

# bulletin

**NHS**

*UK Transplant*

The newsletter for everyone involved in organ transplantation and donation  
Issue 49 Winter 2003

**In this issue:** Reflections of a leading organ transplant surgeon. Religious perspectives on organ donation. Leave more than memories campaign launch. New legislation on human organs and tissue. Conference paves way for non-heartbeating donation in Scotland.



*Season's  
greetings  
to all our  
readers*

I was delighted to be present at two excellent conferences recently. Firstly the non-heartbeating conference in Scotland organised by the Scottish Executive to consider the issues for non-heartbeating organ donation in Scotland and, secondly, the multi-faith conference organised very expertly by Rachel Howitt on UK Transplant's behalf. These were high quality events with excellent speakers and thought-provoking content.

I was, however,



dismayed at the number of people who still continue to use the word "harvest" in presentations and

discussion. I would like to take this opportunity to suggest that we ban the use of the word and respectfully remind colleagues who may use it that it is inappropriate. The dictionary definition of "harvest" is the reaping and gathering of crops or the season's yield. This conjures up an image of a grim reaper that is crass and disrespectful to organ and tissue donors and their families.

Organ donation is truly the gift of life and the language we use should

reflect this tremendous act of thoughtfulness and kindness. Can we assign "harvest" to the bin and use "donation" when referring to the donors' gift and "removal" for the actual taking out of organs?

Christmas seems to have crept up very quickly this year! Season's greetings to you all.

*Sue Sutherland*

Sue Sutherland  
Chief Executive  
UK Transplant

## bulletin

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*Front cover picture:*

*The snowman logo is part of  
UK Transplant's Christmas  
campaign.  
See page 5.*

## NEWS

# Cynthia's *Nursing Times* award

Cynthia Davis, manager for the African and Caribbean Organ Awareness Project has won the *Nursing Times* award for Innovation in Working with Patients from Different Ethnic Groups for her "outstanding" work in improving awareness.

The project, based at the South Thames Transplant Co-ordination Service at King's College Hospital, was set up to raise awareness of the need for organ donation among the African-Caribbean population in south east London.

Cynthia says: "This is a further step in the right direction to raising the important issue of organ donation in the black community."

After identifying the main barriers to organ donation among the black community in south east London,



*Cynthia Davis, delighted with the recognition of the importance of work with black communities.*

Cynthia launched a major community awareness drive aimed at dispelling some of the myths and fears surrounding this issue.

The judges concluded: "This is a fantastic project – although locally based it could easily be transferred across the country and across different sections of the population."

# Nurse Consultant Advisor - living donor schemes

**In August this year, Lisa Burnapp was appointed by UK Transplant to take on the role of Nurse Consultant Advisor to the 23 funded living donor schemes across the UK. Here, Lisa describes her new role.**

In May 2002 I was appointed as a Nurse Consultant for Living Donor Renal Transplantation at Guy's & St Thomas' NHS Trust. The post was funded as part of the UK Transplant living donor schemes initiative and my appointment was a culmination of a great deal of team effort and investment in our own living donor transplantation programme over a number of years as well as a welcome leap of faith on behalf of UK Transplant.

I was not only encouraged by the enthusiasm with which my colleagues supported the concept of the role but also by the momentum that living donation seemed to have gathered at a national level. I imagine that five years ago living donation would not have been considered one of the immediate priorities for a Nurse Consultant appointment.

In August 2003, I was delighted when UK Transplant asked me to take on the role of Nurse Consultant Advisor to the living donor schemes across the UK. The role is primarily designed to support, advise and enhance links between the postholders in order to share expertise and best practice, but I also provide clinical support and advice to UK Transplant. There are a number of exciting challenges ahead.

Firstly, the UK Transplant funded schemes are almost exclusively based in transplant centres, each of which receives patients for transplantation from referring



**Lisa Burnapp, left, links up with colleagues at the meeting on living donation at Guy's Hospital.**

nephrology units. Within these units there are numerous co-ordinators, link nurses and members of the multi-disciplinary team who are responsible for preparing donors and recipients for living donor transplantation and placing them in the hands of the transplant centre for surgery. It is important that the living donor network is as inclusive as possible and that the contribution made by all colleagues to the bigger picture of living donor transplantation is acknowledged and reflected within it.

Secondly, the appointment of dedicated living donor co-ordinators under the UK Transplant schemes has brought together nurses from a wide range of backgrounds: renal, intensive care and regional co-ordination, with a collective diversity of skills and expertise. Whilst this is a definite strength of the programme, this level of diversity must be addressed and the development needs of the individuals concerned adequately met.

Finally, the development of a national forum for colleagues has become a priority and the Consultant Advisor role has enabled

me to make progress with this work in conjunction with my co-ordinator colleagues across the UK. A meeting, attended by approximately 50 delegates from around the UK, was held at Guy's Hospital in London in November in order to establish what the forum might "look like" in the future. The meeting generated lively discussion and a consensus view of how the forum should proceed was achieved, which was one of the key objectives. A twice-yearly meeting is planned together with a number of ideas for broadening the network on an ongoing basis.

So, in summary, I feel living donation has an optimistic future in the UK and I am privileged to be in a position to contribute to it. I would be delighted to hear from anyone who may have suggestions about how my role can be used to maximum benefit and I look forward to seeing more of all of you in the future!

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*Networking was an important part of the day.*

## Publicity partnership meeting

**Thirty-one people representing 19 organisations with an interest in publicising organ donation and transplantation met with staff from UKT's communications directorate at Bristol in September.**

Attendees represented professional organisations and charities supporting donor families, patients and transplant recipients and their families.

The meeting was designed to enable representatives to gain a better understanding of each other's aims and objectives and to explore ways to work together with a view to securing a more co-ordinated approach to promoting

organ donation and transplantation.

The day was packed with presentations by representatives of the various organisations, many of whom had never met before. Participants agreed it had been a useful start and to build on these relationships to work more closely together in the future.

It was suggested that smaller groups could meet to discuss specific issues. These included improving distribution of literature about organ donation, co-ordinating events to mark the tenth anniversary of the NHS Organ Donor Register next year and initiatives to target minority ethnic communities.

## Living donor expenses

**The Department of Health has issued an updated policy document on the reimbursement of expenses to living donors.**

Although the Human Organ Transplants (HOT) Act forbids the offer of payment of any inducement for the supply of a human organ, it permits the payment of expenses to a donor for travel, accommodation and loss of earnings.

The NHS is not legally obliged to make payments: whether the NHS Trust or a PCT refunds the donor is a matter for the specialised commissioning groups. Details of reimbursement, personal expenses and loss of earnings are set out in *Reimbursement of Living Donor Expenses* by the NHS, Gateway No 1908, August 2003.

See: [www.doh.gov.uk/transplantframework/livingdonorexpenses.htm](http://www.doh.gov.uk/transplantframework/livingdonorexpenses.htm)

## Nottingham Save a Life campaign

**When Nottingham City Council decided not to take part in this year's Vote for Life, UKT suggested other options.**

Working with Nottingham transplant co-ordinators, a wide-ranging campaign was launched giving the city's residents the opportunity to find out more about organ donation.

"There was a real commitment from the council to encourage more local people to join the organ donor register," says Tamsin Friend, Transplant Co-ordinator at Nottingham City Hospital. "We provided posters, leaflets and our exhibition stand for a big press launch at the end of September.

"Three transplant recipients and the widow of a tissue donor came along and met the Lord Mayor. My colleagues, Richard Bowen, Jo Gregg and Deirdre Cunningham were also heavily involved with the various TV, radio and press interviews that were needed."

