

solomon's bureaucracy

WITH TOO FEW ORGANS TO GO AROUND, THOSE SETTING THE RULES FOR DISTRIBUTION CANNOT PLEASE EVERYONE. BUT THAT DOESN'T STOP THEM FROM TRYING.

By Donald C. Dafoe, MD

On Sunday morning their lives were unrelated: One person was bed-ridden, while the other was preparing for a picnic. One was inching her way up the waiting list for a liver transplant, while the other did not know that such a list existed. But by Monday morning, both were competing for the same liver. The newcomer won out. Without an immediate transplant, our picnic-going patient had just 48 hours to live, so he climbed to the top of the ladder and got the liver, while our long-suffering patient slipped down a rung, no closer to her life-saving transplant.

Transplant teams confront situations like this every working week, and the choices are getting harder. At the end of 1988, the patients waiting for liver transplants numbered 616. By the end of 1995, a year in which just 3,926 liver transplants were performed in the United States, there were 5,701 on the list. The number of patients dying while on the list quadrupled over the same seven-year period. Transplantation has become a victim of its own success, with the better immunosuppressive drugs and greater success rates leading more patients to opt for a transplant.

I am a regional counselor and a member of the board of directors of the United Network for Organ Sharing (UNOS), a national body that oversees the procurement and distribution of organs. We attempt to keep as many people as possible both happy and — more importantly — alive. Recent changes in our policies for assigning livers for transplantation highlight the difficulties inherent in overseeing such a scarce, lifesaving resource.

Managing a scarce resource

Those who have been on the transplant waiting list for a long time are justifiably frustrated. Many of them are in a reasonably healthy state, a state that should allow them to recover well from a major surgery,

with an excellent chance for long-term survival. And yet they usually will not become eligible for a transplant until their situation deteriorates. Once in the intensive care unit (ICU), their transplant will be a priority, but they will be approximately 30 percent less likely to keep the new liver for five years than if they had been assigned it before they were hospitalized.

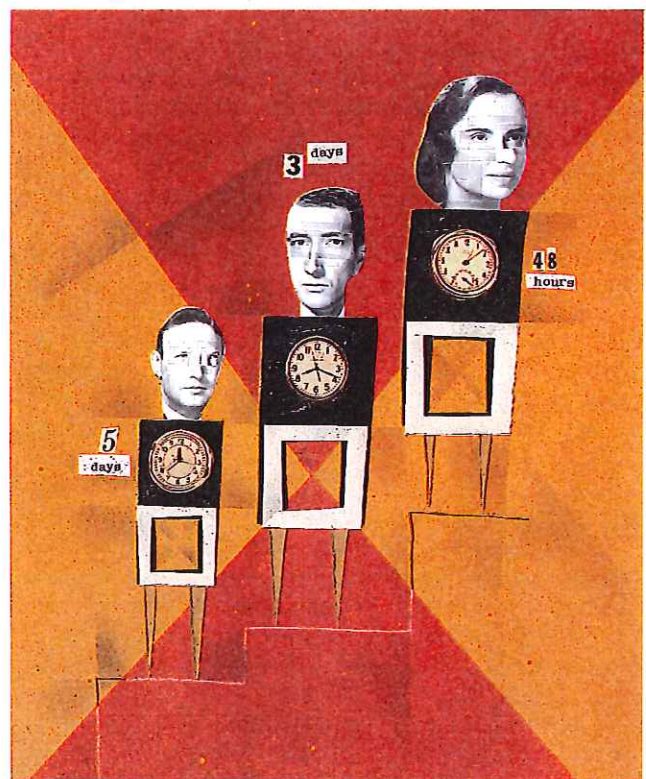
Unfortunately, the alternative is not pretty. A compassionate doctor cannot treat a chronically ill but functioning patient while leaving a critically ill patient in the ICU to die. So in 1992, UNOS defined categories for patients, with those in an ICU being assigned to Status 1 and getting first chance at any available livers.

