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Kidney Transplantation: *Beacon of Hope*

By Harriet Jackson Scarupa

For 10 years and 3 months now Scottie Leftdwrige has been walking around with the kidney of a dead stranger implanted in his body.

The 45-year-old Howard University Hospital medical aide is the first person to have received a kidney transplant from the hospital's transplant center.

His transplant followed a period when he was so weak he couldn't walk two blocks without stopping to rest, when his weight dropped alarmingly because he was unable to keep food in his stomach, when his urine was tainted with blood, his heartbeat irregular, his whole body wracked by nausea. One night, when the nausea drove him nearly out of his mind, he sought out a doctor. The diagnosis: kidney failure.

When kidneys fail because of disease, damage, or some congenital abnormality, the body does not excrete enough water, salt and other substances. This causes the volume of water in the body to increase and tissues to swell. Without medical intervention—dialysis or a transplant—the composition of body fluids will change steadily until it becomes so abnormal that death will ensue.

For 10 months Leftdwrige was on dialysis—a time-consuming process of cleansing the blood through an artificial kidney machine. When the nephrologist [kidney specialist] who was treating him suggested he consider a transplant, Leftdwrige was frightened by the idea of an operation at first. But when he considered the alternative—being hooked up to a dialysis machine for 12 or more hours a week and then still feeling weak much of the time, having to make do on a severely restricted diet, not even being able to drink a glass of water whenever he felt like it—he decided to chance the operation. "I just wanted to get better," he recalls.

8 He did get better. Much better. Two weeks after the transplant, he was discharged from the hospital. Gradually his strength returned. Gradually he was able to resume working, though in a new job in the central supply section of the hospital instead of in his old job at a laundry. Today, he says, except for not being able to lift heavy objects, he can do just about everything he could before kidney disease struck him down.

Recently Leftdwrige participated in a group therapy session which the Howard transplant center runs for past, present and future transplant recipients. As the session began, the nurse leading it asked the patients to share some of their positive thoughts of the day. When it was Leftdwrige's turn, the soft-spoken, reserved father of six willingly obliged: "I'm thankful for being able to work, for being able to do things I couldn't do on the [dialysis] machine. I'm thankful my appetite's much better and that I don't have as much sickness. I'm thankful I'm able to live a normal life."

Scottie Leftdwrige's experience represents the up side of the kidney transplantation story. So do the experiences of many of the center's other patients. People like Vernita Howard, who's had "her" kidney for nine years now, she proudly tells you, and even more proudly tells you that she's been able to give birth to a healthy child. Or Ronald Norris, who received a transplant eight years ago and later went on to win first place in the 150-meter run at a special olympics in Athens, Greece, for transplant patients from all over the world. Or Alvin Brown, a three-time kidney recipient, who founded a group to help make the hospital stays of low-income transplant patients more comfortable and to educate the larger public about kidney disease and transplantation. Or Tomeka Batey, who was transformed from a listless invalid to an



Scottie Leftdwrige (left), the first person to receive a transplant from the Howard transplant center with Reather Felton, head nurse of the Howard University Hospital's dialysis unit.

active schoolgirl after she received a kidney from her mother six months ago. [See Box, "A Mother's Story."]

But there's another side to the transplantation story. The down side. A week after Leftdwrige shared his blessings about being able to live a normal life in that meeting room on the hospital's fourth floor, another kind of drama was taking place in a basement intensive care unit. There 27-year-old Denise Chasten, who made medical history in October 1982 by being the first woman with sickle cell disease *and* a kidney transplant to have a baby, had just been admitted as a patient. She was lying on a bed hooked up to a dialysis machine while an electrocardiograph was monitoring her heart and new entries were rapidly being penned on her medications chart. Her manner was lethargic, her breathing labored, her jowls heavy with excess fluid.

Denise Chasten was in the midst of a rejection episode, her body reacting to her transplanted kidney—the second one she'd received in three years—as if it were some hostile foreign invader that must be attacked. The rejection action had caused the potassium level in her bloodstream to shoot up and if the pre-

scribed medication wasn't able to bring it down, her heart could be endangered. Her condition: critical.

