheim Pharmaceutical, Inc.
Carol Gutierrez, The Boston Beer Company
Gladys Giselle Rodriguez, Trans American C.H.B. Inc.
Samuel Lane, Lane Import

JOB SATISFACTION AS PERCEIVED BY
INDEPENDENT PHYSICIANS IN FLORIDA:
AN EMPIRICAL INVESTIGATION 12
James Farah, The Florida Coastal School of Law in Jacksonville, Florida
Layla A Halawi, Quinnipiac University

EMPLOYEE ABSENTEEISM AND LATENESS AS IT
RELATES TO TURNOVER AMONG MEDICAL
PROFESSIONALS 13
Yaly Flores, Everest Institute
Daniel Salazar, MedVance Institute
John Square, University of Miami School of Medicine
Michael Martinez, Allstate Insurance
Shawn M. Carraher, Cameron University

PRIMARY CARE PHYSICIANS AND OFFICE
WORKFLOW DESIGN PLAY A CRITICAL ROLE IN
THE ADHERENCE TO COLONOSCOPY SCREENINGS 18
Bernard J Healey, King's College
Lisa Grazul, King's College

CUSTOMER ORIENTATION: EFFECTS ON
CUSTOMER SERVICE IN HEALTH CARE 22
Jesus Martinez, Noven Pharmaceuticals, Inc.
Emilen Medina, Nova Southeastern University
Samuel Lane, Lane Import

THE ENORMOUS COST OF MEDICAL ERRORS 27
Michele McGowan, King's College
Bernard J Healey, King's College

FACTORS AFFECTING ENTRY INTO FOREIGN
MEDICAL DEVICE MARKETS 31
Jeremy Phelps, University of New Mexico School of Medicine
Shawn M. Carraher, Cameron University

CUSTOMER LOYALTY IN HEALTH CARE 39
Samuel Lane, Lane Import
Cira Posada, Oscient Pharmaceuticals
Melissa Manzanero, Stephen James Associates
Stephen Cohen, Baptist Health

ECONOMICS SHOULD PLAY NO ROLE IN THE
DISTRIBUTION OF BODY ORGANS FOR
TRANSPLANTATION 44
James Sysko, King's College
Bernard J. Healey, King's College

CUSTOMER RELATIONSHIP MANAGEMENT SYSTEMS AND EMPLOYEE SELECTION PROCESSES WITHIN HEALTH CARE ORGANIZATIONS

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ABSTRACT

The purpose of this research paper is to discuss the correlation between Customer Relationship Management systems and Employee Selection Processes within healthcare organizations. Recruiting employees who have personality traits consistent with customer-orientated behavior positively contributes to the successful implementation of Customer Relationship Management System. Traditional methods are also useful when conducting interviews to identify the best candidate for the job. Knowing what you need, asking the right questions, assessing your management style, setting expectations clearly or offering competitive compensation benefits and rewards. Peer interviewing is an innovative method of selecting employees during the hiring process. This method incorporates involving employees with the same skill set conducting interviews with the inclusion of their management. Implementing a collaborative environment can contribute constructively to the success of any organization. Creating a win-win scenario where both sides find agreeable outcomes, concepts and solutions that go beyond the interest of the individual involved can advance rather than decline the success of the implementation of any Customer Relationship Management system and Employee selection process within the healthcare field.

INTRODUCTION/CONCLUSIONS

Customer Relationship Management (CRM) is a method that uses information technology solutions to develop an ongoing relationship with customers to maximize the value an organization can deliver to their customers over time. The objective of CRM initiatives is to establish a service-oriented architecture where customer data can be shared across business functions and applications. The CRM system would allow interconnected functional areas of the company, sales and support, service and support, and marketing to share demographic and activity data about the customers. Several stages must occur before any computer system, such CRMs, can be implemented successfully within any organizational environment. There are at least four stages required for the successful implementation of any system; planning stage, design stage, build stage, testing stage and then go-live.

Future research is suggested based upon prior research (Buckley and associates, 1992-present; Carland and associates 1984-present; Klentzman & Associates.

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AN ANALYSIS ON CUSTOMER SERVICE ORIENTATION AND ITS BUILDING FACTORS: HOW THE VARIABLES OF PERSONNEL SELECTION AND PERSONALITY TYPES, PERFORMANCE METRICS AND DELIVERED QUALITY VERSUS CUSTOMER EXPECTATIONS MAKE IT OR BREAK IT IN HEALTH CARE

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Carol Gutierrez, The Boston Beer Company
Gladys Giselle Rodriguez, Trans American C.H.B. Inc.
Samuel Lane, Lane Import

ABSTRACT

The purpose of this study is to research about the different variables involved in determining what quality customer service is and how the factors of personnel recruitment, performance metrics and customer expectations are truly involved in being able to create and deliver customer service satisfaction in health care settings. We will dive into how personnel recruitment and the selection of specific personality factors such as extroversion, openness, agreeableness, neuroticism and conscientiousness, better known as The Big Five, can create better customer service. We will conduct research on the recommended criteria to use when hiring employees applying for positions that entail customer service, such as interpersonal skills and character traits necessary to be a successful customer service representative along with suggestions, strategies and best practices for individuals, organizations and their Human Resource Departments to employ when dealing with the matter of being customer service oriented. We will also talk about how customer service expectations vary across the different generations.

INTRODUCTION/CONCLUSIONS

Please contact the first author for a copy of the full paper.

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JOB SATISFACTION AS PERCEIVED BY INDEPENDENT PHYSICIANS IN FLORIDA: AN EMPIRICAL INVESTIGATION

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ABSTRACT

The purpose of this study was to gain a more complete understanding of the factors that pertain to independent physician job satisfaction. This group of physicians consists of physicians who own their own practice or who are employed in a privately owned medical practice in the State of Florida. The present study tested a model of job satisfaction for independent physicians practicing in the State of Florida building on the widely accepted Stamps and Cruz (1994) scale. A total of 350 surveys were distributed to independent physicians. Of the 350 questionnaires mailed, a total of 117 responses were returned. Factor analysis and regression analysis were used to analyze the study's model. Six hypotheses were developed. Five hypotheses were supported. This research was limited in that the study sample was derived from a limited geographic area and the survey population was also relatively small.

Keywords – Job Satisfaction, Stamps and Cruz's job satisfaction scale, independent physicians, Florida.

EMPLOYEE ABSENTEEISM AND LATENESS AS IT RELATES TO TURNOVER AMONG MEDICAL PROFESSIONALS

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ABSTRACT

Every year companies spend millions or even billions of dollars to replace employees due to absenteeism and turnover. Companies end up paying for time lost, recruitment and training. Since companies have lost tons of money, research are trying to figure out which individual and organizational behaviors prompt these behaviors and associate them with psychological factors (Albion, Fogarty, Machin, Patrick, Australian Health Review 2008). Absenteeism and turnover are the most extreme factors associated with withdrawal. Researchers are trying to come up with models to see if they can come up with a solution to reduce the costly out come (Albion, Fogarty, Machin, Patrick, Australian Health Review 2008).

INTRODUCTION/CONCLUSIONS

This study was designed to examine the relations between positive and negative psychological states and both absenteeism and turnover intentions. It was expected that both positive and negative psychological states would be associated with absenteeism and turnover intentions in the health professions; and that absenteeism (in particular, absence duration) and turnover intentions would be unrelated in the health professions as found by Albion, Fogarty, Machin, & Patrick. Future research is suggested based upon prior research and theory (Buckley and associates, 1992-present; Carland and associates 1984-present; Klentzman & Associates, 200).