The city council's campaign involved:

- an article and registration form in the civic newspaper *The Arrow*, delivered to more than 125,000 households
- a link from the council's website direct to UKT's website
- information leaflets and forms made available at all council offices, libraries and leisure centres
- an employee donor recruitment campaign via staff e-mail, payslips and internal newsletter, reaching 14,000 members of staff.



**NHS**  
UK Transplant

**Give life.  
Organ  
donation.**

**0845 60 60 400**

**www.uktransplant.org.uk**

## Christmas campaign

Christmas is a time when our thoughts turn to giving and UKT is mounting a media campaign to raise awareness of the NHS Organ Donor Register in a drive to get more people to sign up.

A snowman logo has been designed as part of the campaign and this image is also available as a Christmas sticker for use on hospital and personal mail.

Supplies of stickers have been sent out to all transplant co-ordinators and donor liaison nurses. For more supplies e-mail: [Nicole.Sutherland@uktransplant.nhs.uk](mailto:Nicole.Sutherland@uktransplant.nhs.uk)

# New legislation on human organs and tissue

**New legislation to regulate the taking, storage and use of human organs and tissue, will be introduced in the current Parliamentary session in England, Wales and Northern Ireland.**

The Department of Health will also be working closely with the Scottish Executive to minimise differences of approach from the rest of the UK.

Sue Sutherland, Chief Executive of UK Transplant said: "It is pleasing that the proposed legislation addresses all of the issues to which the UKT Advisory Group responded when consulted on *Human Bodies Human Choices*."

The new legislation is not expected to disrupt existing activities (including those of UK Transplant) relating to organ donation and transplantation, but these activities will be carried out within the new legislative framework. The Human Organ Transplants (HOT) Act will be repealed and a new Human Tissue Act introduced.

The importance of consent from individuals will underpin the new legislation, and relatives will not be able to reverse an individual's wishes. In the case of organ donation, the person's wishes while he or she was alive would, where known, take precedence over the views of relatives or next of kin.

A new statutory body, the Human Tissue Authority (HTA) will be established. Its remit will cover the taking, retention, use and disposal of human tissue, and it will take on responsibility for approving live transplants and developing policy on new transplant procedures.

The HTA will also have a role in producing codes of practice including guidance on the definition of death and the removal and use of tissue and organs.

Other points that the new legislation will cover are:

- there is no property in a body
- donation is a gift
- there should be no commercial

gain from the use of organs/tissue

- there will be no statutory definition of an organ or death
- the legislation will explicitly allow "cold perfusion".

### Further information

The Department of Health and the Welsh Assembly have published an interim framework of materials that might underpin the new legislation. This includes a statement on the use of human tissue and organs, model consent forms, leaflets and codes of practice. This information and the document *Proposals for new legislation on human organs and tissue* can be found at [www.doh.gov.uk/tissue](http://www.doh.gov.uk/tissue)



**UK Transplant has sponsored a league-topping London softball team to carry the message "Organ donation. So life can go on." Nurse Lauren Smith, who works in the transplant co-ordinators' office at King's College Hospital, South London is a member of The Orphans softball team.**

**Pam Buckley**, Directorate Manager for Renal and Urology Services, Newcastle upon Tyne Hospitals NHS Trust (former Senior Transplant Co-ordinator), remembers a very special man...

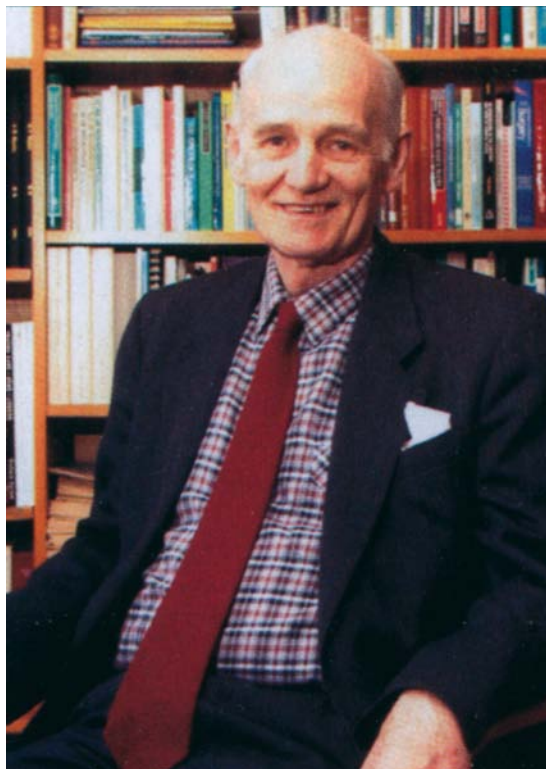
## **Robert Murray Ross Taylor** *CBE, MB, ChB, DObst RCOG, ChM, FRCS (Edin), FRCS(Eng)*

**Ross Taylor passed away on 24 October 2003 following a short illness.**

Ross qualified in Glasgow in 1956 and spent his early postgraduate medical training in Ayrshire. On completion of two years' National Service, during which he served in Cyprus and Jordan, he continued his training in Bishop Auckland as a Registrar in Obstetrics and Gynaecology, and Surgery. He was then appointed to the Newcastle Teaching Hospitals where he was a Registrar, Research Fellow and Senior Registrar. During this period he was awarded the Mastership of Surgery by the University of Glasgow.

In 1970 Ross was appointed to the post of Consultant Surgeon and Senior Lecturer to the Royal Victoria Infirmary and University of Newcastle upon Tyne. Following the retirement of Professor John Swinney in 1973 Ross became the Surgical Director of Renal Transplantation in Newcastle, a position he held for over 22 years. He was fiercely proud of the Newcastle unit's record of organ donation and transplantation, the success of which was largely due to his leadership, enthusiasm and innovation. He was involved in the establishment of the cardio-thoracic and liver transplant programmes in the city.

His academic interests were in the clinical and immunological aspects of renal transplantation and subsequently in the immunological behaviour of neoplasms. He had many publications in this area and supervised numerous MD and MS students. Ross was a founder member of the International, British and European Transplant Societies. He was President of the



***Ross will be much missed by the many people lucky enough to have worked alongside him.***

British Transplantation Society from 1986-89 and made an invaluable contribution to the many organisations with which he was involved.

Ross was very interested in the ethical aspects of organ donation and transplantation, a subject on which he became a highly regarded spokesperson in the media.

Whilst his clinical and academic achievements are obvious, it is Ross Taylor the man who is irreplaceable. His involvement in charities and fundraising started more than 20 years ago, when as a member of the executive of the Northern Counties Kidney Research Fund, he took up distance running to raise funds. He subsequently ran four marathons, tens of half marathons

and other events raising £500,000 for this fund. Two senior research posts were established from his efforts.

In 1983 he became Chairman of the (now) Transplant Sports Association of Great Britain (TSAGB), a post he held for 20 years. The annual British Transplant Games are a highly successful vehicle for the promotion of organ donation. His contribution to the TSAGB is immeasurable.

Ross's popularity with all recipients and their families involved with the games knew no bounds. He had a unique relationship with the thousands of patients who have participated in the games. His interest in people was overwhelming and in return he received their affection and respect.

In 1993 he held the Transplant Games in Newcastle and due to the success of his fundraising efforts the Transplant Patients' Trust was born. This charity gives financial support to needy patients. Ross personally raised more than £1m for his charities and was awarded the CBE in the 1997 Birthday Honours, an award he richly deserved.