Two sides of the same story . . . Yes, kidney transplantation offers the dazzling promise of a better quality of life to those whose own kidneys have failed. In fact, since the first successful transplant was performed in 1954 on identical twins at Peter Bent Brigham Hospital in Boston, Mass., thousands of transplant operations have been done with increasing rates of success.

But kidney transplantation isn't always *the* answer. Sometimes it doesn't work and even when it does work there is the ever-present threat of rejection and the often troublesome side effects from the drugs recipients must take to prevent that rejection.

Who Decides?

"All I do with patients is give them the pros and the cons," says Dr. Clive Callender, the noted transplant surgeon who serves as director of the Howard University Hospital Transplant Center. "I don't tell anyone, 'You must have a transplant.' I say, 'These are the pros. These are the cons. What do you want?'"

Scarupa: Kidney Transplantation: Beacon of Hope
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has performed about 160
transplants...

The patients attending that group therapy session seemed united in their view that they would willingly undergo one, two, even more transplants, if necessary, if it meant freedom from that dreaded [dialysis] machine. (A social worker assigned to the center points out that there are also patients who do well on dialysis and who choose to continue this mode of treatment even if they would be good transplant candidates.) "The mortality rate for patients who have transplants is about the same as for those on dialysis," Dr. Callender says. "The big difference is that the *quality of life* after transplantation is generally so improved."

A further note on the mortality question: Previously the average life span of a person on dialysis was considered to be 10 years. But with improvements in the procedure, that life span has been extended significantly. Those involved in treating patients who are on dialysis or have transplants shy away from making any blanket predictions about how long such patients will be able to live, pointing out that so much depends on individual variables — a person's overall health before being struck with kidney disease, conscientious adherence to doctor's orders, heredity, lifestyle, will to live... Some people on dialysis or with a transplant have lived for years and years, others for weeks.

The allure of being able to enjoy an enhanced quality of life helps explain why the number of patients in the nation awaiting transplants continues to exceed the number of available organs. The general thinking among many involved in transplantation is that 30 percent of all patients who are on dialysis are potential candidates for transplantation. As for the present state of affairs: A report prepared by the Forum of Network Coordinating Councils, which facilitates the exchange of information among the nation's end

stage renal disease networks, noted that in 1982 [the most recent year for which it released figures] there were 5,358 transplants performed in the nation's transplant centers, while 6,720 people were on transplant center waiting lists. Of the total transplants performed that year, 3,681 of the kidneys came from cadavers, i.e. from people who recently had died, while 1,677 came from living relatives of patients.

Donations from living relatives have a much higher success rate than those from cadavers. A National Kidney Foundation publication points out that when the transplanted kidney comes from a closely matched brother or sister, for example, the long-term chances of that kidney functioning are about 90 percent. When the kidney comes from an unrelated dead person — as is still the case with most kidney transplants — the success rate drops to between 50 and 60 percent two years after the transplant. (Comprehensive statistics are not kept for a longer period.)

Since Scottie Leftdwrige's transplant on January 28, 1974, Howard's center has performed about 160 transplants, with about 20 percent of these involving donations from relatives — with none of the donors experiencing any problems.

Of those patients who received transplants at Howard, 50 percent are still alive with functioning kidneys, 25 percent have returned to dialysis, while the other 25 percent have died from causes related directly or indirectly to kidney problems. Dr. Callender shares these figures, then goes on to add a pointed footnote: "I think our statistics compare with the national averages. But I don't deal with that issue [of comparisons]. It's like comparing apples and oranges because most centers have predominantly white patients and our patients are Black."

As he had testified last October before

a Senate committee holding hearings on a proposed organ transplant bill:

"Blacks who suffer from end stage renal disease and who require dialysis and transplantation are a unique group who appear to do poorer after transplantation than whites or other minority groups. The reasons for this are unclear but may relate to the fact that American Blacks are disadvantaged from the cradle to the grave for the following reasons:

1. They are born weighing less than whites.
2. They have twice the infant mortality rate of whites.
3. Their life span is 4-5 years shorter than whites.
4. They have hypertension 3-4 times as frequently as whites.
5. They suffer end stage renal disease from hypertension 17 times as frequently and end stage renal disease, in general, four times as frequently as their white counterparts."