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PRIMARY CARE PHYSICIANS AND OFFICE WORKFLOW DESIGN PLAY A CRITICAL ROLE IN THE ADHERENCE TO COLONOSCOPY SCREENINGS

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ABSTRACT

Colorectal cancer, the second most common cause of cancer death in the United States, is preventable if detected at an early stage. A readily available screening test can prevent many cases of cancer by identifying and removing pre-cancerous polyps. Unfortunately, the majority of eligible Americans are not screened.

The primary care physicians can play a critical role in early detection of this very dangerous form of cancer. By educating their patients on the importance of colorectal screenings, primary care physicians can decrease advanced stages of the cancer, increase survival rates, and decrease overall healthcare expenses. Therefore, it is very important that primary care physicians utilize office workflows that maximize efficiencies while allowing for critical preventive care discussions like the need for colorectal screening to be discussed with patients. This paper focuses on the role that needs to be played by the primary care physician in increasing early screening for colorectal cancer in this country.

INTRODUCTION

Yarmall, Pollak et al. (2003) found that despite evidence that supports the effectiveness of preventive services the delivery of many of these services is very low. One of these very effective preventive programs is the screening for colorectal cancer. This form of cancer can be prevented by regular screening examinations by a health professional in the detection and removal of precancerous growths, as well as the diagnosis of cancers at an early stage when they are most treatable. Unfortunately, the majority of Americans are not screened for this very preventable form of cancer. In fact, almost 45% of adults age 50 years or older have not had a colonoscopy screening.

Colorectal cancer can be prevented by performing tests that allow the doctor to detect and remove the polyp which may harbor a cancerous growth. These tests, commonly referred to as health screenings, are tests or physical exams that are used to assess your health. Several tests can be performed alone or in conjunction to detect colorectal cancer. They are the fecal occult blood test, flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema. According to Gennarelli, Jadorf et al. (2005) the screening of asymptomatic patients for colorectal cancer reduces morbidity, mortality and is cost effective.

Typically, colorectal screening recommendations vary depending on the test performed as well as among national organizations. According to the Centers for Disease Control and Prevention, CDC (2009) colorectal cancer screening for average-risk adults should begin at 50 years of age. The CDC also recommends that the FOBT test be performed annually. They recommend the flexible sigmoidoscopy test be performed every 5 years, the colonoscopy be performed every 10 years, and the double-contrast barium enema be performed every 5 years. The Centers for Disease Control and Prevention (CDC) (2009) recommends that colorectal cancer screening be performed on adults ages 50 to 75

It is also recommended that those patients with an increased risk factor need to start a screening program as early as age 20. Elevated risk factors are those patients with "a personal history of polyps or cancer; a personal history of inflammatory bowel disease; a mother, father, brother, or sister with colorectal cancer; or familial hereditary colon cancer syndromes. It is important to detect the cancer in the early stages not only to reduce mortality, but also to reduce the cost of total healthcare expenditures associated with this disease. Maciosek, Solberg et al. (2006) argue that colorectal cancer screening remains a missed opportunity for saving lives and reducing the costs of health care delivery in this country.

LITERATURE REVIEW

Klabunde et al. (2009) found that the main reasons patients do not participate in the recommended screening rates include cost, knowledge, and fear of testing. Lower screening rates are also due to primary care physician's lack of discussion and recommendation for screening during the patient visit. Denberg, et al. (2003) argues that the major barriers to screening can be found in three specific categories of cognitive emotional, logistic, and health system.

The best opportunity for increasing colorectal screening were those related to the health system. This highlights the importance of primary care physician's influence on increasing colorectal screening rate. Simply by discussing and recommending the screening to their patients, as well as implementing ease of scheduling, primary care physicians can positively impact patient compliance with this recommended screening test that saves lives.

In order to emphasize the critical role primary care physician's play in influencing screening rates, it requires an understanding of where they fit in the healthcare delivery system. They serve as the coordinator in assisting patients not only with clinical care and information, but in understanding and navigating the healthcare system. The primary care physician holds a strategic position for the delivery of preventive services to the population. Depending on the particular scope of the problem, the primary care physician may refer the patient to a specialist. Their office will contact the specialist's office to arrange for an appointment. Their office will also be responsible for ensuring their insurance covers the service and that any ancillary testing is completed before their scheduled appointment. This will ensure that the specialist has all of the relevant information regarding the patients' medical condition when they arrive for their appointment.

RESULTS

The literature review confirmed that the primary care physician's role is substantial in promoting and increasing colorectal cancer screening rates. There are at least four components necessary for the successful delivery of preventive healthcare: knowledge, skills, attitude, and organizational structure.

Knowledge refers to the education of the physicians. Primary care physicians play a key role in promoting colonoscopy screening so it is critical that they understand the positive impacts of screenings. It is also important that physicians have the skills necessary to effect patient change. This requires continued education courses to keep them up to date with prevention strategies in an effort to change patient attitudes. Increasing physician knowledge and skills regarding colorectal cancer and the importance of screening requires the organization to develop a systematic approach that is convenient and effective for the physicians to gain more knowledge about the importance of this screening test.

Another necessary component for physicians to have successful preventive services is the organizational structure of their office. It is critical that the physician's time be efficiently managed to allow their patients access to their services. This system based change will require a focus on workflow design. In light of the shortage of primary care physicians and reimbursement tied to quality services, it is more important than ever to have the most efficient workflow design in the office. Redesigning the traditional workflow model in the office that identifies those patients who fall within the guidelines for colonoscopy screenings, and ensures their compliance with minimal impact to the time allotted for the patient visit will be influential in driving physician participation. The model must be designed to allow the physician enough time to maximize the patient's visit by addressing multiple problems including the need for preventive care. There are a number of different workflow designs that can be implemented in a primary care office. The key is to create and implement a design that works best for the individual primary care physician's office.

The focus needs to be not on how much more the physician must do independently in order to increase screenings, but on what the organization can do collectively within the office to enhance physician participation in screening recommendations to their patients. Gennarelli, Jandorf et al. (2005) argue that In order to accomplish this task organizations need to adapt the following key elements in the office structure: an explicit written practice policy; the development and implementation of specific screening plan, computer-based tracking and recall system, reminder systems for both patient and providers, delegation of responsibility to office staff and periodic audits of performance with personalized feedback

The written practice policy will make it very clear to the physicians what the criteria is for screening. The development and implementation of a specific screening plan within the office is the key to successful preventive maintenance because it clarifies the process for the staff and physicians. A multifaceted plan should include a computer-based tracking and recall system that will contact those patients that meet the criteria for a screening. Physicians and their staff do not have the time to follow-up with those patients who have been referred for a colon screening. An automated system will ensure they have completed the test.

The success of the office workflow design is very dependent on the staffing efficiencies. Having dedicated staff assigned to key steps in the office workflow allows for the physicians and

nurses to continue to see patients within the average time required to ensure access to their practice while providing quality care.

It is also important for the primary care physician to incorporate performance reviews. Even though there is an automated follow-up system, it will be critical to the office to incorporate an audit of their patient panel to determine if the plan is working. The audit results will tell the physician where they need to adjust the plan to ensure their patients are being reached with regards to preventive maintenance.