Whilst we, his colleagues, miss his enormous generosity, friendship, support and commonsense it is Ross's wife Margaret, children Linda, Jill, Anne and Bill, and ten grandchildren who have lost a loving and devoted husband, father and grandfather. To them we offer our deepest condolences. At the Transplant Volleyball Competition held in Newcastle on 15 November we sang the Games anthem he loved "You'll never walk alone" and remembered a very special man.



*Supporting organ donation at one of the melas. From left to right: Daljit Toor and Riminder Dosanjh, both kidney recipients, and Nina Wadia, TV actress and comedienne.*

## South Asian community gets the message

**The South Asian organ donation campaign has broken new ground in recent weeks by visiting 13 freshers fairs and melas (South Asian community festivals) to talk to young South Asian people and families about organ donation.**

Stands at the events, staffed by South Asian recipients and patients registered for a transplant who talk to visitors about their experiences, are designed to give people information about donation, answer their questions and give them the opportunity to join the NHS Organ Donor Register.

Despite the great success of the events – 568 people joined the register at the freshers fairs and 350 at the melas – they have revealed a number of new challenges for the South Asian organ donation campaign.

“We had a great response,” says Angie Burton, UK Transplant’s Marketing and Campaigns Manager, “but also came across a lot of barriers, particularly amongst

the students. Many said they wanted to join the register but needed to discuss it with their families first, who might be resistant to the idea. So it’s evident that the campaign needs to reach all generations, educate them about the issues for the South Asian community and encourage them to support organ donation.”

The highlight of the mela at Wembley was a visit by actress Nina Wadia who is a passionate supporter of the campaign. Nina’s mother died waiting for a kidney transplant.

“Having lost my mother made me very aware of the fact that we as a South Asian community do not understand the issues that surround organ donation,” she said. “There are so many myths and fears that need to be addressed, and I will do whatever I can to help the education process. Going through the pain with my mother and the never-ending wait for a suitable donor took its toll on the whole family.”

## Government review of UKT

**UKT is to be reviewed as part of a Department of Health programme. At the Select Committee Health Secretary John Reid spoke about reducing numbers working in arm’s length bodies.**

In November the DoH announced 1,400 job cuts as part of a reduction of central control and Mr Reid reiterated the need for more responsibility to be devolved to those who provide local services.

National health and social care bodies employ over 19,000 people and the Department will be looking at the role of the bodies, how efficiently they are operating and how they can reduce demands on frontline services.

The review of arm’s length bodies will be completed by April 2004.

## Vote for life

**A total of 11 English councils sent organ donor forms to their electors this autumn alongside the annual electoral register form and many more ran campaigns in their own newspapers.**

The Vote For Life mailing reached nearly one million people in their homes but the campaign was much reduced from last year when 41 councils ran the scheme – reaching six million people and prompting 412,000 responses.

In 2002 Vote for Life brought in the highest proportion of new registrations to the NHS Organ Donor Register of all UK Transplant’s partnership schemes.

## Pancreas transplants to treble

Life-changing pancreatic transplant operations are set to treble to around 150 a year following an announcement in November 2003 by Health Minister Rosie Winterton to make pancreatic transplantation a national specialist service from 1 April 2004.

Pancreas transplants are usually combined with kidney transplants for people with Type 1 diabetes and established renal failure.

Together they remove the need for both insulin injections and dialysis, a life-changing event for recipients and their families.

This increase in pancreatic transplantations should meet the national demand by 2009.

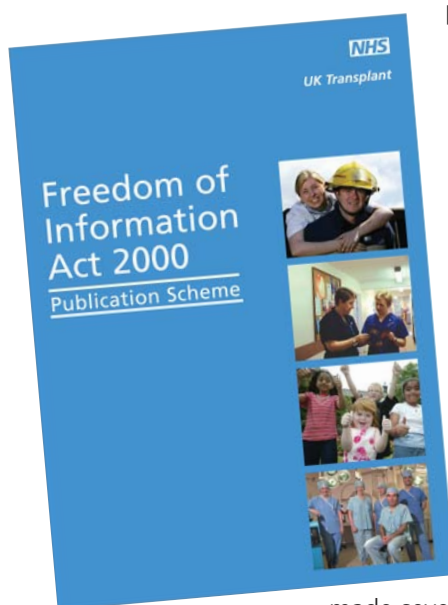
Chris Rudge, Medical Director at UK Transplant, said: "This is a very significant and welcome development. Combined kidney and pancreas transplantation is now a well-established procedure that offers real benefits to appropriate recipients.

"It will help the further development of this service that in future it will be commissioned and funded by National Specialist Commissioning Advisory Group (NSCAG), and this will ensure that all suitable patients have the opportunity to be considered for this form of treatment."

The seven centres in England receiving national designation and funding from NSCAG are: Addenbrooke's Hospital, Cambridge; Manchester Royal Infirmary; Royal Liverpool University Hospital; The Freeman Hospital, Newcastle; Churchill Hospital, Oxford; Guy's Hospital, London; St Mary's Hospital, London.

## What's new on UKT's website

A major addition to the site is the section which fulfills the requirements of the Freedom of Information Act (2000) in providing a publication scheme. This aims to identify all the information which UKT makes routinely available. The publication scheme is also available as a printed document.



The Statistics section has been updated with the addition of Transplant Activity 2002-2003. Once again there are separate sections for the UK and the Republic of Ireland. Amendments have also been made to incorporate the new allocation scheme for pancreata.

The number of online registrations to the NHS ODR continues to rise, aided by the introduction of an e-mail registration initiative aimed at employers.

Over the last few months we have made several cosmetic changes to the structure with the aim of enhancing usability. We are always keen to receive details of life stories and other information for possible incorporation into the website.

Any stories or feedback on your use of the site should be e-mailed to: [Trevor.Jones@uktransplant.nhs.uk](mailto:Trevor.Jones@uktransplant.nhs.uk)

## New posters

**UKT has produced two standard A3 poster templates for transplant co-ordinators and donor liaison nurses to advertise local events and information.**

**The templates will enable them to display tailored information at the same time as projecting consistent images and messages.**

The artwork is also available in Word format enabling them to type in their own text without altering the design.

From feedback that transplant co-ordinators have already given us, we envisage the posters will be used for study days, nurse/doctor type events on organ and tissue donation, internal teaching sessions, charity events, and displaying local transplant list information.

For further copies of the posters please contact the Communications Directorate.

E-mail: [Nicole.Sutherland@uktransplant.nhs.uk](mailto:Nicole.Sutherland@uktransplant.nhs.uk)



# Leave more than memories

**A new campaign – “Leave more than memories” – is being run in partnership with the Driver and Vehicle Licensing Agency (DVLA).**

The biggest single source of registrations to the NHS Organ Donor Register is through the driving licence application form. Nearly 4.6m drivers have pledged to help someone else by donating organs and tissue after their death since the scheme was introduced with the launch of the register in 1994.

More 16-18 year-olds join the ODR than any other age group and the majority of them enrol by the driving licence route.

“The scheme is very successful but it only reaches new drivers or people who have had to apply for a new licence in the past nine years perhaps because they’ve changed their name or address,” says Penny Hallett, UK Transplant’s Communications Director.

“We believe many more drivers would be willing to register – we just need to reach them.”

The new campaign will see registration forms sent to the owners of six million vehicles with their vehicle tax reminders in January and March 2004. If the pilot is successful, UK Transplant hopes to secure sufficient funding to extend the opportunity to the drivers of all 33m vehicles in Great Britain.