Among some of the other facts he shared during his testimony: that 70 percent of the patients who are on dialysis in the southeastern part of the United States are Black; that Blacks do 10-20 percent poorer after transplantation than whites; that the District of Columbia, with its 70 percent Black population, has the highest incidence of renal disease in the United States. "These shocking facts," he emphasized, "indicate that Blacks suffering from end stage renal disease require special treatment and are a population that must be listened to."

The Howard Center

The Howard University Hospital Transplant Center is the only transplant center in the nation affiliated with a predominantly Black university. And the special population it serves — of whom and for whom Dr. Callender spoke so forcefully during that testimony — has shaped not

¹⁰ only the center's approach to kidney transplants but the role it has carved out for itself in the larger medical-sociopolitical community.

The center dates back to 1970 when Dr. LaSalle Leffall, chairman of the department of surgery of what was then Freedmen's Hospital, suggested that Dr. Callender, who had been chief resident in surgery the previous year, apply for a special postdoctoral fellowship in transplant immunology at the University of Minnesota, a national leader in organ transplantation. Dr. Callender received the fellowship, spending two years under the tutelage of noted transplant surgeon Dr. John Najarian, and returned to Howard in 1973 to launch a transplant center [See Box: "God Should Have the Glory."]

In November 1975, following a concerted lobbying effort, Howard's center received certification from the Department of Health, Education and Welfare, thus making it eligible to receive federal reimbursement for transplant operations. (A typical transplant, including pre- and post-operative hospital care, costs about \$20,000; complicated cases run much higher. Thanks to special legislation, most kidney transplants are now covered by Medicare.)

Through the years, the center has been able to tally up some important achievements:

- It was the first transplant center in the Washington area to use the drug antilymphocyte globulin (ALG) to reverse kidney rejection and the second in the nation to experiment with total lymphoid irradiation as an anti-rejection treatment.
- It has shown remarkable success in transplanting and rehabilitating a group of patients many hospitals dismiss as hopeless — heroin addicts — and has innovated in the use of group therapy for all its patients.



- It has conducted research in such areas as pancreatic transplants, organ preservation and the pretreatment of kidneys with ALG and has helped medical students, interns and residents become more knowledgeable about transplantation.
- It has played a small but significant role in enlarging the pool of the nation's Black transplant surgeons. (Consider, for example, the fact that only three of the 303 members of the prestigious American Society of Transplant Surgeons are Black.) Dr. Joel Stevens, the center's assistant director, was trained in transplant surgery both at Howard and the University of Minnesota. He has been followed by Dr. Jock Simon, currently receiving special training in

kidney, liver and pancreatic transplants at the University of Minnesota. He is expected to rejoin the staff of the Howard center in May.

- It also has extended its training and treatment efforts beyond the continental United States. (Since October 1982, the Howard center has been involved in training a medical team in the U.S. Virgin Islands to do kidney transplants. The first transplant the joint Howard-St. Thomas Hospital medical team performed on the islands on December 14, 1982 received major coverage in St. Thomas newspapers and on television and was hailed by the governor as heralding "a new plateau in the quality of health care now available in the Virgin Islands." In dedication



ceremonies in February 1983, St. Thomas Hospital's new transplant center was named after Dr. Clive Callender. As of this writing, the center had performed six kidney transplants, with all but one still functioning. Plans call for the Virgin Islands transplant team to be completely autonomous in two years.)

Given the center's accomplishments and given the national reputation it has earned, few on the Howard campus were surprised in April 1982 when it received the university's Outstanding Achievement Award in the Division of Health Sciences.

As an organizational entity, the transplant center serves as the surgical arm of Howard University Hospital's renal unit.