DISCUSSION

Colorectal cancer is a serious and costly cancer that accounts for approximately 50,000 deaths per year and is the second most common cancer in the United States. Colorectal cancer can be prevented with a focus on following the recommended guidelines for screening tests. While this seems like a simple solution, current colorectal screening rates show that testing for this form of cancer remains very low. The barriers for which the focus should be in order to have the most impact is the primary care physician's knowledge and office workflows. Gennarelli, Jadorf et al. (2005) argue that an effort must be made to increase physician knowledge of current guidelines regarding colorectal cancer prevention and detection.

Providing educational resources for physicians that are available to them via teleconferencing allows them the opportunity to become aware of the need for cost effective recommendations that they provide to their patients. This should result in an increase in screening rates because of the relationship they have with their patients. However, the education must be coupled with an office workflow that is designed to promote increased screening rates while taking into account the time and resource constraints of the primary care physicians.

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CUSTOMER ORIENTATION: EFFECTS ON CUSTOMER SERVICE IN HEALTH CARE

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ABSTRACT

The effects of being customer oriented on service performance perception and the effect it has on the behavior of the customer in health care settings is the focus of our study. To be more precise, we attempt to discover how service value, customer satisfaction, consumer outcome behavior, and quality perception is affected in customer-oriented firms. We researched studies and consumers and, not only concluded, that there is a direct correlation between service, physical goods, and customers' evaluations of employee service performance to customer orientated firms; but there are also indirect effects on value attributions, outcome behaviors, and organizational quality. The results of the research are discussed further, along with their limitations.

INTRODUCTION/CONCLUSIONS

A copy of the full paper is available from the first author.

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THE ENORMOUS COST OF MEDICAL ERRORS

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ABSTRACT

The Institute of Medicine (1999) reports that up to 98,000 patients die each year from preventable medical errors. According to Sultz and Young (2009) medical errors, especially in hospitals, have been a well known problem which commands very little attention by those in power. In many instances physicians and hospitals would be reimbursed for having the error and then reimbursed again for rectifying the error if the patient lived. These errors included diagnostic and treatment errors, surgical errors, drug errors and delay in treatment to name a few.

It is frightening to hear that one of the major causes of medical errors was miscommunication among health care professionals Brownlee (2007) points out that lack of cooperation among the players in the current health care delivery system is one of the major reasons of the epidemic of medical errors in medical care. Emanuel (2008) points out that too many patients are the victims of preventable medical errors and infections that occur in the hospital.

This paper will attempt to find the major causes of medical errors and make recommendations to reduce these preventable mistakes that result in lives lost, disability and enormous costs for our health care delivery system.

INTRODUCTION

The health care delivery system in the United States is facing tremendous challenges as it attempts to respond to calls from everyone for reform. There are calls from government, businesses and consumers for better health care at a price that we can all afford. This reform effort is uncovering many problems involving costs, access and our poor health status when compared to other countries. There is another problem found in health care that is rarely mentioned by the media that involves errors in medical care delivery. There is overwhelming evidence that many people are being hurt by the very system that is supposed to be offering them a cure for their medical problems. These people are being hurt, disabled and killed by the medical care system that is thought to be their only way to get their health improved.

Medical care and hospitals on one hand provide us with a hope of the cure of illness and disease and on the other hand can be very dangerous and in some cases actually be a threat to our life. There are mistakes made in medical care delivery that could be avoided. The Institute of Medicine, IOM, (1999) released a study revealing that as many as 98,000 of the 33 million individuals hospitalized each year die and many more receive secondary infections because of poor quality health care while hospitalized. According to Black and Miller (2008) the percentage of hospital admissions experiencing injury or death is 2.9 percent on the low side and 3.7 percent on

the high side. Medical errors and hospital acquired infections have become epidemic in this country and the problem seems to be getting worse.

The IOM (1999) defines medical errors as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." These errors typically occur in operating rooms, emergency departments and intensive care units. There is mounting evidence that entering the medical care system at any location increases the risk of adverse drug events, errors in care delivery and hospital acquired infections. These errors are increasing the cost of health care delivery, longer hospital stays, disability, death and the loss of trust in medical care. In fact, medical errors are now estimated to be the eighth leading cause of death in the United States.

Health care services are produced as required and are not prepared ahead of demand so they must be evaluated as produced. Therefore, if mistakes are made in the delivery of these services it is too late to correct the faulty delivery. This makes it very important that systems be designed to prevent errors in the delivery of health care services before they are delivered.

Epidemic of Medical Errors

According to Sultz and Young (2009) medical errors, especially in hospitals, have been a well known problem which commands very little attention by those in power. In many instances physicians and hospitals actually received reimbursement for having the error and then are reimbursed again for rectifying the error if the patient lives. According to Brownlee (2007) the most common error in medical care delivery involves administering drugs to patients. These drug errors include the administration of the wrong drug, the wrong dose of the right drug or drug interactions that harm the patient. The IOM (1999) points out that these drug errors add \$5,000 to the cost of every hospital admission.

Emanuel (2008) points out that too many patients are the victims of preventable medical errors and infections that occur in the hospital. It is frightening to hear that one of the major causes of medical errors is miscommunication among health care professionals. Brownlee (2007) points out that lack of cooperation among the players in the current health care delivery system is one of the major reasons of the epidemic of medical errors in medical care. In many instances the teams of medical care professionals simply do not talk to each other about the care of their patient. These mistakes are often made because there is not adequate knowledge on how to make the system work error free.

HOSPITAL ACQUIRED INFECTIONS

According to the Centers for Disease Control and Prevention (2009) Healthcare-associated infections, or nosocomial infections, are infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting. A very good example of this type of hospital acquired infection is Methocylene Resistant Staphylococcal Areaus better known as MRSA. These healthcare-associated infections are one of the top ten leading causes of death in the United States.

THE NEED FOR TEAMWORK AND COMMUNICATION

The cause of the vast majority of these medical errors are a direct result of poor communication among health providers and a lack of team work in the delivery of health care services. The solution to this problem will require the development of a culture of safety in health services delivery.

The current health care delivery system is a fragmented system of care that usually requires patients to see multiple providers in many locations virtually guaranteeing that these providers do not have access to complete patient information. Making matters worse there is no incentive to improve safety and quality of care. These medical errors are caused by a faulty system that actually encourages mistakes.

The system must be better designed so that it becomes more difficult for mistakes to be made. Brownlee (2007) argues that the system requires far too many people to do everything right every time in order to arrive at a successful patient outcome. This type of system is perfect for "latent errors." These are mistakes in medical care delivery that are waiting to happen.

According to Spear (2009) the old approaches to medical care delivery must be replaced with a more sophisticated approach that is improved when problems are revealed and modified or dropped completely when the situation changes. This is clearly the case with medical errors which need to be eliminated by dealing with the known flaws found in this complicated system. This can only be accomplished by medical staff not attempting to work around this problem but immediately redesigning the process when problems are uncovered.

Spear (2009) recommends that the approach followed by ALCOA in reducing workplace injuries by a substantial amount be applied to the epidemic of medical errors currently found in the delivery of health care services in this country. The new CEO of ALCOA, Paul O'Neill, made safety problems reportable directly to him within twenty four hours of their occurrence. He then designed a system that had the ability to detect problems when and where they occur. These safety problems are then swarmed at the time and place of occurrence. This makes it possible to gather information that would probably be lost over time. After a solution to the problem is discovered the new knowledge is then shared with everyone who needs to know. This approach, utilized by high velocity organizations, usually exhibit the following capabilities: it is designed to capture existing knowledge and building in tests to reveal problems, swarming and solving problems to build new knowledge and sharing the new knowledge gained throughout the organization.