The thought-provoking graphics have been designed specifically for motorists and have been tested with members of the public and donor families. The pilot will be supported by media relations activity aimed at motorists and vehicle fleet managers, including drive-time radio interviews.

A poster carrying the same image will be available in January 2004 for transplant co-ordinators, donor



***The thought-provoking image that will drop through the letterbox of six million vehicle owners in January and March next year.***

liaison nurses and others to use.

- Legislation combined with improved vehicle and road design has led to a big drop in the number

of donors from road accidents. In 1994, 171 organ donors died as a result of a crash – compared to 89 in 2002 – a 48% drop.

# Looking back... with pride

**Liverpool's world-renowned organ transplant surgeon Professor Robert A Sells is retiring. For the past 32 years he has led an eight-strong team at the Royal Liverpool University Hospital, which has carried out more than 1,600 transplants. Here, Professor Sells looks back...**

In 1971 I came to Liverpool from Sir Roy Calne's Unit in Cambridge in order to set up the first Merseyside Renal Transplant Unit. Transplantation was then in its very early stages, immunosuppression (Imuran and Prednisolone) was primitive and hazardous, the quality of cadaveric organs was relatively poor since all the kidneys came from non-heartbeating donors, and only 50% of the grafts could be expected to function at one year. But dialysis programmes were springing up all over the country, and nephrologists persuaded the Department of Health that kidney transplantation should become an integral part of the treatment routinely available to patients with end stage renal disease.

Dialysis centres were overcrowded and there was an age limit of 50 years on patients accepted for treatment of end stage renal disease. The challenge in those days was to develop the technique of kidney transplantation from a research tool into a successful, acceptable and integral treatment, to allow more people to enrol on the restricted number of dialysis machines, and to improve the quality of life for those suffering end stage renal disease.

Liverpool had an extremely successful dialysis programme developed by the energetic nephrologist Dr John Goldsmith at Sefton General Hospital – but unfortunately the first brave attempts at transplantation had



failed. The board of the (then) United Liverpool Hospitals decided to set up a special unit at the Liverpool Royal Infirmary. So we built a portakabin unit with eight dialysis beds, an operating theatre for vascular access, a huge tank of dialysis concentrate and an office/conference room for me, my doughty secretary Irene Frost, and her dog Monty. The only space available for the unit was the nurses' tennis court. I was not popular! The unit was opened in 1972 by Sir Peter Medawar, after

whom the unit was named.

Having general surgical sessions at the Royal, and at Broadgreen Hospital four miles away, had its advantages: In those days general surgical complications were common, particularly bleeding and perforated peptic ulcers caused by excessive steroid therapy. We were able to manage these patients surgically "in house", a tremendous advantage which is now virtually prohibited by the current training structure in specialist surgeons.



**Robert Sells (left ) showing local journalists around the new unit when it opened in 1972.**

A busy general surgical practice also brought me into close relationships with intensive care unit staff. The crucially important cadaver donor recruitment programme started well, with tremendous, insightful co-operation from the neurosurgeons at Walton as well as intensivists at the pioneering unit in Whiston Hospital and six other ICUs in Merseyside and North Wales.

Organ donation was a very new concept on Merseyside and public relations were crucial. To guide us through this ethical minefield, we set up an Advisory Committee consisting of the Professor of Law, the Bishop of Warrington, the Public Relations Officer at the University, and the City Coroner. *The Liverpool Echo* has always been an ally of this Unit and we were very grateful for positive reporting of transplant events, particularly living-related donation. Radio Merseyside has on more than one occasion put out a call for a lost recipient for whom we had a kidney waiting.

The donor "campaign" was greatly helped also by the appointment of Jim Colbert who was the first

transplant co-ordinator in the UK. We recruited him from Sir Peter Morris' Unit in 1979, and I always felt that the fact that he had trained in the SAS gave him special qualities for the job!

Another crucial "first" for Liverpool was the purchase of the first version of CDS "Proton" computerised data system which was absolutely essential for effective patient management. Barbara Temple was our first computer officer (later Business Manager of the Directorate) and helped develop this programme nationwide.

There were glitches, some of them quite famous: a kidney in its Dewar flask was delivered by me to the stationmaster at Lime Street who personally gave it to the guard on the five o'clock express to Euston. Unfortunately the train broke down at Nuneaton; the guards van was shunted back to Liverpool and everyone ignored the Dewar flask. Two weeks later the flask exploded in the lost property office at Euston and several hundred lost items had to be destroyed and the warehouse cleansed. Thankfully this was in

the days before terrorist attacks with biological weapons, so an international crisis did not result.

The Unit increased its activity and in 1978 we moved to the new concrete monolith, now the Royal Liverpool University Hospital. The birth pangs were horrendous, troubled by the political issues around the closure of six Victorian hospitals in Liverpool, and the first serious strikes in the National Health Service. The following year a really big step in clinical transplantation occurred when we started using Cyclosporin.

The next ten years were happy and productive with expansion of the donor pool consequent upon the improved survival of our recipients and their kidneys, and a massive drop in iatrogenic complications. In 1984 I became President of the British Transplantation Society and we set up the Training Committee in order to systematise and improve postgraduate education in kidney transplantation and to recruit young postgraduate trainees to the field.

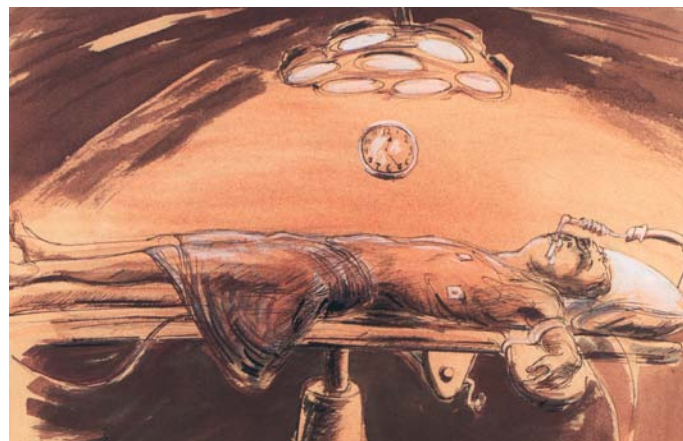
Before taking up transplantation I had done research at Guy's Hospital into blood sugar control in type 1 diabetics. I was impressed early on by the misery of patients suffering rapidly progressive diabetic microangiopathy: these patients seemed to have "a full house" of clinical symptoms including diabetes, renal failure, gangrene, stroke and angina. Fortunately only a small proportion of diabetics suffer the full range of vascular disease. But for the unfortunate few the outlook was particularly dire since the attrition rate on dialysis and after renal transplantation was very high.

From an early point, we were looking at ways of transplanting a pancreas with the kidney in these patients. Cyclosporin gave us that opportunity, because we could safely lower, or omit, the dose of Prednisolone which was a very high risk drug in this group. On 2 October 1982 we performed our



*Julia Midgely spent several months as artist in residence at the Royal Liverpool and Broadgreen University Hospital Trusts. She spent a day with Professor Robert Sells in 1997, as he performed operations to transplant a kidney from a mother to her son. These illustrations are from her book *Drawn from Experience* along with quotes from her text.*

*Above left: "Professor Sells and his team transplanting the kidney into the recipient. The team*



*explain to me that one of the wonderful things about transplants is that rather than removing something bad as is the case with most operations, something healthy and well is 'put in'."*

*Above right: "An important job has been successfully completed, there was a palpable sense of collective satisfaction and genuine delight. For a few moments the young man with his new kidney lies alone. He is in a curiously timeless pose almost cruciform."*

first simultaneous kidney and pancreas transplant in a patient who had already lost one leg, but whose heart was in good condition.