As a physical entity, it consists of various offices, laboratories, treatment and operating rooms within the hospital. But the center is also people, people who work together as a team. It is transplant surgeons (Drs. Callender and Stevens.) It is surgeons with other specialties (Dr. Aaron Jackson, a urologist who heads the team operating on kidney donors; Dr. Oswald Warner, a specialist in vascular access, i.e. providing a connection between artery and vein, a preliminary step that is necessary for hemodialysis). It is specialized nurses (Josephine Flores and Patricia Dillard); a social worker (Earlene Reavies); a dietician (Sylvester White); a perfusionist (Rodney Smith) who is in charge of organ preservation; a transplant coordinator (Curtis Yeager) who pulls to-

gether all aspects of the center's work; secretaries (Loyce Battle and Thelma Washington) who take care of its detailed paperwork. Working closely with the staff of the transplant center are nephrologists (Drs. Adrian Hosten, Martin Dillard and Iluminado Cruz) who recommended patients for transplant and care for them when they are on dialysis.

The Surgical Procedure

When a dialysis patient is deemed suitable for a transplant and he or she wants a transplant, the center's mechanisms start rolling. Transplant coordinator Yeager explains how:

Family members of the patient are brought together to see if any of them would be willing to donate a kidney. If so, they are tested to see if their blood and tissues are compatible with those of the patient. The best donor in the family is then identified, someone who not only has compatible blood and tissues, but is also in good general health. If that person decides to donate, the case is scheduled, patient and donor are matched and brought into the hospital for the actual operation. (Having just one kidney generally causes no particular problems because one kidney is able to do all the work of two. Some people, in fact, are born with one kidney.)

If no relatives are willing or able to donate a kidney, information about the patient's blood and tissue type is put on a computer listing which goes out all over the country in hope that somewhere a compatible kidney will be found from someone who recently has died and had agreed to organ donation. (The ideal donor would be someone who had been in good health but died suddenly — from a gunshot wound or in a car accident, for instance.) Once a suitable kidney is located, the hospital in question is informed of the Howard center's need for it and

A Mother's Story

Feeling helpless as your child wastes away before your very eyes is undoubtedly the greatest torment a parent can endure. Here Doris Dotson, a Nashville mother, speaks of her daughter Tomeka's struggle with kidney disease and the road both of them took so that Tomeka could have a more normal life. Her's is a story of pain and anger, of courage and hope.

¹² transportation is arranged. Here, time is of essence. A kidney removed from a cadaver will only be good for transplantation for 37 hours (when packed in ice) or 72 hours (when put in a special renal preservation machine.)

The actual operation varies depending on whether the kidney comes from a cadaver or a living relative. Dr. Joel Stevens gives the highlights of a typical 4-6 hour donor-recipient operation:

An incision is made, usually on the recipient's right lower abdomen, and the large blood vessels are exposed just above the thigh. At the same time, the donor is being operated on in an adjoining room. The donor operating team takes out a kidney, the one that previously has been identified as best for transplant, closes up the spot from which the kidney has been removed and closes up the abdomen.

Meanwhile, with great care, the recipient operating team hooks up the kidney in this manner: The vein of the donor kidney is attached (using sutures) to one of the large veins that has been exposed and similarly the artery of the kidney is attached to the artery that has been exposed. Then the recipient's bladder is exposed and hooked up to the ureter of the donor kidney. The abdomen is then closed, completing the surgical procedure. Generally, the transplanted kidney starts working immediately.

In some cases, a surgeon will have removed the recipient's old kidneys in an earlier operation, in other cases they would have been left in, depending on individual circumstances.

During surgery, the greatest risks to the transplant recipient come from any adverse reactions to the anesthetic and from excessive bleeding, Dr. Stevens points out. After the operation, the biggest threats become infection and rejection, although sometimes bleeding still

At the age of four, Tomeka—who had always been tiny—seemed to be gaining a little weight. Suddenly one night her whole abdomen sort of swelled up and we took her to the emergency room and her pediatrician called in a nephrologist. At the time it was determined that she did, in fact, have a kidney problem: protein was spilling through her urine and causing her body to swell. It was called nephrotic syndrome. For two years, while she was on medication for that, we were hoping and praying the problem would go away. Instead, it turned worse. Christmas 1982 her kidneys totally failed.