DISCUSSION

These medical errors and hospital acquired infections can be prevented but it will require a great deal of reform in the way medical care is delivered in this country. Medical care is a service that is intangible produced by individuals who are quite capable in making mistakes in the way the service is delivered. This care is produced by the system developed to deliver medical care services to Americans. Systems usually get precisely the outcome that they are designed to deliver.

There are several targets that require transformation in health care. These targets are unjustified variation in care, fragmentation of care giving and perverse payment incentives that reimburses by units of work rather than payment for predetermined outcomes. The health care

delivery system needs to approach medical errors the way ALCOA reduced safety problems. They need to solve the problems the minute they occur not accept them as a cost of doing business. They need to swarm the problem, discover the cause and immediately share the results with the rest of the organization.

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FACTORS AFFECTING ENTRY INTO FOREIGN MEDICAL DEVICE MARKETS

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ABSTRACT

The medical device industry has been steadily growing for several decades. Following globalization trends, the industry has increasingly looked to enter foreign markets. A number of factors, however, affect the conditions of entry into foreign medical device markets. Five primary categories of factors unique to medical device markets were identified and include: market, scientific seeds, commercialization/venture capital, regulatory/policy, and sociopolitical context. The elements of these factors are delineated and discussed in terms of their pull, push, or drag effects. Finally, a discussion of possible modifications to these factors and the subsequent effects that these changes would create is undertaken.

INTRODUCTION

The population of the world was estimated to be six billion people in the year 2000. Conservative projections of world population by the United Nations estimate a world population of approximately eight billion people by the year 2030. These estimates increase to approximately thirteen billion if the current population growth rate is maintained (United Nations, 2001). The population increase is due not only to increased birthrates, especially in Africa, Asia, and South America, but also to an ever increasing life expectancy. The 2000 United States (US) census reported that 12.4% of U.S. citizens were 65 years of age or older and that this percentage would likely increase significantly as the Baby Boomer generation ages (Hobbs and Stoops, 2002). Guezuraga and Steinbring (2004) report that 16% of Europe's population is greater than 65 years of age and this percentage is expected to increase to 25% by the year 2020. Increases in population coupled with increasing life expectancies have created an expanded the need for medical services as well as increased health care expenditures in the USA, Europe, Japan, and Latin America (Schrenker, 2009; Atun, Shah, and Bosanquet, 2002). This universal expansion of services has concomitantly increased the need for the medical devices utilized to provide care for patients. The medical device industry is indispensable for the delivery of healthcare and innovation in a clinical setting (Altenstetter and Permanand, 2007). Nass, Alexis, and Crocker (2006) state that the healthcare market is poised to grow relative to the general economy for the foreseeable future, making it an attractive market for domestic and international producers. As the need for medical devices increases, companies have rushed to meet the need of both the population and medical community. Technological innovation and invention have also served to introduce a multitude of new medical devices to the market (Atun, Shah, and Bosanquet, 2002). Traditionally, medical devices were manufactured and utilized in relative geographic isolation. Trends toward globalization

have led medical device companies to increasingly seek out and enter international markets. Despite the increased opportunities afforded by globalization, these opportunities are often difficult to realize (Anast, 2001). While a full evaluation and review of the medical device market is beyond the scope of this paper, it will provide a description of the key features of the medical device market and discuss characteristics unique to the development of these devices. Furthermore, it will attempt to describe the crucial factors that must be considered for a medical device company to enter an international medical device market. Differences in individual countries will be utilized to emphasize key aspects of these factors. Additionally, these factors will be evaluated in terms of their pull, push, and drag in foreign markets.

Medical Device Market

A medical device is defined as an appliance whose primary mode of action affects the patient independently of being metabolized (as with medications and other biologic agents). While the devices provide a therapeutic benefit without being metabolized, they can assist in the delivery of medications or other biological agents (Werner, 2003; Atun, Shah, and Bosanquet, 2002). Medical devices have long been attributed to increases in both quality of life and health improvement for both individuals and communities (Eng, 2004; see also Ackerly, Valverde, Diener, Dossary, and Schulman, 2009; Burns, Housman, and Robinson, 2009). Due to the number and types of conditions that the devices are used to treat, the market is large (over 7,500 different devices are marketed each year (Russell and Tippett, 2008)) and diverse. The industry has annual sales of between \$100-160 billion dollars globally (Russell and Tippett, 2008; Atun, Shah, and Bosanquet, 2002). US companies had estimated sales of \$40-60 billion dollars in 2002, with the European Union (EU) and Japanese companies sales equaling \$41 billion and \$24.5 billion dollars, respectively (Russell and Tippett, 2008; Atun, Shah, and Bosanquet, 2002). Industry growth is between 8-9% annually (Russell and Tippett, 2008; Werner, 2003) with US, EU, and Japanese companies demonstrating growth rates of 7%, 5.5%, and 4%, respectively (Atun, Shah, and Bosanquet, 2002; see also Anast, 2001). The US exports approximately 60% of its production (Werner, 2003) while the EU exports approximately 60% of its production (Atun, Shah, and Bosanquet, 2002). The opening of new markets, especially in Asia and Latin America, have both allowed and driven companies to expand their markets. Russell and Tippett (2008) state that US firms face significant competition from EU and Japan, as well as China and India and that the large populations and companies from these countries will push the US into using their devices.

While the industry is large and competitive (Dixon, Brown, Meenan, and Eatock, 2006), it is also relatively fragmented (Atun, Shah, and Bosanquet, 2002). The customer base is also diverse with large and small volume customers coming from both the public and private sectors. Medical devices have high turnover rate and relatively short life cycles with new technology and devices supplanting older ones cycles approximately every 18 to 24 months (Russell and Tippett, 2008). New product development is critical to the ongoing success of the industry (Dixon, Brown, Meenan, and Eatock, 2006). Innovation in the medical device industry relies heavily on financial measures, resource availability, and time-to-market lead times (Russell and Tippett, 2008). As a result of these basic requirements, medical device firms typically spend a higher proportion of its revenues on research and development (US Food and Drug Administration (FDA), 2004). This is especially true in the US, where Ibatá-Arens (2008) reports US research supports 75% of the industry market.

Despite the need for continued innovation and product development, the FDA (2003) feels that real innovation has been absent in the industry for many years. This perceived “lack of innovation” is most likely secondary to a focus of companies on non-disruptive (incremental) innovation and alterations to their devices. If poorly regulated or inappropriately utilized, medical devices may place patients at risk (Altenstetter and Permanand, 2007) and, consequently, are highly regulated (Dixon et al., 2006). Altenstetter and Permanand (2007) list the objectives of device regulation as the promotion of trade and the service of public health needs by ensuring devices meet objectives of safety, quality, and efficiency. Development costs are typically higher due to regulatory requirements and the need for clinical testing (Russell and Tippett, 2008). Unlike the pharmaceutical industry, the medical device industry has no well-defined route to the market (Dixon et al., 2006). Dixon and colleagues believe that this is secondary to a large number of companies with very different backgrounds (from small start-ups to large international corporations) and the diversity and number of medical devices.