Several years later a clutch of physicians from The London College attended a Grand Round and the celebrated diabetologist, Dr David Pyke, asked my patient: "How long have you been diabetic?" The patient replied, "Dr Pyke, I am NOT diabetic" to general applause. He survived for seven excellent years and lived to see his grandchildren.

It has been a real privilege to work during a period when the prognosis for the diabetic with renal failure has been transformed by the good results of simultaneous pancreas and kidney transplant. We have learnt over the years two crucial things: that the operation is only safe after objective valuation of the coronary artery circulation to the left ventricle, and corrective surgery if possible for coronary artery stenosis; and that autonomic neuropathy (which causes postural hypotension and a high risk of death in diabetics) usually

improves during the months and years after the pancreas is transplanted.

Despite the terrific advances in immunosuppression, transplantation worldwide is dogged by the most obdurate problem of all: the lack of donors. I have always felt that the bioethical issues intrinsic to living and cadaver organ donation require very careful examination and debate to ensure acceptance by the general public, the government, and by the profession, before progress can be made in this area. There is tremendous variation in cultural attitudes and practice between countries.

In 1995 we formed the International Forum For Transplant Ethics, a multi-national, multi-disciplinary body whose self appointed task was to identify the moral and ethical basis of practice and publish papers for debate in the hope of clarifying directions for progress towards solving the problem of organ supply. I think this has been a useful exercise, and it has been deeply satisfying to collaborate with colleagues in

other countries in identifying factors, which are important in the development of "best practice" in this difficult field.

As the time to leave approaches, it is a pleasure to look back at the remarkable advances in British transplantation during the last three decades. Key strategic innovations have been better, non nephrotoxic immunosuppression and the development by UKT (and the Regional Alliances) of a kidney distribution system, which makes superior matching the rule rather than the exception. The zonal retrieval teams have greatly improved the quality of life for kidney transplant surgeons and trainees and save a lot of time.

It is also very encouraging that more living-related donor transplants are being done. I have always felt it a privilege to assist a relative or friend enact the most generous and priceless gift of all – the donation of a healthy kidney to a relative or friend.

I am sad to be leaving and cannot think of a more challenging and satisfying field in which I could have worked.

# Religious perspectives on organ donation

The UK Transplant initiative to explore religious perspectives on organ donation is now coming to an end. The project has laid the foundations for widening discussion and education into the diverse religious communities of the UK. Here, Rachel Howitt, the project worker, reviews the work achieved to date, particularly the outcomes of a national conference for hospital chaplains, and looks to the future.

The project has highlighted the need to include religious perspectives on organ donation in education programmes and has produced specific literature to support this work. This has taken the form of a series of leaflets and a more detailed information booklet. Following on from this a national conference was organised and a new leaflet, a summary of the series for the general public, is planned for Spring 2004.

## Supporting literature

The leaflet series, widely distributed within the transplant community, was designed to be a guide to donor transplant co-ordinators, donor liaison nurses and ICU staff to be used when dealing with potential donor families who may have uncertainties about their religion's viewpoint. They were designed to introduce the views of the religions and should be used sensitively as every individual's personal religious views and interpretations may differ.

The information booklet, specifically for co-ordinators and donor liaison nurses, was written to support the leaflet series. This gives more



**The national conference panel discussion provoked lively debate. From left to right, David Katz, Office of the Chief Rabbi; Olive McGowan, Lead Transplant Co-ordinator Yorkshire; Sheikh Dr MA Zaki Badawi, Principal, Muslim College London; Dr Indarjit Singh, Director, Network of Sikh Organisations UK.**

background to the different religions so that information can be included in education programmes.

A new summary leaflet is also currently being developed which gives an overview on all the major religions' perspectives on organ donation in a single leaflet. This leaflet, *Organ donation and religious perspectives*, is being written in response to the demand generated by the project from people outside the NHS. It will be available early in 2004 and will be distributed widely.

As with the previous leaflet series, the public leaflet is being produced in close co-operation with the various religious authorities, organisations and interfaith networks that cover the Christian, Sikh, Hindu, Buddhist, Muslim and Jewish faiths.

## Feedback from the conference

Hospital based chaplains are frequently dealing with bereaved relatives and yet they rarely have access to study programmes on specific issues such as organ donation. The national conference, held in September 2003 in Birmingham in conjunction with the Hospital Chaplaincies Council (UK), was organised to bridge this gap.

The conference gave chaplains valuable information on the certification of death by brain stem testing; the organ donation process and the role of transplant co-ordinators. Feedback from chaplains after the conference indicated that this information would help them greatly in supporting the transplant teams in their areas. The conference also

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focused on the needs of donor families and the chaplains' role in providing support.

Speakers representing each of the six major religions (Christianity, Hinduism, Buddhism, Sikhism, Judaism and Islam) made presentations at the conference. All were encouraging and gave positive messages about organ donation. Many issues were raised in the discussion session and the key ones, along with the response from the panel of religious leaders and others, are highlighted here.

**1** *What can we do to support those people who associate the physical body with a person's identity?*

This is an area of concern that is common to many. The association between the physical body and the belief that it carries the identity and personality of the deceased can be very strong. This view may be less accepted among those with a medical or scientific background, but it is nonetheless a very real concern for some.

Decisions about donation are often made in the context of sudden tragic death, and deep fears may surface in a more emotional manner than if the subject was being discussed in an "ordinary" situation.

The lessons to learn here are that firstly it is so important to encourage discussions about death, donation and the body in a non emotional setting in everyday life and also for professionals to recognise that there may be views about an individual's spirituality in relation to the body that may affect their decision whether to donate.

**2** *How can chaplains be involved in supporting relatives in organ donation situations?*

It is very important that chaplains of all faiths are involved in all aspects of bereavement and they have a major role to play in this

## Background to the project

This project stemmed from the shortage of organs donated by members of minority ethnic groups and the uncertainty surrounding different religions' viewpoints on organ donation. Despite the strong consensus in support of organ donation shown by the major religions, the same message was not being disseminated into the community or some areas of health care.

Many research studies have explored attitudes towards organ donation amongst black and Asian populations and highlighted various areas of concern. Religious beliefs are sometimes cited as a reason not to donate organs, which is contrary to the message being given by the religious authorities.

The project was set up to research and produce educational information for health care staff and potential donor families from different religious backgrounds about religious perspectives to organ donation.

The series of leaflets on organ donation and religious perspectives and the information pack can be found on the website at:

[www.uktransplant.org.uk](http://www.uktransplant.org.uk)

Enquiries about the project, after December 2003, should be directed to: Sue Falvey, Director of Donor Care and Co-ordination, UK Transplant.

area in relation to organ donation. Some are already actively involved and have good links with acute areas and transplant teams.

There are many ways in which the chaplaincy can offer support – by taking a service, performing last rites or simply praying or talking with the family. This may help them come to terms with the death.

There is also a strong need for the chaplaincy to be involved in offering psychological and spiritual support to the recipients in the transplant process.