This system was wide open to abuse. Any patient on the list could be wheeled into an ICU — a location defined by geography not by medical status — and automatically qualify for a new liver. In some cases, doctors were trying to boost their patients' chances of an early and successful transplant. In others, truth be told, the surgeons were attempting to expand the size of their programs and the flow of dollars and prestige to their hospital.

UNOS responded in November 1996 by redefining Status 1, which now covers only the few patients with acute liver failure resulting from a toxin (such as that from a poisonous mushroom) or the loss of a recent transplant. This policy change prompted a flood of agitated and passionate e-mails to myself and to other members of UNOS, from both surgeons and their patients who found themselves further down the list.

Many of their concerns were answered in July 1997, when we divided Status 2 into two sets of patients. The new Status 2a covers chronically ill patients whose condi-

tion suddenly worsens. Though it acts as a safety net for the chronically ill, it is open to the same type of abuse mentioned above. The two criteria for Status 2a, both of which are subjective, are residence in an ICU and a life expectancy of under seven days. We have therefore initiated a system of inter-institutional peer review and spot checks by chart review of such cases. In the longer term, the best solution would be replacement of these criteria with more ex-



acting measures of liver function. Physicians also need data to support the most difficult decision — to do nothing — when waiting for death is the best option.

The emphasis in defining these rules is on limiting abuse, increasing trust among centers, and ensuring uniform standards across the United States. We do not, however, want to make the process so bureaucratic that working physicians have their hands tied. It is impossible to codify every clinical situation. And we want doctors and patients to make the decisions, not government officials in Washington, D.C.

Fear of overarching bureaucracy drives another debate in transplantation medicine, CONTINUED ON PAGE 32

but this one is territorial. With an organization like UNOS in place, it would be possible to assign each organ to the "sickest" person in the nation, regardless of where the organ was procured. This form of "nationalized sharing" has been advocated by some groups recently. But until now, a system of "local primacy" has, and I believe correctly, been the dominant model. In simple terms, a liver whose donor died in San Francisco will most often end up in a patient in the Bay Area.

Transplantation began as an elite surgi-

shrinking, while at Stanford, for example, Pittsburgh-trained Carlos Esquivel, MD, PhD, is part of a world-class liver transplant team with an increasing caseload.

If transplants can be done locally, they should be done locally. Stanford is typical of most centers in that it collaborates with a modest number of local centers (in this case, the University of California, San Francisco, and the California Pacific Medical Center) to solicit increased organ donation (in collaboration with the California Transplant Donor Network (CTDN)). If national distribution dominates, there is no incentive to continue these programs.

Local donation also keeps patients

nationwide network is not warranted.

The ideal solution to the organ shortage is more organs, either through initiatives to improve donation or through medical advances in xenotransplantation (using, for example, pig livers). But as long as there are fewer available organs than waiting recipients, organ distribution will be contentious. The equal treatment of alcoholics and the alleged preferential treatment of celebrities such as Mickey Mantle and musician David Crosby are just some of the other issues that arise. What is encouraging is the self-organization of the transplant community under the umbrella of UNOS. There is no UNOS jail, and we

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cal technique, practiced in only a few hospitals. It was natural, therefore, for both patients and organs to be flown to large centers from all around the country. The Presbyterian University Hospital at the University of Pittsburgh is one example — in 1990 the liver team there carried out over 17 percent of the liver transplants performed in the United States that year.

But now liver transplantation is standard fare at almost all large U.S. hospitals. Programs at places like Pittsburgh are

closer to families and support systems and makes the patients more likely to comply with physician requests. The logistics and expense of organ transport are reduced, and with shorter trips and decreased storage time, the risk of organ deterioration is lessened.

For the sickest patients who need organs most urgently, the net can be cast more widely. For Stanford, this extended network could include centers such as University of California, Los Angeles, but a

have only the court of public opinion to keep doctors in line, and yet we are developing a decision system of which Solomon would have been proud. *sm*

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