She was put on peritoneal dialysis, the quickest and shortest kind of dialysis, because it was determined that my tissues were compatible and I could donate a kidney to her for a transplant. No, I wasn't frightened to give up a kidney—even though a lot of people tried to talk me out of it. They said, 'Why would you endanger your own life?' and 'Why don't you just wait for a kidney to come, a cadaver kidney?' and 'Shouldn't you think about your own health, after all, you have two other children?' and things like that. But I didn't want to hear those kinds of things. The only thing that did frighten me was that my baby was so ill and I couldn't help her. When I found out I could help her [by donating a kidney], there was no question in my mind about what I would do.

Since February ['83] we had been in consultation with a white doctor at Vanderbilt Hospital about having the operation. I was under the impression we would get a kidney transplant about May because I work with the school system [as a teacher's assistant for handicapped children] and I wanted to have enough time to recuperate before school started. Around July 1st I still hadn't heard anything and I was getting worried because soon it would be time for me to go back to work and also because Tomeka wasn't doing any better. Also, by this time, with the worrying and all, I had picked up some weight. So this white doctor said that I was overweight and that he couldn't do the surgery—even though he

had never tested me or even gotten a history of my health or anything!—and that Tomeka would have to go on hemodialysis.

On the day she was being operated on to get the fistula [a surgical joining of artery and vein beneath the skin done so that hemodialysis can take place] I really shrilled out. I just got so distraught because I couldn't go through seeing her go through hemodialysis, couldn't see her being a slave to that machine. That same day someone had told us that there was a kidney center up at Howard University. While Tomeka was still in surgery, my husband called Mr. Yeager [Curtis Yeager, transplant coordinator for the Howard center] and told him about our situation, telling him how my weight problem was supposed to be the reason for the holdup of the transplant here. Mr. Yeager said he and Dr. [Clive] Callender were supposed to be at a conference in Nashville in about two weeks and would be glad to look at us.

They came and when they saw me, they laughed. They said they were looking for a lady three feet tall and three feet wide. They said I didn't seem to have a weight problem as far as they were concerned. The next day they went to Tomeka's doctor's office and they examined her and told me how terrible she looked and asked why anyone would wait to do the surgery. Later I learned that when they were talking among themselves outside the clinic doors they said that Tomeka wasn't going to make it very long [without a transplant], that she was, in fact, dying. Dr. Callender asked me if I was still ready to have the surgery. I told him, 'Yes.' He said, 'How soon can you come?' So, naturally, I said, 'Two or three weeks.' He said, 'No, I'm not even going to ask you. Be there next week.'

So we went and stayed up there at Howard University Hospital 21 days. The date of the operation was September 16, 1983. The hospitality of the patients and the workers and the medical attendants really helped me a lot to not be afraid. It was the first time I've ever been in an experience where the medical people themselves actually presented God as some type of strength for me to hold onto. And this is a big part of what gave me confidence in Dr. Callender because he told me that he could do 150 percent and God would have to do the rest. And I really liked that. Because I think you have to believe. I'm serious. It really does help. . . .

Since the operation we're both doing great. Tomeka's on a few medications, two of them she'll have to take for the rest of her life or the life of the kidney. She had to learn her medications and dosages and she does well with them. We put her medications in a little case and she takes them with her to school.

Tomeka turned seven last October 30th. Before the surgery, she was listless and didn't want to do anything. Since the surgery, she's had a 360 degree turnaround. She's able to play now. She does real well in school and has made the principal's honor roll. Before, she was sick every day, every day. Now, she's really enjoying life. □

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can be a problem. Before, during and after surgery, the patient is given immunosuppressive drugs, drugs which suppress the body's natural tendency to attack foreign substances (in this case, the transplanted kidney). But in suppressing the immune system so the body can keep the kidney, the body is less able to fight off any invading germs, thus becoming much more vulnerable to infection. "That's why reaching the precise level of immunosuppression remains such a challenge," Dr. Stevens points out.