**3** *It is very difficult to match the certification of death by brain stem testing with the actual point that the soul or spirit leaves the physical body. What are the religions' guidelines on this?*

It is an almost impossible question to answer, as the "soul" is an undefined quantity. Some religions believe that reciting prayers or passages from religious scripts will assist this process. Some Buddhists, for example, believe there may be certain physical signs that the soul has departed. Others (some Christians for example) may hold the view that the key is in how

people relate to each other and so the soul leaves when the family stop relating to the body as alive and say goodbye.

Organ donation can only occur after a diagnosis of death has occurred. In some cases the family may also choose to consult with a specific religious leader and time for this should be allowed.

The one most important factor is that it is the needs and beliefs of the individual family concerned that are paramount, irrespective of the general religious views, as it is they who have to reconcile themselves with the situation and the action they want to take.

**4** *The message from the Muslim authorities has clearly been in favour of organ donation as an acceptable issue in Islam. However, some groups will give an alternative view that donation is not acceptable to Muslims. Is there a consensus in Islam?*

According to the Muslim Law (Shariah) Council of the UK, there is a consensus view throughout the academic Muslim world that organ donation is acceptable. This includes the views of the Islamic



academies of research worldwide and is based on the principle of "necessity". The view that saving of life is of high priority means that sometimes it necessitates overriding what would normally be forbidden.

There are, however, other Islamic jurists who hold an alternative view that organ donation is not acceptable. This view is based on the principle that the body is not a human property and mutilation of the body is forbidden and cannot be overridden.

This is where the confusion arises. Some believe that the dissenting view is based on cultural and social views and that religious law would allow donation. Others believe that it is religious law and not culture that prevents donation.

One of the major problems is that whatever the religious authorities and academies accept it is usually the local Muslim leaders, chaplains, Imams and Muftis that the lay Muslim will approach for help or advice and it is at this level where disagreement is apparent.

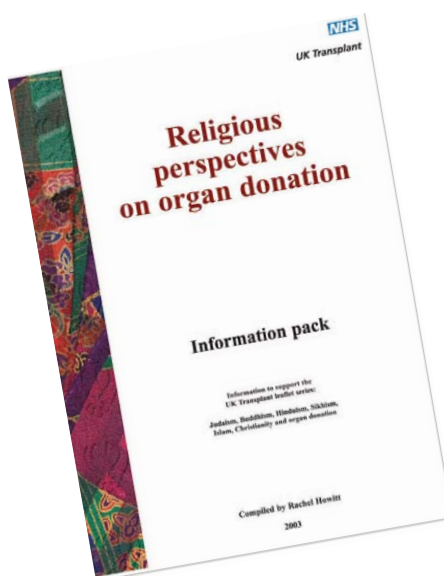
It has been suggested by the Shariah Council that a national meeting to include local religious leaders from different Muslim traditions and schools of thought is necessary to discuss these issues.

### The way forward

The project has laid solid foundations but now the real test is in the ongoing awareness raising that donor transplant co-ordinators, donor liaison nurses and others are able to do with chaplains and

religious leaders from the wider community as part of their education role.

There is a vast amount of work still to be done to keep the momentum



going. Religious communities have shown that they are keen to participate in discussions about donation and it is important to encourage this at both a national and local level as it is often the communities themselves that hold many of the solutions to the issues.

As the project comes to an end, my recommendations for UK Transplant, which could be delivered through the co-ordinator networks and other similar projects, are to:

**1** continue to include religious views in organ donation education programmes for all NHS staff

**2** encourage discussion of the issues and views, even the negative ones, in order to promote understanding on all sides

**3** access and make the most of the religious networks already in place through hospital chaplaincy teams

**4** look at how we can harness support, which is already very strong, from the different religious communities. Some religious authorities have offered their help in organising meetings with local leaders and discussing organ donation issues with their members. This path of communication is absolutely essential to drive forward the discussions.

**5** look at the possibilities for involving the younger generation and community groups and leaders to try and provide public education through as many different channels as possible. Getting the message and issues discussed before people reach a donation situation is vital.

**6** continue to support projects and initiatives targeted at religious and minority ethnic communities. Religious leaders are key in facilitating discussion at community level but they cannot do it without the support and guidance of the transplant community.

### End of project

I will soon be finishing work on the project. On a personal note, I would like to say that over the past 18 months I have enjoyed a fantastic experience and I am grateful for having such a wonderful opportunity. I feel the project has been successful in its short time and has provided a basis for much more work in this area.

There are some great opportunities opening up to continue work with all the religious communities and I feel that they have a lot to offer in raising the profile of organ donation. I wish UK Transplant the very best in the future.

# Conference paves the way for non-heartbeating donation in Scotland

**In September 2003 a consultation meeting was held to look at the way forward for non-heartbeating donation in Scotland. John Forsythe, Chair of the Scottish Transplant Group, and Jackie Bradie, Transplant Co-ordinator at the Royal Infirmary of Edinburgh, report back from the meeting.**

Some years ago, it was suggested, from a source that is now unclear, that non-heartbeating donation was in some way illegal under Scottish law. After significant work by a number of individuals, it is now clear that there is no statutory law which affects a non-heartbeating programme in this way.

The meeting in Stirling was very useful in taking this further with participation from clinical colleagues in intensive care, A&E and stroke units. In addition there was input from the Crown Office and Procurator Fiscals. The following key points were raised.

**1** The general mood of the meeting was that it would be unhappy with an approach based on considerations of the "public good" which led to the over-ruling of the wishes of individuals and families, as happened in relation to post-mortem examinations instructed by the Procurator Fiscal. The autonomy of the patient was a concept, which had grown over the years, accompanied by a reduction in levels of medical paternalism. There seemed to be general agreement that patients and relatives should, in as many cases as possible, have at least the availability of donation open to them as an option.

**2** More information was needed about the logistical issues involved in the maintenance of a non-heartbeating donor programme, not least because of the resource

implications. Much could be learned from existing programmes and the protocols developed in other centres in the UK.

**3** The clarity about the legal position, which the Crown Office had been able to provide, was vital in considering the development of such programmes in Scotland.

**4** The Potential Donor Audit (PDA) being conducted by UK Transplant would be extremely valuable in tackling some of the anecdotes circulating in this area. It was important to bear in mind the point made by the Scottish Intensive Care Society about the value of feedback to ICU staff, with the reasons why organs were not used. This could be done by accessing information from the rigorous audit of all such cases, which UK Transplant carried out.

**5** Stroke care could be improved by developments in relation to organ donation. There had been an unwritten rule in the past that stroke patients should not be admitted to ICU and, it was suggested that once issues about access to CT scanning had been sorted out, there should be a conversation between stroke units and ICUs about the management of stroke patients in ICU.

**6** Uncontrolled non-heartbeating donation in an A&E department was very difficult and was probably not the best way of introducing a new programme in Scotland. The concerns associated with this were linked to the time constraints and the problems associated with contacting and involving relatives.

**7** In the controlled non-heartbeating donor setting, it was important to bear in mind the precept of Rafael Matesanz that making organ donation available

to patients and families should not be seen as a favour to the transplant community but as a benefit to the patient and family as part of the continuum of care offered by the NHS.

## Next steps

The conference established that a non-heartbeating donation programme is now a realistic and possible option for increasing donor numbers within Scotland. A great deal of collaborative work and education to gain support for such a programme will be needed, alongside the establishment of clear protocols and guidelines.

The possibility of the introduction of a non-heartbeating donation programme needs to be looked at by transplant units, A&E departments, stroke units and ICUs. Some ICUs are clearly more in favour of the development than others, and it would be helpful to identify these as potential starting points.

