Reassessment and Reevaluation

FREDERICK K. MERKEL, 1978–79

My Dear Colleagues,

It has been a privilege to serve as ASTS president for the past year. In the beginning, our society emerged as an outgrowth of several ad hoc meetings some of us had with the Social Security Administration and U.S. Department of Health, Education, and Welfare (HEW) agencies during the development of the end-stage renal disease program. Initially, we maintained a low profile and concerned ourselves primarily with scientific matters. In this respect, we were quite successful. Tom Starzl, Fred Belzer, Tom Marchioro, and John Najarian, previous presidents, aided by Tony Monaco's unstinting support as program chairman, provided us with a record of annual scientific meetings of ever-increasing merit. Although our society has, in this way, grown steadily, I believe we must now firm up our position on a number of burning issues and perhaps make some changes in our direction. This is a critical period for us.

The following five points seem most crucial: 1) the function of our society in relation to all organ systems, not just the kidney; 2) the relationship of our society and its members with other specialists, such as nephrologists; 3) how our society and its members can help provide better delivery of health care; 4) the interaction of our society and its members with the government; and 5) structural changes in our society that would make it more effective.

First, ASTS is a society of all transplant surgeons. Although papers dealing with liver, pancreas, heart, lung, and parathyroid have been presented at our meetings, we must encourage and direct our Program Committee to select more papers dealing with other organs, even if it means increasing the length of the meeting or decreasing the kidney-oriented papers. We must attract all transplant specialists if we wish to further enhance our programs and provide the cross-fertilization at our meetings that specialists in different subfields can provide. We must clearly let transplanters of other organs besides the kidney understand that they have an equal place. Our organization can benefit them, not only in terms of information they gain from the kidney program, but also because we have much in common with one another. The clinical kid-

ney program, as the only federally funded catastrophic health care program now in existence, will certainly serve as a model for future federal health care delivery systems involving other organs.

Second, it is clear that our individual relationships with neurologists have often been less than ideal. Although many nephrologists and transplant surgeons get along well together, significant numbers of nephrologists throughout the country are dialyzing large numbers of patients who should be referred to surgeons for kidney transplantation. On the surface, the problem appears to be caused by economic considerations. However, transplantation as a treatment is not foolproof; so it does not take much for nephrologists to convince themselves that dialysis is just as good and that they are doing patients a service by avoiding a supposedly dangerous and unnecessary operation. It becomes easy for nephrologists to take the position that, from the standpoint of survival, transplantation is inferior to dialysis. This is not true. Recent studies indicate that, when transplantation is feasible, it is superior to dialysis from the standpoint of long-term success in reversing renal failure, enhancing the patient's general medical well-being, and rehabilitating the patient's self-esteem.

Unfortunately, we as transplanters are not in the driver's seat. These patients are referred to us by nephrologists if, and only when, they decide to do so. Furthermore, because of the dependent type of relationship with their nephrologists, patients often won't stimulate a request for a transplant themselves. We become a passive bystander. Rules and regulations have been developed, and more rules and more regulations will come and go. But as such, they can and probably will always be circumvented by some. Enforcement will always be a difficult issue, especially since we are far outnumbered by our nephrology colleagues. To solve this problem, we need to look to our own problems in health care delivery and to our own relations with the government.

Third, more than 35,000 patients are now undergoing chronic hemodialysis in the U.S. Although many of these patients may not be suitable transplant candidates, certainly 20,000 of these patients could be. Unfortunately, never, during the past four or five years, has the rate of transplantation in the U.S. gone above 4,000 per year. Last year, only 3,700 patients underwent kidney transplants. To this end, we are not doing our job. It is critical that we markedly increase the availability of cadaver organs. We must encourage the growth and development of existing transplant programs and initiate new programs when needed.

At present, an argument often quoted by those seeking to minimize the growth of transplantation is the shortage of donor kidneys. By concentrating on organ procurement, we can make the kidneys available so that this argument cannot be used. I believe organ procurement is one of the most difficult and sensitive aspects of kidney transplantation. It requires a personal interaction between the donor team members, including the transplant surgeons and the staff of community hospitals throughout the U.S. Personal contacts and relationships must be developed even superior to those one normally uses in building a clinical practice of surgery. Programs such as the one developed in the Centers for Disease Control (CDC) office of organ procurement should be used to determine the donor potential of hospitals throughout the country and to then achieve the potential for organ procurement. Again, as long as kidneys are

in short demand, we are not doing our part. ASTS must help its members by providing consultations, education, and site visits for new and developing programs so that we may eventually have the finest possible nationwide organ procurement program.