Some rejection episodes can be reversed by temporarily increasing the dosage of immunosuppressive drugs. That was the fortunate denouement of that scene with Denise Chasten in the hospital's intensive care unit. She was able to keep her kidney. If a rejection episode cannot be reversed, the patient returns to dialysis and may opt for another transplant later on.

Because Blacks statistically do less well after transplantation than whites, the Howard center has evolved some special modes of treatment to deal with this problem, Dr. Callender explains. Before a transplant operation, a patient's kidneys may be removed to control hypertension (far more prevalent amongst Blacks than whites). The spleen also may be removed to raise a patient's white blood count (which is generally lower in Blacks than whites) so that the use of immunosuppressive drugs is less likely to cause infection and to raise his platelet count so there is less chance of excessive bleeding. Because the center also has found that Blacks tend to tolerate steroid anti-rejection drugs less well than whites, it makes greater use of the non-steroid drug, antilymphocyte globulin, to fight rejection than do centers treating predominantly white patients.

Once a patient has been operated on successfully, he continues to be closely

'God Should Have the Glory'

When Dr. Clive Callender finishes a successful operation, his face lights up with jubilation, erasing the fatigue etched around his eyes and making his short crop of greying hair look as if it must belong to someone else.



Yet the boyish-looking demeanor of the nationally-recognized transplant surgeon seems to mask a complex, driven and often enigmatic personality. He tells you of some of the dismal events of his childhood—his mother dying during a home delivery when he and his twin brother were coming into the world, a year spent in a foster home, a year and a half spent in a hospital with tuberculosis—and then says, “None of those things really bothered me.” He’s on the phone, laughing uproariously and exchanging anecdotes about his favorite basketball team, the Bullets, and later switches gears to speak in spiritual tones about the profound impact religion has had on his life.

He admits that to work as hard as he does is “insanity,” that he’s surprised he’s not dead because of the abuse his body has taken from his hectic schedule, and then tells his secretary to make a plane reservation for him *for tonight* because he has to go back to the Virgin Islands to check on a patient. He tells you he’s already achieved his childhood dreams—to be a doctor and to serve in Africa—and now feels he has “no more miles to conquer” and then enthusiastically shares his hope that the Howard University Hospital Transplant Center become a national referral center for Black transplant patients, that it open its doors to Black patients from all over the nation and the world, that it go into other types of transplants. . . .

The man at the center of these contrasts was born in Harlem 48 years ago. There he and his twin brother were raised by a dedicated and devout aunt following the death of their mother, the remarriage of their father to a woman whose own problems made childrearing impossible and that year-long stay in a foster home. (Carl Callender is a prominent New York attorney and minister. That the two brothers have become Harlem success stories instead of Harlem casualties, Dr. Callender attributes to two factors: “our aunt and our religious background.”)

Dr. Callender says he decided to become a doctor when he was seven. “One day in church something the minister said struck a chord,” he recalls. “He said, ‘The best way you could serve man-

14 monitored for signs of rejection and infection. He or she also must learn to cope with a new identity as a transplant recipient. And this is where the center’s regular Thursday morning therapy sessions play such an important role.

Group Therapy

These sessions bring together those who are awaiting transplants, those who have had successful transplants, those who have been rehospitalized following complications with their transplants and sometimes family members of those in each category.

One recent Thursday, a dialysis patient awaiting transplant told of his yearning for that which most people take for granted: a glass of water. (Patients on dialysis must severely restrict their fluid intake.) Some who have had transplants worried aloud about one of the side effects of their anti-rejection medications: bone deterioration. A father of a patient awaiting a transplant spoke of the way his son’s frustration caused him to lash out at everyone, while a patient who already had received a transplant told of how she once had interpreted her family’s concern for her health as an attempt to smother her.

