PART XV

Symposium  ON PSYCHOLOGICAL AND SOCIO-ECONOMIC ASPECTS OF DIALYSIS AND TRANSPLANTATION

Chairman:  H E de Wardener
PSYCHOLOGICAL AND SOCIO-ECONOMIC ASPECTS OF
DIALYSIS AND TRANSPLANTATION

INTRODUCTORY REMARKS

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The title of this symposium is ‘Psychological and socio-economic aspects of dialysis and transplantation’. These are subjects about which it is often difficult to make precise measurements. How do you put a p value on happiness, which is anyhow so difficult to define? By what means can you measure precisely the despair that some of you heard last night in that piece by Mozart, composed when he was ill. When it is not possible to measure what one is talking about the argument becomes fierce. This afternoon Dr Kaplan de-Nour and Dr Levy are going to address you on the psychological aspects of dialysis and transplantation. My main job is to see fair play.

You will notice therefore that there is no one to discuss the socio-economic aspects of dialysis and transplantation. Perhaps this is not surprising. People interested purely in these subjects are hard to find among one’s friends. We in this room are doctors and nurses and our concern is the individual patient. The patient comes to us for help and we do the best we can. Social scientists and economists however are political animals. In order to pursue their aims they have to suppress the individual, they have to see the whole picture and generalise. Doctors are not comfortable in their presence for we know that they have a point. But neither are they happy in our presence for they know that one day they will be ill, and then they want to be treated as individuals. A compromise has to be reached. But our duty is to represent the patient’s need and to keep on hammering this need to those who make the final decisions. I think it is important that we as a profession are never involved in the final decisions except as providers of information. The final compromise decision is the Ministry’s ineluctable burden. Our burden is to pick up the pieces afterwards, and to face the patient. I think it is
more honourable to be overruled than to collaborate.

The economic aspects of dialysis and transplantation are very simple. If you, as an individual, or as a nation have the money you have as much dialysis and transplantation as you can afford. In India with a population of over 600 million where the average yearly wage is 150 dollars, there are about 40 patients on dialysis. For the EDTA countries and some others which are comparable, it is interesting to note that though the decisions on how much shall be spent in each country are so agonising, there is good correlation between the gross national product of a country and the numbers of patients with end-stage renal failure on treatment. Those above the correlation have much private practice; those below have governments who are economising on patient care more than others.

As regards the social consequences of dialysis and transplantation I think these are usually pretty obvious to those who look after the patients, and in general they are predictable. The social consequences depend on the character and age of the patient and the success of the treatment. It is important to realise that the social consequences may come in any form. Mozart died at the age of 35. It is reckoned that he died of renal failure and hypertension. The first patient that our unit placed onto dialysis in 1964 was about 30 years old. He is now nearly 50 and well. It is tantalising to speculate on the additional social benefits which we might all enjoy now, had Mozart lived another 17 years with dialysis and transplantation.

MEDICAL STAFFS’ ATTITUDES AND PATIENTS’ REHABILITATION

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A number of factors influence the vocational rehabilitation of chronic dialysis patients: it has been suggested that family attitudes influence the rehabilitation as well as sociological factors, e.g. rehabilitation rates in different countries vary greatly. Patient personality was found to be a major factor, and it has been possible to predict rehabilitation by a pre-dialysis personality assessment [1–3]. Yet it was found that while only few patients did better than predicted, about a quarter of the patients did not do as well as predicted. These mistakes were found in some units but not in others, which led to the suggestion that staff attitudes influence vocational rehabilitation (Table I).

In order to understand what happens in the different units the nephrologists in charge were asked to assess the percentage of patients working half-time or more, and their assessment was compared to an ‘objective’ assessment by a team of nephrologist-psychiatrist. In units A and B great discrepancies were found between the two sets of assessment. This finding was interpreted to mean that physicians A and B are using denial [4] (Table II). The next step was to study the expectations of the rest of the medical team about the behaviour of ‘good’