At the meeting it was agreed that the offer to work up protocols with the Crown Office & Procurator Fiscal Service (COPFS) should be taken forward by a small working group under the aegis of the Scottish Transplant Group. The draft guidelines for coroners produced by the Freeman Hospital might be a good starting point. One issue to tackle might be the possibility of getting group consent from COPFS, along the lines of the list of deaths that had to be referred to the Fiscal, rather than getting agreement on a case-by-case basis. This would require further discussion and the British Medical Association might wish to be involved in this work.

Establishing a non-heartbeating donation programme will be on the agenda for the next Scottish Transplant Group meeting.

# ...Sue Fuggle

**Sue Fuggle is Director of Clinical Transplant Immunology at the Oxford Transplant Centre and Scientific Advisor to UK Transplant.**

After graduating from Manchester University with a degree in biochemistry and a Master's degree in immunology, Sue has worked in the fields of histocompatibility and transplantation for many years.

She continued to pursue research in HLA and transplantation in the Nuffield Department of Surgery first as a Post Doctoral scientist and then as a Group Leader.

In 1995 she was appointed as the Scientific Advisor to UK Transplant and in 2000 was appointed as the Director of Clinical Transplant Immunology at the Oxford Transplant Centre. Sue is an active member of both the British Society for Histocompatibility and Immunogenetics and the British Transplantation Society where she has served on the Council.



**Q What prompted you to become a scientist in the field of transplantation?**

**A** I was fortunate early in my career to have the opportunity of working in the histocompatibility laboratory in Manchester. Following a move to Oxford I spent a brief, but very exciting period, working with Walter and Julia Bodmer. This was at the time when their laboratories were at the forefront of the new monoclonal antibody technology that was revolutionising our understanding of the cell surface.

The atmosphere in the laboratory at the time was vibrant and dynamic, so much so that when they left Oxford, for Walter Bodmer to direct the Imperial Cancer Research Fund, I moved to the Nuffield Department of Surgery. There I continued the monoclonal antibody work with Alan Ting and Peter Morris while studying for a D Phil in the field of HLA and transplantation.

**Q How did you become involved with UK Transplant?**

**A** I was appointed as the Scientific Advisor in 1995 when the Authority advertised for a transplant scientist to provide input into the work of UK Transplant. This was a great opportunity for me and allowed me to use the experience I had gained in a wider context.

**Q What else might you have done?**

**A** During my degree course I had become convinced that I wanted a career in medical science and I would probably have pursued another similar field.

**Q What aspect of your current role gives you most satisfaction?**

**A** I enjoy my current work enormously and consider myself fortunate that my job is a blend of clinical science, research and teaching together with the advisory work at UK Transplant. It is difficult to say which aspect gives most satisfaction, but certainly successful transplantation of immunologically complex patients must rank towards the top of the list.

**Q What aspect do you least enjoy or find most frustrating?**

**A** Along with others in the field, one of the most frustrating aspects of our work has to be the shortage of organs for transplantation.

**Q What has been the most radical change since you have been involved with transplantation?**

**A** In transplant laboratories the technology used for HLA typing and antibody specificity definition has changed radically since I entered the field. When I first

started, one technique was used for both HLA typing and antibody definition, whereas modern laboratories now use a sophisticated array of techniques in the immunological work-up of patients for transplantation.

**Q If you were made Secretary of State for Health tomorrow, what would you do?**

**A** Ensure that staff in all areas of the NHS were valued and properly remunerated and that resources available reached those providing patient care.

**Q What is your most memorable moment?**

**A** There have been many memorable moments and it is difficult to single out one in particular. However thinking back to the start of my research career, I will never forget the elation I felt when after a long series of experiments I made one of the first polymorphic monoclonal antibodies to HLA class II. This was one of my first research "highs" and the antibody subsequently became widely used.

**Q How do you relax?**

**A** I enjoy walking, reading, spending time with my family and, most recently, have developed a passion for the garden.

### Transplant Co-ordinators Advisory Group

#### TCAG met on 5 September 2003

- Nominees were being sought for the vacancies of both renal and cardiac recipient transplant co-ordinator representatives on TCAG. A reply was also awaited regarding a nominee to act as British Association of Critical Care Nurses' representative.
- The group reviewed updates on policies being considered by the previous TCAG. Members noted that *Hospital Policy on Organ and Tissue Donation* had now been issued; lack of objection forms/donor assurances were being printed; forms for GP information were being printed; and the Positive Virology policy was put before the Board in October 2003 for approval.
- Documentation of recipient and donor blood groups. It was agreed that a copy of the laboratory report should accompany each organ in the transport box. Donor transplant co-ordinators should ensure that all donor specimens have a minimum of three patient identifiers and specimens are correctly labelled.
- Potential donor audit. Agreement was reached on circulation of the reports to units. A revised form has been piloted and is due to be implemented in January 2004, following training.

### Cardiothoracic Advisory Group

#### CTAG met on 17 September 2003

- Discussions were in progress with Central Office for Research Ethics Committees to produce a template on consent issues. If approved, this template would form an explanation of how clinical trials on cadaveric donors could be instituted.
- National Specialist Commissioning Advisory Group had agreed the reorganisation of cardiothoracic zones from April 2003 and this would be reviewed annually. It was agreed that Harefield should have first access (after the zonal centre) to organs from hospitals that have been transferred from their zone to the Birmingham or Papworth centres.
- As a requirement of the Data Protection Act, UKT was piloting patient consent schemes to develop a robust system for gaining explicit patient consent for the use of patient information.
- Urgent heart allocation schemes. Members agreed to keep the urgent pool of seven allocations available to all seven centres in order to maintain flexibility.
- Members discussed a paper examining an imbalance in waiting time to adult heart transplant across blood groups. After discussion it was agreed that the current system of allocation should continue with a review of the data in one year's time.
- Republic of Ireland responsibilities. Members agreed there should be no change to the current donor allocation system to advantage an Irish patient.
- Members raised concerns about the impact of European Working Time Directives (EWTD) on both the retrieval and transplantation service. The proposals being developed by

the Organ Retrieval Working Group may ease the retrieval situation but not that for transplantation. Due to the impact of this issue on the transplant service, and therefore on UKT's targets, it was agreed this would be raised with the Department of Health.

### Organ Retrieval Working Group

#### ORWG met on 5 September 2003

There have been increasing difficulties in providing a multi-organ retrieval service in the UK, because of a shortage of transplant surgeons and unavailability of theatres, theatre staff and anaesthetists in the donor hospitals. The ORWG has been working over the last year to look at detailed evidence of current practice and produce some workable solutions.

The model that is being developed for consultation is that of having three or four integrated retrieval teams (IRTs) based in centres where liver and cardiothoracic centres are nearby. It is proposed that the teams would be self sufficient comprising intra-thoracic and intra-abdominal surgeons, anaesthetic support and a multi-skilled theatres team; and that they would be free of elective commitments during their time on call.

Trainees would be seconded part-time to the team for a six month period to gain intensive training in organ retrieval. Kidney only and non-heartbeating donation retrievals would continue to be undertaken by local teams.

Work has been done to look at the geographical location of the centres, travel times, staff requirements, rotas and EWTD compliance, training and options for anaesthetic input into the team.

A detailed proposal is being worked up by members of the ORWG and will be sent to members of all the UKT advisory groups and other major stakeholders for comment. It is hoped that transplant units will be able to sign up to the underlying principles, allowing for some of the specifics which will need more detailed discussion, prior to a fully costed proposal being produced.