“One of the main problems transplant recipients face,” says social worker Earlene Reavies, “is that at some point they forget that the kidney is not theirs, that they weren’t born with it, that if they stop taking their medicine, they’re going to reject. It’s a psychological step they go through. So you have to remind them that the kidney is not theirs.” She’s also found that sometimes patients have trouble adjusting to a more normal lifestyle after being dependent on dialysis for a long time or that they refuse to listen to “the bad stuff” about transplants so when something goes wrong, even though they’ve been told all the risks, they feel betrayed. Then there is all the anxiety

kind was to minister to the body and soul of mankind.' And I thought I could best do that by becoming a doctor." Why would a seven-year-old be concerned with something as lofty as "ministering to the body and soul of mankind?" "I thought that was the ultimate thing to do with your life," he answers as if it was the most obvious thing in the world, something any dummy would know.

Among the landmarks along his journey to fulfilling his childhood dream of a medical career: Hunter College in New York; Meharry Medical College, where he finished first in his class; Howard University's Freedmen's Hospital, where he did his residency in surgery; Port Harcourt General Hospital in eastern Nigeria, where he was a consultant in surgery; the University of Minnesota, where he received advanced training in transplant surgery; Howard University, to which he returned after that training and where he now is not only director of the transplant center but vice chairman of the department of surgery in the hospital and college of medicine; St. Thomas Hospital in St. Thomas, the U.S. Virgin Islands, which has named its transplant center in his honor for his work in making transplants available to the local populace.

Dr. Callender says he was initially attracted to transplant surgery because "it was a new and challenging field." Through the years, he estimates, he's been involved in between 400 and 500 kidney transplant operations. Through the years, too, he's received so many awards and honors, participated in so many professional organizations, made so many presentations in so many varied settings, authored or co-authored so many research papers that his *curriculum vitae* runs to 27 closely-typed pages.

Yet he seems uncomfortable in the limelight ("shy" is the word one of the center's secretaries uses to describe him) and tries to deflect all the praise that has come his way for the successful transplants he's performed. For one, he emphasizes, the transplant effort is a team effort with many people contributing their expertise and concern. For another, he jokes, "I don't like too much praise because if you can get too much praise, you can get too much criticism — and I don't like that." But there's another reason and it's a reason that relates to the depth of his religious beliefs:

"I do what I know how to do. I put a kidney in and draw on my knowledge and training to do the best job I possibly can. But whether the transplant is successful or not is not up to me. It's up to God. I tell my patients we'll do all we possibly can but I also tell them that God is the final arbiter. And we ask them to pray that God will direct us and guide us because I've always felt that in all things God should have the glory." □

that can build up as they wonder if a transplanted kidney will fail and "the stages of depression and loss and mourning" they go through if it does. 15

The Thursday morning sessions are the place where transplant patients feel free to drop the masks they wear out in the world and reveal their innermost feelings about what is bothering them. It's also the place where they can join together to grope for solutions to common problems. The sessions serve to further patient education as well.

"The key to the whole thing in transplantation is self-care," says Patricia Dillard, nursing supervisor for the center. "We do whatever we have to do. We connect the kidney. We adjust the medications. But if the patients are sent out without a good understanding of what's going on from point A on, we can't even think about success. The patient has to understand that if he misses *one* dose of prednisone [an immunosuppressive] that could mean he could reject — not just because we say so, but because he understands transplants. He understands that a, b, c, d are the signs of rejection so therefore if he doesn't take his prednisone which has a, b, c, d side effects then he has a chance to reject his kidney."

Indeed, as a result of the group therapy sessions, even those patients with limited formal education speak knowledgeably about platelets, white blood counts, ALG (antilympocyte globulin), creatinine . . .

Public Education and Advocacy

While the group therapy sessions reflect the center's goal to have "an informed patient and an informed family," as transplant coordinator Yeager puts it, the center's staff also has been involved in a larger educational effort; to spread the word about the importance of organ transplantation and donation and to encourage more people, especially Black

people, to will their organs after death.

A Gallup Poll commissioned by the National Kidney Foundation found that 95 percent of whites were knowledgeable about organ transplantation, compared to 84 percent of Blacks and that while 27 percent of whites were willing to donate their organs after death, only 10 percent of Blacks were willing to do so. A National Kidney Foundation of the National Capital Area press release also noted that in the District of Columbia, where 70 percent of the kidney patients are Black, fewer than 20 percent of the donors are Black.

