EDITORIAL

MANAGEMENT OF END STAGE RENAL DISEASE (ESRD) — THE DEBATE CONTINUES

YCK is a 27-year old male Chinese. In 1977 he was discovered to have microscopic haematuria and proteinuria at a routine urine test prior to part-time VC training. Since he felt well he did not seek further medical treatment. In 1979 he began to have headaches and saw a general practitioner. He was discovered to have hypertension with evidence of renal dysfunction. Because of his business commitments he was not regular or compliant with his medication. By the late 1981 he was in obvious ESRD and require substitution therapy either in the form of dialysis or transplantation. Unfortunately he does not fulfill the social criteria to enter the already filled hospital dialysis programme as he is self-employed and a bachelor. Neither is he affluent enough to support himself on private dialysis. Fortunately he has a very supportive family and is at the moment being assessed for a living transplant. This is a true story culled from a recent hospital experience. According to national statistics such a story is repeated two hundred times a year and only less than 10% are lucky enough to be offered any hope of treatment and hence survival. Almost daily some doctor in Singapore agonizes over the fate of his patient under similar circumstances. Such a dilemma facing the medical profession is highlighted in O. T. Khoo's article in this issue of the journal. We the medical profession in Singapore together with other health care delivery agencies must now take a second look at the management of ESRD and formulate effective countermeasures to alleviate at least some of the suffering.

End stage renal disease we are often told is relatively rare compared to ischaemic heart disease and cancer. On the face of it, the treatment appears to be expensive and it has been argued that utilization of health service resources in this way may be unjustified - the proverbial pouring money down a bottomless pit concept. In the U.S. the thrust of this argument has been that one billion US dollars are spent to keep 50,000 patients alive. More dismal still 40% of ESRD patients are incapable of a level of physical activity beyond that of caring for themselves. Despite what the protagonists say ESRD consumes only a small part of the health dollar in the U.S. Also the cost of a ESRD programme must be placed within the entire context of modern medical care. Despite incessant progaganda to the contrary, almost no progress has been made toward a cure for cancer. The most recent data available from the National Cancer Institute in the U.S. show no decline in cancer deaths over the last 50 years. Yet billions of dollars are spent on chemotherapy and oncologists and surgeons spend considerable part of their professional life treating such patients. We have yet to hear anyone suggest that we curtail cancer therapy since it is cost ineffective. Similar arguments could be said about geriatric medicine. Why spend money on old people whose likelihood of rehabilitation decreases with every passing day. Most physicians in fact spend a major portion of their time caring for people who have diseases with little hope of rehabilitation let alone recovery e.g. severe emphysema, strokes, heart failure, diabetes with its complication and chronic liver disease. Hence ESRD management programme should be looked in the context of the entire problem of dealing with chronic diseases in a population and the desirability of spending money on the management of all such chronic diseases for which there is no cure available.

The next debating point is one of facilities and man-power. Developing countries are woefully short of both. Fortunately for Singapore both are available although in relatively short supply. All local opinion is agreed that our solution in ESRD management lies with a vigorous ongoing transplantation programme as our health budget will not be able to support a comprehensive dialysis programme. Kidneys from living donors will never solve the problem. Given the diverse ethnic, cultural, social, educational and religious background of our population, voluntary organ donation after death will never reach a level that will be sufficient to help all the patients. Public opinion must be galvanized and garnered and a "push" is necessary from the authorities. Unfortunately a recent suggestion from the Minister of Health on the "opting out" rule has drawn less than enthusiastic support from the public judging by newspaper reports. Most members of the public are unhappy over the fact that government "will remove my organs for transplant purposes upon my death" They forget the most important thrust of the opting out rule - that is they still have the option to say "no". Current thinking is that it is still premature to apply this rule to the whole population. Perhaps a pilot programme with a softer option could be carried out in a subset of the population namely those holding valid driving licenses. In California since 1976 the Department of Motor Vehicles has provided a pink sticker which may be affixed to the back of a driver's license and upon which the license holder states his/her willingness to donate organs. Law officers and medical personel are supposed to check whether seriously injured or ill individuals are would-be donors. Such a programme is worthy of study by the Health Ministry, the ROV and the medical profession. Finally in the cut and thrust of the medical cost debate we have often forgotten the most important ingredient - the consumer. What does YCK and the two hundred of his compatriots think of all this sound and fury. My surmise is that none of them are impressed and almost all of them prefer treatment to death!.

In conclusion therefore all health care delivery agencies are guilty of taking the easy way out in

regard to ESRD treatment. There must be more debate, more public education programmes in the form of symposia, seminar and forum to inform and nurture public opinion. Prejudice is frequently born of ignorance and it is fairly certain that this applies to the attitude concerning treatment of ESRD. Inspite of persistent gloom, those involved in the management of ESRD should not be discouraged. Of all chronic illness, ESRD is the only disease entity that can boast of 80% survival of patients suitably treated compared to certain death a decade ago. Surely this must be a record by all standards. To borrow an American phrase "You have come a long way!". Meanwhile details of the results of dialysis and transplantation should be much more widely available and put in proper perspective with those for other terminal diseases. Using figure for carcinomas of adult life - breast, stomach, colon and lung - it can be shown that cumulative survival figures are only similar between dialysis and transplantation and breast cancer; lung, stomach and colon carcinomas have much worse survival rates. Although relative quality of life and rehabilitation are much more difficult to assess, it is extremely unlikely that renal replacement therapy could be shown to offer worse chances than treatment for many malignancies. Similarly doctors too need to be further educated and they need to adjust their attitudes from one of defeat to one of challenge in the care of patients with chronic renal failure. We all look forward to breakthroughs in the field of transplant immunology that will result in major improvements in the success of nonrelated living donors so that transplantation can be carried out more like blood transfusions with more compatibility and less complications. Meanwhile both doctors and patients will suffer the agony of defeat and the ecstasy of success.

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