Considerations for International Expansion

As globalization increases, both large and small medical device companies are increasingly seeking to expand into international markets. Companies must understand and traverse a multitude of factors in order to successfully enter any market and seek to be entrepreneurial (Carland & Carland and Associates). These factors are numerous and often quite complex, consequently, an extremely thorough delineation and description of all possible factors is beyond the scope of this paper. There are, however, several key issues that every medical device firm must address when entering a market either domestically or internationally. Companies must apply the appropriate principles of entrepreneurship, invention, management, marketing, and finance to each of these areas in order to be successful. Many of these issues are compounded when moving abroad. The factors for entering a foreign medical device market are divided into five distinct categories: market, scientific seeds, commercialization/ venture capital, regulatory/ policy, and sociopolitical context. For ease of discussion, the description of each will follow in a step-wise progression from the creation of the device to the entry into the market. Additionally, each factor will be evaluated in terms of pull, push, and drag. Iyata-Arens (2008) defines these terms as follows: pull- factors drawing companies into the market, push- factors which actively promote entry into the market, and drag- factors which delay or impede entry into the market. Specific differences between countries in relation to these factors will be addressed. As medical devices are utilized in every country throughout the world, it would be unrealistic to assume that the subsequent discussion of individual country differences will be exhaustive. This paper hopes, however, to provide a well-rounded discussion of differences in the major markets of the world.

Market

A market may be defined at its most basic level as a collection of buyers and sellers of a particular product (Mankiw, 2009). Utilizing this basic description, the two primary forces within the medical device market are the consumers of the devices (patients and the medical care providers (be they facilities such as a clinic, hospital, or an imaging center or physicians)) and the current status of the market. As mentioned previously, the world population is steadily increasing. This is coupled with increased life expectancy in the US, EU, and Japan (Hill and Sawaya, 2004; Iyata-

Arens, 2008; Atun, Shah, and Bosanquet, 2002) and has created an increased demand for medical devices. Additionally, China, with an estimated population of approximately 1.3 billion people, provides an enormous potential market (Ibata-Arens, 2008; Russell and Tippett, 2008; Anast, 2001). Similar statements could be applied to the large populations on the Indian Subcontinent. Not only are large populations responsible for increasing potential markets, but the standard of living in each country also plays an important role in the establishment of a favorable market. It is clear that and increased gross domestic product has been correlated with increased life expectancy, adult literacy, and internet usage (United Nations, 2007). Increases in life expectancy undoubtedly increase the market demand for medical devices, but the standard of living, adult literacy, and internet utilization indirectly increase the market as well. Atun, Shah, and Bosanquet (2002) report that lifestyle changes in markets point to time-poor consumer societies with increased disposable income which create consumers desiring the rapid delivery of expected services. Increased disposable income provides the ability to afford the use of medical devices as part of medical treatment plans. Moreover, increases in literacy and internet utilization create consumers with an increased understanding of their condition and a knowledge of the available treatment options, including medical devices. This can translate into patients demanding tests, technology, and devices (Guezuraga and Steinbring, 2004). Increased disposable income also permits a greater amount of recreational activity including active sports and fitness pursuits which may increase the need for non-prescription injury and sports-medical products (Atun, Shah, and Bosanquet, 2002). Increasing prosperity may enable countries to establish medical training programs which would train physicians on the most current medical treatments, including appropriate medical device utilization. Larger disposable incomes for physicians allows them greater access to emerging medical knowledge through electronic journal subscriptions and other electronic educational material (Smith et al., 2007; Aronson, 2004; Horton, 2000) as well as travel to medical meetings to learn the most current medical techniques. Exposure to new technology and techniques will serve to increase the physicians' desire for access to various medical devices, thereby increasing the potential market.

When considering entering any market, a survey of the competitive environment is paramount. The number of competitors within a market, their market share, and their control over items such as distribution channels plays a major role in the attractiveness of a market (Nass et al., 2006). Burns, Housman, and Robinson (2009) assert that market entry is influenced both positively and negatively by the number of competitors in the market. They maintain that if there are too many competitors within the market companies will have difficulty establishing themselves and, if too few competitors are present the market may not be large enough to support the entry of a new company.

The primary factor pulling a company into a new region is the market. Market evaluation is the most critical element in assessing whether or not to enter a particular market. If the market is non-existent or is not conducive to entry, attempts to enter are unlikely to be profitable. Factors such as population and demographics changes are relatively consistent throughout the developed world (e.g. US, EU, Japan, and Australia). Less-developed nations are steadily increasing their prosperity, education, and infrastructure providing favorable conditions for large, new markets. This is easily illustrated by the development of both China and India over the last two decades, but may also be seen in Latin and South America, Southeast Asia, and Northern Africa (Russell and Tippett, 2008; Atun, Shah, and Bosanquet, 2002). As individual prosperity increases, both patients and healthcare

providers will increase the demand for medical devices. Evaluations of current competitors and their position in the market also play an important role in the decision to enter a new market.

Discussion

The medical device industry has been well established in many areas of the world. Those areas which do not currently possess well-developed medical device industry are clearly aware that the devices exist. Additionally, new medical devices are created with increasing frequency and these devices will require dissemination to foreign markets (both established and unestablished). These factors have created strong “pulls” for medical devices to enter these markets. Additionally, factors such as national and regulatory policy, venture capital policies, and cultural and societal norms have created “pushes” for device companies to enter foreign markets. There remain, however, difficulties when attempting to introduce devices into these markets. These drag factors are often similar to the discussed push factors and often what constitutes a push in one country may be viewed as a drag in another. While developed and non-developed nations follow similar innovation and implementation processes, different factors may play a role in the ultimate achievement of these purposes (Zain, Richardson, and Adam, 2002). In order to increase both push and pull factors, as well as reduce drag factors, several measures may be implemented. Increasing the pull factors will be relatively difficult as the primary deterrents at this point are social and cultural in nature. These deterrents may be overcome through time and education, but the process will be lengthy. Increasing push factors and decreasing drag factors will provide the highest likelihood of facilitating entry into foreign medical device markets. Major hurdles faced by device manufacturers include regulatory and marketing requirements. Although these are relatively easy to manage in countries with well-developed regulatory policies or by large multi-national firms, the majority of industry expansion will be by smaller firms who are less-equipped to navigate the regulatory process or in less-developed nations with regulatory policies which are relatively new and unsettled. Atun, Shah, and Bosanquet (2002) assert that the major driver of medical device globalization will be the harmonization of industry standards, quality, and operating systems. Furthermore, they feel that the coordination of industry standards will promote merger and acquisition which favors companies with a regional or international focus. Russell (2008) echoes this sentiment, stating that the adoption of global standards could help streamline the movement of medical devices internationally thereby saving time and money for the manufacturers, saving the time and resources of the countries, and developing a common quality platform which would benefit patients. The EU has been a leader in this endeavor, but a complete standardization has yet to be achieved (Faulkner and Kent, 2001). Altenstetter and Permanand (2007) believe that the EU system is failing due to a lack of central expertise, considerable delays, disagreements amongst standard setters, and the allowing of “protectionist interests” at a national level to undermine EU level policy. While the national requirements in Europe were to be phased out beginning in 1992, this has yet to occur and EU policies are implemented by and subject to individual country control. This has led to an increase in national product regulation despite regulatory reform and liberalization of the EU market (Altenstetter and Permanand, 2007; Atun, Shah, and Bosanquet, 2002). Some argue that governments are ill-equipped to lead efforts to regulate medical devices (DoBias, 2009) due to their historically poor record when dealing with clinical issues. Regardless of the regulatory agencies involved, decreases in regulatory requirements of enter foreign markets would transform drag

factors into push factors, encouraging entry into new markets. Resources regarding and facilitating the compliance with regulatory processes are increasing available in many countries (Boerner, 2001). These resources have enabled companies to tailor product designs and create specific goals for their devices which greatly increase the likelihood of regulatory approval (Alexander and Clarkson, 2002). These measures have served to decrease the drag factors of the regulatory process. Guezuraga and Steinbring (2004) suggest that foreign governments should be convinced that spending in the medical device industry is valuable in terms of reduced mortality, disability, and hospital stays, as well as extended life expectancy. Declining reimbursements for medical devices have pushed some companies from the medical device markets into other, more lucrative endeavors such as cosmetics (Ackerly et al., 2009). Additionally, Ackerly et al. (2009) feel that protecting the venture capital sector is important in terms of stimulating an innovative system of healthcare delivery. Restrictions on the litigious nature of certain countries such as the US would likely stimulate an influx of foreign medical devices. The policies of individual countries will enable these drag factors to either be reduced or be changed into push factors, facilitating greater entry into foreign medical device markets.