Directly tied to this is the need for enhanced sharing of kidneys. Although some programs claim they transplant all the kidneys they are able to get, many times local situations make it impossible to use kidneys at exactly the moment they become available. This may be because of inadequate facilities or personnel. It is important to see that kidneys removed and not used locally can be used by other programs. We have demonstrated that kidneys can be preserved for up to 67 hours without adversely affecting short- and long-term results. Yet, loss rates of 30% are not unusual today. The kidneys lost are good organs that simply have not been placed successfully for transplant. Just by using all available kidneys, we could increase the number of transplants per year to 5,000. As more kidneys are procured, sharing is going to become more complex. The South Eastern Organ Procurement Foundation (SEOPF) and United Network for Organ Sharing (UNOS) are reasonably successful approaches toward organizing kidney distribution. However, it seems to me that, since ASTS is a society for all transplant surgeons in the country, perhaps we could do a better job.

One approach might include one or more central crossmatching labs where lymph nodes could be sent the moment a kidney is harvested. Then when it appears that one of the kidneys will be available, crossmatches could be done at that lab and thus minimize the transportation of multiple specimens here, there, and everywhere in an attempt to find a home for the unused kidney. For example, such a center could be developed at the O'Hare Airport, which has accessibility to all parts of the U.S. A well-functioning professional kidney distribution organization under the aegis of our society could speed the exchange of organs and minimize our loss.

ASTS must encourage and help develop our many transplant programs. I do not think we should be trying to shut down small programs. Instead, we should stimulate small programs to grow larger and inferior programs to become better. Because transplantation is a relatively new therapy, just making itself felt in the medical world, we can't afford to close small programs and eliminate their transplant surgeons. No one will be left to do the work that needs to be done. We must support and enlarge our field. Our society can do this by offering help to programs having difficulty.

Various potential solutions to local problems can be offered. While some large programs have a seemingly limitless capacity, most transplant programs in the country are limited either by space or personnel. If we are to achieve our objectives of superior delivery of health care, we need every person and program we can get.

Fourth, the symposium preceding our scientific meeting represents the first major attempt of our society and its members to meet, and develop a dialogue with, the various agencies of the federal government. It is important that this dialogue be continued and enlarged, so ASTS can improve relations with the government agencies both for scientific reasons and for health care delivery. Our Scientific Studies Committee has begun by developing a cooperative study of donor pretreatment. This is only a beginning. We can also push for increased funds for transplantation research, and this means increased funds not only to the big and successful programs, but also

to other smaller programs as well. Less than 2% of the funds expended for kidney transplantation are spent on research. We must have more support. ASTS can provide advice to young investigators and small programs as to how they can best go about getting research monies.

We can also follow the lead of our advisory committee in discussing the many aspects of health care delivery with HCFA, covering such areas as quality and financing of health care.

Fifth, it may be time for ASTS to make some structural changes so that we can better help our members and patients. A logical extension of the work begun by our advisory committee is to obtain the services of a permanent liaison with the federal government, a lobbyist if you will. Only by having direct contact with what is going on in Washington can we be fully aware of the legislative and political events that will affect transplantation. Furthermore, it is important that ASTS and its individual members get better feedback on what's going on. To accomplish this, we must, at some point, establish a permanent office with a staff whose job it would be to carry out these activities. I realize there are many problems in developing a staff office for societies, but the issues today and in the future are important enough to warrant the ongoing support that only a permanent office can provide. To inform our members, we need a quarterly newsletter that will provide us with up-to-the minute information. The permanent office could communicate with the medical information system, which so far has been very ineffective in providing us with needed information on the successes and failures of our transplant programs. We need a registry, which could be a part of our permanent office.

Finally, we must all get more involved in the functioning of our society. Jim Cerilli has done a tremendous job in initiating meetings with the government. Let's all pitch in and work together!