One preliminary study conducted by Howard University researchers found that the most common reason Black respondents gave for not willing their organs was lack of information. This, in turn, made many superstitious.

Some expressed fears about being cut up after death. (Dr. Callender's response to this fear: "Everybody gets cut up after death — unless they get cremated. If you're going to be embalmed, they cut you up anyway. Besides, after you're dead you don't have any pain.")

Some were afraid they wouldn't be able to "get into heaven" if their bodies were not completely intact. (Again, Dr. Callender's response is to cite the embalming procedure, adding, "So you're not going intact *anywhere* [after death].")

Then there were those who expressed apprehension that if they will their organs, when they are sick in a hospital they will not receive proper care because the doctors will be so eager to pluck out their organs and give them to someone else. (Dr. Callender's answer: "Basically, the doctors who determine whether you're alive or dead neurologically are completely separate from those doctors who are going to do transplants. That separation should always exist.")

Dr. Callender currently serves as chairman of the D.C. Organ Donor Project, a pilot project supported by the National Kidney Foundation, which aims to help Black Washingtonians overcome their reluctance to donate kidneys. The project includes conducting an education campaign through the Bureau of Motor Vehicle Services in which drivers seeking licenses are given information about organ donation and given the option of having their licenses stamped on the spot if they wish to be classified as donors. It also includes developing and implementing a lesson plan for the D.C. public

schools that covers organ donation and utilizing the media and community meetings to spread the word about its importance.

For the Howard center's staff, the rationale for such an educational project is self-evident. Says Dr. Callender, who has signed an organ donor card himself: "Here we are in the District of Columbia, which has the highest incidence of renal disease in the nation, so it seems to make sense to leave our organs behind when we die so that other Blacks who suffer from this affliction could have an improved quality of life. We talk about doing things to help each other, so here is the greatest time to help. . . . After you die, you're not going to use your organs anyway."

Not only has Dr. Callender and his staff been involved in bringing the transplantation perspective to Blacks, but they also have been instrumental in bringing the Black perspective to transplantation. In Congressional and other testimony, Dr. Callender has warned that most minority persons cannot afford cyclosporin A, a major new anti-rejection drug that is being hailed as a breakthrough in transplantation. (The drug costs approximately \$5,000 a year and is not covered by Medicare as is true for all out-of-hospital transplant medications. So if one is not eligible for Medicaid, one would have to foot this hefty bill.)

He also has spoken out against the entire idea of organ selling. (Several bills have been introduced into Congress to ban this most controversial variant of "free enterprise." Efforts to get such a bill passed came after widespread publicity about a Reston, Va. man's intent to open a profit-making organ brokerage firm.)

"Selling organs is the *worst* thing that could happen to transplant surgery," says Dr. Callender, with vehemence. "What would happen is that Blacks — again — would be victimized. Someone would say to some Black guy, 'Here's \$20,000 for your kidney so we can give it to someone else.' It is my belief that organ selling would result in the socioeconomically-deprived groups being abused and for that reason I am as strongly opposed to it as I could possibly be."

Concern with the victimization of minorities also has fueled the center's interest in doing liver transplants. "We hope to be able to offer liver transplantation to minorities who, at this point, are

discriminated against because they don't have the funds," Dr. Callender observes. "Liver transplants are not covered by Medicare so most of the white folks who have transplants raise funds. It's easy to figure out that it's much easier for a white person to raise funds among whites for a liver transplant than for a Black person to raise funds among Blacks for one. If a Black person goes to his friends, he might raise \$200 or \$1,000. But when we talk about a liver transplant, we're talking about \$50,000 to \$100,000."

As he looks to the future of the Howard University Hospital Transplant Center, Dr. Callender also envisions it evolving into a referral and treatment center for Black transplant patients from all over the nation.

It seems an overreaching dream. But then, again, so did the whole notion of kidney transplantation, itself, at one time. That the dream is now a reality is something for which the Scottie Left-dwriges of this world are most grateful. Amen. □