CONCLUSION

Healthcare in the 21st century has become increasingly dependent upon medical devices whether they are condoms, masks for the operating room, catheters utilized in cardiac catheterization procedures, spinal fusion implants, or proton beam accelerators for the treatment of tumors. The increase in device utilization has given rise to a large and profitable medical device industry. As globalization has increased, the medical device industry has expanded as well. Medical device companies seeking to expand into foreign markets must be cognizant of many forces which affect market entry. These forces may create pull, push, or drag and, ultimately, will affect the ability and ease of entry into these markets. While seeking to limit the discussion to those forces specific to the medical device industry, the primary factors influencing entry into foreign markets may be grouped into five categories: market, scientific seeds, commercialization/ venture capital, regulatory/ policy, and sociopolitical context. While each of these factors may create a pull, push, drag, or a combination of these forces, countries are able to manipulate them to variable extents creating an environment more conducive to the entry of foreign medical devices. The primary means by which this may be accomplished are a decrease in the regulatory policies through standardization and education and the creation of national policies (such as decreased import tariffs, increased device reimbursement, and improved intellectual property laws) which would increase the attractiveness of the market in their country.

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CUSTOMER LOYALTY IN HEALTH CARE

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ABSTRACT

Gaining customer loyalty requires a customer-focused attitude in the organization (Hawkins et. al, 2001). Customer loyalty depends on committed teams of employees and suppliers. To gain lifelong loyalty, an organization must continually meet and exceed customer expectations. The customer must believe that the organization is treating them fairly and is concerned with their overall well-being; therefore, customer service is of utmost importance. Customer service representatives are the front line troops in the battle to win the customer's loyalty. Loyalty can only be earned when leaders put the needs of their customers and their partners ahead of their own interests (Reichheld, 1996). In this paper we examine customer service and its importance in the health care field looking at both pharmaceuticals and hospital care. We find that there are differences in how organizations can develop customer loyalty in two branches of the health care field.

INTRODUCTION/CONCLUSIONS

A copy of the full paper is available from the first author.

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ECONOMICS SHOULD PLAY NO ROLE IN THE DISTRIBUTION OF BODY ORGANS FOR TRANSPLANTATION

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ABSTRACT

An area where economic analysis may not be very useful is in the shortage of body organs for transplantation. The demand for body organs is far greater than the supply of body organs which results in thousands of individuals dying every year as a result of this market shortage.

Embracing an economic model for organ "donation" will likely reduce social altruism; weaken the bonds that encourage familial donation; and engender "sales" that create human tragedies. Granting tax credits to donors are thinly disguised payments

A system of "presumed consent", adopted in many European nations, should be the model to replace voluntary donation and avoid the ethical hazards of any model driven by economic forces.

INTRODUCTION

Organ transplants were first performed in this country in December of 1954. Since that time, organ transplantation has been responsible for saving thousands of lives. Kidneys, livers, hearts, lungs and other organs are routinely transplanted saving the lives of thousands who otherwise surely would die. According to Kaserman (2007), since 1988, kidney transplants have increased by 70.45 and the number of heart transplants during the same period increased by 22.7%. The number of liver transplants has grown by 231% while the number of lung transplants has increased by 3000%. During the period of 1988 - 2007 approximately 200,000 patients benefited from an organ transplant.

Unfortunately, the supply of transplantable organs has not kept pace with the demand for these organs. Clearly something needs to be done to increase the number of transplantable organs available. Paying for organs may be an answer. Educational campaigns have yielded little in terms of quantifiable results. Kaserman (2007) argues that a system in which presumed consent is the law would be preferred. Individuals could opt out and indicate that they are not willing to donate their organs post-mortem. Several European countries have an "opt-out" policy in which individuals are presumed to be willing organ donors unless they have stated otherwise. It is expected that we could see an increase of approximately 25 – 30% with such a program. It would not fully alleviate the organ shortfall but would make significant improvement and save many lives that otherwise would be lost.

The Law

The National Organ Transplant Act of 1984 made it illegal to offer or receive payment for organ transplantation. A black market for the purchase of body organs has developed but demand still exceeds supply requiring a rationing system for the available organs. The United Network for Organ Sharing (UNOS) reported a waiting list of candidates for organs at 97,534 individuals and the number of donors, as of January 2007, was only 7,170. It is clear that the market forces for organ donation are not working as evidenced by the critical shortage of organs available for patients in need.

In an effort to increase availability of transplantable organs, organ procurement organizations and other advocacy groups have targeted outreach aimed at encouraging individuals to declare their intentions to become organ donors. Individuals are encouraged to use formal means of indicating their intentions such as a notation on their drivers' licenses, an organ donor card, a living will or some other means of registration. It is also important that potential donors discuss their intentions with appropriate/immediate family members

The (UNOS), under contract with the U.S. Department of Health and Human Services, maintains a centralized computer network of available body organs. UNOS links procurement operations and transplant centers together. The individual in need of a transplant is referred by a doctor for evaluation. If the center makes the determination that the patient is a candidate for a transplant, the patient's medical profile is added to the national waiting list for possible organ transplants. When an organ is located, a list of potential recipients is produced by the computer. A number of medical factors are utilized along with location to determine the recipient of the organ. A large number of individuals die while waiting for the phone call.

In the current living related donor system, there has been no third-party financial incentive to encourage a relative to donate an organ. Generally, the love, compassion, and genuine goodwill that people feel for their relative has been sufficient enough to motivate altruistic donations. Many patients were able to find the help they needed through loving, related donors. However, many more were not so fortunate and waited, in vain, for a match to be found.

Ethicists have worried about less measurable effects on society if there was a market for human organs. They are concerned that financial incentive policies will change peoples' view of humanity itself leading many to think of themselves as objects that can be bought and sold. Of further concern to ethicists is the thought that donors might have a financial incentive that would change the course of peoples' lives. Ethicists fear that there are those who might choose to end a loved one's life prematurely because they are unable to pay for medical care or because they are eager to receive a windfall from an estate.

Economic Approach to Shortages

To economists, the underlying cause of the organ shortage is patently obvious: supply and demand. Specifically, the National Organ Transplant Act (NOTA) of 1984 proscribes any payment to organ donors or their surviving family members to encourage increased collection rates. Under this law, the legal price of organs is set at zero. According to Beard et al. (2004) it is hardly

surprising that shortages have persisted year after year, despite ongoing efforts to increase supply through expanded public and professional educational campaigns.

According to Kaserman (2007) “economists define a shortage as an excess of the quantity demanded of a good over the quantity supplied of that good at a given price.” Since 1988, there has never been a single year that the supply of solid organs available has met the demand of those needed. Waiting lists for organs have increased every year. The current organ transplant procurement policy has consistently failed to meet patients’ needs. An overhaul of the system is needed but there is significant debate as to what needs to be done.