**Keith Rigg,**  
Consultant Surgeon and Chair of ORWG.

### New ways of working

Papworth Hospital is one of 19 pilot sites exploring "new ways of working" in preparation for the reduction in junior doctors' hours as part of the EWTD. As part of the pilot a new role has been developed – the Donor Care Physiologist (DCP).

Five trainee DCPs commenced post in September 2003 and are currently undertaking a one-year in-house training programme led by a consultant anaesthetist. The five DCPs are a mixture of science graduates and operating department assistants. At the end of the year it is anticipated that the DCPs will substitute the Specialist Registrars (SpR) in Anaesthetics during donor retrieval operations, enabling the SpRs to comply with the EWTD, whilst maintaining the quality of the service provided.

Further information: Ann-Marie Ingle, Project Manager  
E-mail: Annmarie.Ingle@papworth.nhs.uk

# Review of kidney allocation scheme

By Claire Hamilton, Senior Statistician, UK Transplant

**Since 1998 several changes have been made to the kidney allocation scheme. The results of the first five years of the revised scheme are reviewed.**

A revised kidney allocation scheme was introduced in the UK in July 1998 based on HLA matching at three levels: 000 mismatches, favourable matches and non-favourable matches. Within these levels paediatric and local patients receive priority and since July 2000 priority has also been given to HLA-DR homozygous patients when the donor is HLA-DR homozygous.

A second change in July 2000 was to give priority to favourably matched paediatric patients anywhere in the country over local favourably matched adults for the second kidney from an adult donor. A further change to the scheme was made at the end of its fourth year: blood group B patients were made eligible to receive blood group O donor kidneys, with overall priority retained by blood group O patients.

Results of the first five years have been compared with those under the previous scheme. Through greater

exchange of organs between centres and increased access to favourably matched adult kidneys for paediatric patients, there have been significant improvements in HLA matching for all adult and paediatric transplants ( $p < 0.0001$ ) including adult regrafts ( $p < 0.0001$ ). HLA matchgrades for paediatric recipients are now comparable with those of adults. The proportion of 000 mismatched grafts has increased from 7% to 15% for adults and from 5% to 12% for paediatric recipients. There has also been an increase in the number of transplants for highly sensitised patients and 62% of these transplants were 000 mismatched.

Increased use of HLA-DR homozygous donor kidneys in HLA-DR homozygous patients has significantly improved HLA matchgrades for these patients: 48% 000 mismatched or favourably matched compared with 30% previously ( $p < 0.0001$ ).

Finally, the most recent change in the scheme has resulted in 38 transplants of adult blood group B patients with group O donor kidneys, including 17 patients who had been waiting for a transplant for more than two years.

E-mail: [Claire.Hamilton@uktransplant.nhs.uk](mailto:Claire.Hamilton@uktransplant.nhs.uk)

## Diary

### World Winter Transplant Games

18 - 25 January 2004  
Bormio, Italy  
Organised by World Transplant Games Federation in conjunction with local Italian association (ANED).  
A week of ski classes and competitions for transplant recipients who have entered as part of their national teams.  
Information: Mary Twomey  
Tel: 01962 865030  
E-mail: [Tsgab@wtgf.demon.co.uk](mailto:Tsgab@wtgf.demon.co.uk)

### 12th Annual Scientific Meeting of the British Association for Tissue Banking

21 - 23 April 2004, Edinburgh UK  
Topics include tissue safety and quality, tissue engineering, implications of the European Directive for tissue banking in the UK, new cell and tissue banking opportunities.  
E-mail: [Sandra.Borthwick@snbts.csa.scot.nhs.uk](mailto:Sandra.Borthwick@snbts.csa.scot.nhs.uk)  
Web: [www.snbts.org.uk](http://www.snbts.org.uk)

### The British Transplantation Society (BTS) 7th Annual Congress

28 - 30 April 2004, Birmingham  
Tel: 020 8875 2430  
Fax: 020 8875 2434  
E-mail: [secretariat@bts.org.uk](mailto:secretariat@bts.org.uk)  
Congress web: [www.bts2004.org.uk](http://www.bts2004.org.uk)

### Understanding Transplantation in the 21st Century

7 July 2004, London.  
E-mail: [michelle.casey@rcpath.org](mailto:michelle.casey@rcpath.org)

### National Transplant Week

18 July - 24 July 2004  
**National Donor Day**  
21 July 2004  
Tel: 0117 931 4638  
E-mail: [sue@transplantsinmind.fsnet.co.uk](mailto:sue@transplantsinmind.fsnet.co.uk)  
Web: [www.timeuk.org](http://www.timeuk.org)

## VOICE RECORDER

### TELEPHONE CALLS TO THE UK TRANSPLANT DUTY OFFICE

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## UK Transplant Emergency Contact Telephone Number

In the event of the main UK Transplant system failing, there is an alternative telephone number that can be used - 0117 931 4777.

During office hours this number will be answered by the UK Transplant receptionist but out of office hours the number is automatically directed to the Duty Office.

**0117 931 4777** should only be used if you are unable to obtain a response from the 0117 975 7575 telephone number.

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# Working with critical care network to raise profile of organ donation

**Alison Pittard, Consultant Anaesthetist, has been funded for three years by UKT to work with the West Yorkshire Critical Care Network. She works one day per week raising the profile of organ donation and developing education for the whole network.**

Alison commented: "I've been welcomed very positively by ICU staff. There are lots of ideas out there and a huge potential to increase organ donation."

By the end of January 2004, Alison will have visited all the consultants working in ICUs that belong to the network and will have gained feedback, through a questionnaire, from all ICU staff to evaluate their feelings on organ donation and how it can be increased.

She is developing her work along four key themes: everyone wants more education, for example on donor management and non-heartbeating donation; staff want up to date information; staff want support in approaching relatives; and trusts could be doing a lot more to support organ donation.

Alison has already started a rolling programme to each unit to deliver regional training every three months. The idea is that each unit will then take charge of its own education. In addition collaborative requesting will be introduced into all the units, where a transplant co-ordinator and a consultant approach relatives together.

Alison has also written to all medical directors and chief nurses of trusts within the network asking them to support organ donation through a health promotion exercise. Posters are being developed to put into hospital entrances and out-patient departments.



**Gary Lineker signs onto the NHS Organ Donor Register.**

Belfast's living donor co-ordinator, Heather Savage, has been working alongside the renal social worker to **raise awareness of organ donation amongst the local Chinese community.** The work stemmed from the local Chinese Welfare Officer who was approached by a patient who could not understand the "waiting" list for a transplant and why he wasn't getting his transplant.

**The West Midlands donor liaison nurses turned out in strength to support a celebrity golf day,** which raised £7,000 for The Gift Of Life Commemorative Trust. They were joined by a host of sports celebrities including Jonathan Davies, Gary Lineker and Steve Ryder.

The Trust has an educational trailer, which will be touring schools, colleges and shows, to

raise the profile of organ donation. The project, partly funded by the Department of Health, is aimed at children, mainly from age eight and upward, and is based around the National Curriculum with an emphasis on Citizenship and Social Accountability.

Co-ordinators at Western Infirmary, Glasgow, have devised a **staff training session which uses professional actors to role-play potential donor families.**

The training aims to give nurses confidence to approach families in an appropriate and sensitive way.

Deirdre Walsh, Transplant Co-ordinator, said: "We've run a pilot session and the feedback from nurses has been tremendous. We now have plans to roll out the programme four times a year and are targeting nurses in ICUs, A&E departments and coronary care units."