The basic economic problem is how to allocate scarce resources in order to satisfy human needs. According to Getzen (2007) the focus of economic analysis is on the market. This market usually results in a mutual agreement between buyers and sellers that makes each side of the market satisfied with the transaction. Getzen (2007) also argues that, even though economic theory has evolved to examine health issues, it is still only one piece of the puzzle. Therefore, even though economics drives many health decisions there is much more to health care decisions than pure economic theory.

Feldstein (2008) argues that the demand for body organs for transplant purposes is outpacing the available supply of these organs. Between 1995 and 2005 the demand for organs increased 121% while the supply increased by only 45%. This left over 50,000 people waiting for the availability of a body organ required to save their life. Feldstein (2008) points out that more than 70% of these individuals are waiting for a kidney. The laws against selling body organs are simply forcing the rationing of organs and the development of a secondary black market for organ purchase.

Feldstein (2008) also points out that the number of transplants is increasing each year. The gap between those waiting for organ transplants and the supply of organs has been growing rapidly as more patients are being recommended for such transplants. Without any incentives for donors or physicians and hospitals to recruit donors, the shortage of organs will become more severe.

There are several possible donor compensation models under discussion. These proposals include: compensating families of donors, compensating donors before death and offering incentives to physicians and hospitals to pressure families of dying relatives to consider donation of family member’s organs after death of their loved one. These models all involve paying for body organs which would probably allow wealthier individuals to have a greater opportunity to receive the body organs.

Transplant Ethics: Easy Answers, No Solutions

The hypothetical dilemmas offered or rebutted by the advocates of altruistic donation, economic compensation or presumed consent in the ethically challenging area of organ donation all saw their “worst case scenario” manifest itself when Dr. Hootan C. Roozrokh allegedly hastened the death of disabled and brain damaged 25 year old Ruben Navarro in 2006 in order to expedite the harvesting of his transplantable organs (Childs, 2008).

When Mr. Navarro died on February 4, 2006, his organs were, ironically, found unsuitable for transplant. Though not germane to our current review, the ethics of the situation were compounded by the fact that Dr. Roozrokh faced a conflict of interest inasmuch as he was a member

of a transplant team as well as the physician managing Mr. Navarro's terminal medical care (Childs, 2008).

Even if the allegations prove to be untrue, the mere publication of the news story will likely arouse the fears and concerns of many citizens who are reluctant to become donors. These people fear that "the doctor may be in a hurry to pull the plug" if the doctor or others know that the patient is a donor. "Most Centers work very hard to prevent the ghoulish scenario of doctors removing organs from patients with the potential to recover. I had hoped Americans had gotten past that concern" (Childs, 2008).

The organ donor crisis can trace its roots to the previously cited National Organ Procurement Act (Pozgar, 2007). What appeared to be an ethically sound and legally insightful law at the time, intended, as it was, to prevent a commercial "market" for human organs and to preclude the potential exploitation of the economically disadvantaged, has, instead, exacerbated the dearth of organs available and suitable for transplant (Carpenter, 2008). The American Medical Association (AMA) and the American Society of Transplant Surgeons have both encouraged a reassessment of the Act and the examination of options to its absolute prohibition of any pecuniary dimension of the organ donation/transplant process (*Scientific American*, 2003).

No ethical analysis of this dilemma can proceed without the recognition of two separate and distinct aspects of this question. First, there is the issue of compensating living "donors" for their "donation" of a body organ, usually a kidney. Second is the conundrum of offering some direct or indirect economic incentive to healthy or ill individuals in order to encourage them to act as organ donors, post mortem.

These two dimensions of the issue are then paired with the three competing models for organ donation: 1) The existing, congressionally mandated, altruistic, free will paradigm; 2) The economic based alternatives that are the center of contemporary debate; and 3) the "presumed consent" or "opt out" model. Only options 1) and 2) could apply to living donors, while all three options could be considered for cadaveric donations. Our discussion focuses exclusively on cadaveric donations.

Donations, Please!

Though ethically sound, the current system is clinically and effectively flawed inasmuch as thousands of patients die each year while awaiting organs that are buried with the deceased and, in effect, ceremonially discarded. These "lost" life giving opportunities occur for a variety of reasons, ranging from inadequate public/patient education to the individual's fear of the sort of "expedited demise" referenced above. There is no doubt that the current program is consistent with Hippocratic principles; the justified primary concern for the human rights of the healthy potential donor; and prevention or control of a "commercial market" for body organs likely to exploit the poor, the uneducated and the disadvantaged (Japsen, 2002).

The existing system recognizes and preserves the Judeo-Christian, and western philosophic principle that all lives are of equal value; the value of same cannot be quantified; and that, absent an informed, free will and heroic action by an individual, the sanctity of one life does not outweigh that of several. "Any attempt to assign a monetary value to the human body or its body parts, even in the hope of increasing organ supply, diminishes human dignity and devalues the very human life we seek to save (Goldberg, 2003).

While many in society may be reassured and comforted by the continuity and consistency of the maintenance and codification of certain ethical principles focused on the individual sanctity of human life, the last fifty years has witnessed and chronicled departures, inconsistencies and justifiable “exceptions” to the historically uncontested “sanctity” of human life, e.g. *Griswold v. Connecticut* (artificial contraception), *Roe v. Wade* (abortion) and the “Patient Self Determination Act of 1990” (Right to Die) (Pozgar, 2007).

While purists may assert that all of these legal decisions and ethical evolutions have begun our descent down the proverbial “slippery slope” into an abyss of human abuse not unlike that contemplated and prohibited by the Nuremberg Code of Medical Ethics (Pozgar, 2007), no such cataclysm has occurred. Similarly, Oregon’s Death with Dignity Act, permitting physician assisted suicide, has been only rarely, and always carefully, applied for the benefit of the individual patient (Pozgar, 2007).

Finally, ample evidence exists to illustrate the fact that there is a thriving international market in human organs wherein exploitation of the poor is rampant (*Scientific American*, 2003). It is estimated that as many as 300 Americans ignore the law and clandestinely purchase organs from the desperately poor in other nations (Shapiro, 2003). Although violation of the law is rarely a very powerful argument to repeal that law, it is a factor to be considered.

In 1978, the Supreme Court determined that sodomy between consenting adults in contravention of a state law enjoyed no constitutional protection (*Bowers v. Hardwick*). Yet, the same court (by authority, not composition) ruled in 2003, in a virtually identical case (*Lawrence et al. v. Texas*) that state laws prohibiting sodomy between consenting adults was unconstitutional. This reversal and philosophical contradiction can only be attributed to the development of the law, generally, and the changes in social standards and morality during the intervening 25 years.

Changes in the law, in medical technology, in medical ethics and in society’s understanding of its rights and responsibilities related to organ donation, transplantation, and matters of life and death in the 24 years since the passage of the National Organ Procurement Act demand a reassessment of the terms and conditions related to living and cadaveric organ donation.

Show Me the Money

Arguments against economic incentives are numerous and have been advanced before and since the passage of the National Organ Procurement Act. Among the assertions against any economic compensation for living and/or cadaveric donation have been:

1. Altruism will be minimized (Japsen, 2002);
2. Incentives will be treated as "prize" money (Anstett, 2002);
3. Money for donations will lead to a commoditization of the body (Shapiro, 2003);
4. Cash incentives will adversely affect the doctrine of free and informed consent (Shapiro, 2003);
5. The money factor will allow the wealthy to exploit the poor (Rovner, 2003);
6. Human life will be assigned an illusory "value" (Goldberg, 2003);
7. Human dignity will be diminished (Goldberg, 2003);
8. Incentive will devalue the human life (donor's) we seek to save (Goldberg, 2003);
9. Incentives could encourage the donor or his/her family to "cover up" disqualifying medical conditions (Goldberg, 2003);
10. Incentives may hasten death (Aleccia, 2008);
11. Raises the question of whether your body is, indeed, your "property" (Murray. 1987);

The extensive list of “arguments” against allowing any economic incentives for organ donation is collectively formidable. Indeed, some of the individual assertions are themselves a substantial challenge to rebut. Although we could spend considerable print discussing, and rebutting, these arguments, we will simply comment on each briefly, *ad seriatim*:

1. While it is desirable and laudable for a society, or any element thereof, to encourage altruism or any other "virtue", the assertion is diminished somewhat when we understand that society does not expect us to enter a burning building in search of possibly trapped inhabitants or to rescue the swimmer in distress. Rather, society chooses to generously compensate firefighters and lifeguards to expose themselves to dangers an ordinary citizen would not be expected to face (Shapiro, 2003);
2. The contemplated incentives are relatively meager and inconsequential in a society addicted to lotteries, legalized casino gambling and office sports pools;
3. If a "commodity" is understood, and defined as, "Anything useful or that can be turned to commercial or other advantage" (Morris, 1979), then it would be conceded that human organs might be "commodified". Safeguards to unbridled "commodification" would have to be established;
4. "Informed Consent" as currently practiced is often a mere formality where patients are presented with a ream of papers to sign not unlike those at the "closing" on a house. Perhaps the addition of an economic incentive will encourage the patients to more fully examine and comprehend the informed consent documents rather than cursorily execute same;
5. This argument borders on the naïve. Nonetheless, such a practice could be prevented if the system adopted allows only payments through a state agency and not from the potential donor or his or her family (Goldberg, 2003);
6. Human life is assigned a value every day in America's courtrooms as wrongful death or medical malpractice cases are tried and millions of dollars are "awarded" to victims and/or their families as injuries are quantified and compensation is calculated;
7. While it would be somewhat facetious to say human dignity is lost as soon as a patient dons a hospital gown, philosophically it would be more correct to say that human dignity is enhanced when the lives of others are maintained even if by a donor whose family received a minimal sum of compensation;
8. If we more aggressively encourage, or even require, patients to sign advance directives, the danger of devaluing the life of the donor is minimized since they have been de facto "triaged" and their treatment wishes would be honored;
9. While certainly possible in emergency care situations, it is highly unlikely that concealment of disqualifying health conditions would occur. The patient's doctor would be familiar with the health history of the patient and/or the battery of tests at a hospital would screen out conditions otherwise unknown;
10. This argument does give pause. The true life scenario at the beginning of this section highlights the importance of separating physicians on a transplant team from those rendering terminal care. And, of course, there is always the question of the avaricious spouse or family member eager to claim an inheritance;
11. The legal and ethical questions regarding whether one may treat their body as property or as a gift from god of which they are merely a "steward" have, in secular circles, been resolved in favor of the latter concept. Whether the issue is the troubling one of abortion, the sobering and medically simplifying character of the living will, the issues of informed consent or donation of regenerative body fluids, all stand as bulwarks of the body as property precept. Economic compensation for organ donation will not change what already is.

The discussion set forth above underscores the fact that economic incentives for cadaveric organ donations face some significant ethical hurdles. Although we have attempted to rebut many of the arguments advanced in opposition to economic incentives, some arguments are stronger than others. Some assertions are, frankly, difficult to refute in a purely ethical fashion. It should be understood, however, that this section's discussion of compensation to donors for organ transplants applies ONLY to post mortem “donations/contributions” and not to the more challenging question

of pecuniary incentives for living donors (kidney, cornea, liver portion). The latter category of donations reinforces many of the assertions against economic incentives and would make a rebuttal too lengthy for some points and ethically implausible for others.

Challenging Choices

Barely ten years after the Congress passed the National Organ Procurement Act, the American Medical Association's Council on Ethical and Judicial Affairs encouraged the government's use of presumed consent by all citizens unless some objection by that citizen was registered (Miller, 2006). Although some opponents of this proposal foresee a lack of option education, particularly among the economically poor and poorly educated strata of society, that fear could readily be addressed through an education and public service announcement program, not unlike that utilized to remind 18 year olds to register for Selective Service.

Other opponents may view the proposed program as an unwelcome and dangerous assault by the government upon individual autonomy. The "opt out" provision offers a practical rebuttal to this fear. Any legal or philosophical objection can be retorted by the utilitarian argument that there are, indeed, times when individual rights, real or theoretical, must yield to the good of society. For example, although parents' may object to the inoculations of their children on religious grounds, that freedom of religion is "trumped" by society's interest in maintaining the public health (*Davis v. Beason*).

The current Prime Minister of Great Britain, Gordon Brown, has endorsed the concept of "presumed consent" (Wintour, 2008). Spain, which has enacted a policy of presumed consent, and is comparable to Great Britain in size, has witnessed a three fold increase in the number of cadaveric organ donations with the number of successful transplants increasing by an average of 1,200 per year (Hawkes, 2008). Belgium's introduction of a presumed consent provision resulted in a doubling of transplants (Beecham, 1999). "Opt out" systems in France, Poland, Portugal and Austria, all culturally Roman Catholic nations have resulted in a donation rate 15% higher than that in the United States (*The Week*, 2004).

The presumed consent concept would certainly have to be carefully crafted to ensure government oversight, extensive public education, guidelines and regulations and the right of the presumptive donor to change their mind without explanation. Despite the challenges of enacting a presumed consent option, the system is likely to positively affect the lives of the almost 100,000 Americans waiting for organ donations and will almost certainly save most of the 6,000 people whose lives are lost while languishing on a waiting list.

The ethically "idyllic" program in effect for almost twenty five years has failed us. The economic incentive model raises too many unresolved ethical questions. Only the presumed consent model seems to offer all citizens appropriate protection from coercion while providing real hope to those in need of transplants; accomplishing both while not seriously compromising most ethical concerns.

DISCUSSION

There is no disputing the fact that the Organ Donor/Organ Transplant “model” currently practiced in the United States is an organizational, medical and ethical failure. The oft repeated statistics related to the tens of thousands of patients on organ donation waiting lists, and the dearth of donors, is a tragic embarrassment of our current standards and procedures. To suggest, however, that an economic model, reliant on some variation of market forces, would remedy the shortage would likely provide only a temporary solution that would ultimately compromise the integrity of the medical community and exacerbate economic inequality.

The current system of voluntary donations is flawed and failing. An economic model is not the solution to this problem. A system of “presumed consent”, adopted in many European nations, should be the model to replace voluntary donation and avoid the ethical hazards of any model driven by economic forces. Barely ten years after the Congress passed the National Organ Procurement Act, the American Medical Association’s Council on Ethical and Judicial Affairs encouraged the government’s use of presumed consent by all citizens unless some objection by that citizen was registered (Miller, 2006).

The presumed consent concept would certainly have to be carefully crafted to ensure and provide government oversight, extensive public education, guidelines and regulations and the right of the presumptive donor to change their mind without explanation. Despite the challenges of enacting a presumed consent option, the system is likely to positively affect the lives of the almost 100,000 Americans waiting for organ donations and will almost certainly save most of the 6,000 people whose lives are lost while languishing on a waiting list.

BIOGRAPHIES

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