VOICE EXPEDITION INTERVIEW TRANSCRIPT
The Oral History of Nephrology
LOUIS DIAMOND, MD
Interviewed by Dugan W. Maddux, MD
December 9, 2008

DWM: It is Tuesday, December 9, 2008, and today I am talking to Dr. Lou Diamond. We are conducting the interview at Dr. Diamond's home in Rockville, Maryland. Dr. Diamond attended medical school at the University of Cape Town and we will talk about that today. His nephrology career has been dedicated to the improvement in the quality and safety of patient care. He is Chair of the Quality Measurement Research and Improvement Council of the National Quality Forum and he is President of the American College of Medical Quality. He continues to serve as President of ESRD Network 5. He is the former Chair of the Georgetown Department of Medicine and is currently the Vice President and Medical Director of Thomson Reuters.

Dr. Diamond, thank you for letting me come today to talk to you about the history of nephrology. So, I want to start by talking about…

LD: Can I do just a minor correction there?

DWM: Yes, absolutely.

LD: I was actually former Chair of the Georgetown Department of Medicine at D.C. General Hospital. I was not the Chair of Georgetown Medicine per se.

DWM: Very good.

LD: Okay.

DWM: All right. We will have that exactly correct.

LD: Okay.

DWM: And I just want to start with where you were born and raised and that will lead us into your education.

LD: I was born in Cape Town, South Africa and raised there and left there in 1971, so born in 1939. I must have been in my early 20s when I left South Africa. I did all my schooling in South Africa as well as all my medical school and subspecialty training at Cape Town School of Medicine, the hospital being Groote Schuur Hospital.

DWM: You may have to spell that for me.

LD: I'll have to write it down before I did that. It's Groote Schuur Hospital.

DWM: Very good. So you were talking about you went to undergraduate school there and medical school there.

LD: Yes. Well the English system doesn't quite have a fully-fledged undergraduate requirement. To get into medical school you do one year of basic sciences. As I recall, it was chemistry and physics, stuff that I wasn't really comfortable with, and biology, which I was comfortable with and botany. So it's one year and then you progress from there to medical school. As I recall we apply to medical school prior to the first year so it's kind of a pre-med one-year and then six years of medical school training.

DWM: What year would you have entered medical school and finished?

LD: Yeah, I think I entered… It was a long time ago. I think I entered in 1958 and I completed my basic training and graduated as an equivalent of a M.D. in 1963.

DWM: Okay.

LD: So it's a six-year training course, which obviously is longer than the training course in the States by a couple of years. And, just a reflection, I remember coming to the States in '71 and very shortly after arriving being assigned a group of third of fourth year students to help them with their training in the conduct of a history and physical. Teaching them how to do a history and physical. I was struck by the fact that this training session for these students was a one or two-hour session twice a week for 16 weeks and I had come from a system where we did history and physical training for an entire year. You know, two months for each system, so it was a bit of a cultural shock for me to be working with medical students and thinking through how are they going to get to know to do a history and physical on a patient . . .

DWM: Two hours a week.

LD: Two hours a week for 16 weeks is my recollection. I remember saying to them, you know if you take a history you've probably got the diagnosis in 50% of the time. I don't think they really believe me but that's still true today I think. So that's where I did my training for six years.

DWM: So when you finished medical school did you have to pick an area of expertise?

LD: Yes. We did an internship and all our internships were, what I think we call in the States, rotating internships. It's not a full year of medicine, obstets and gyne or surgery; it's two of the three. I did an internship in general surgery for six months and general medicine. I then had the option to go out into practice because once you've completed your internship you can then go out into practice and essentially function as a primary care physician. I opted to do training in general internal medicine and at that stage we did a three-year residency training program and then I evolved from there to doing a two-year equivalency of a nephrology fellowship.

DWM: Two years.

LD: Two years, in Cape Town.

DWM: So were they calling it nephrology at that time?

LD: Yes. They were calling it nephrology, yes.

DWM: Okay.

LD: Yes. And at that stage...

DWM: Which would have been the late 1960s.

LD: Yes, the late 1960s. Yes. I completed that in like '70 or something, as I recall, the two-year fellowship training. Then I did a year as a research fellow on a NIH grant. But, yes, they called it… it was a formal nephrology training program. At that stage nephrology, in South Africa, was essentially a consultative nephrology disease burden that we were treating. We had a dialysis unit that conducted acute dialysis with the drums and changing of the water, etc. with external shunts for acute renal failure and towards the end of my training we had a very small, maybe five bed, as I recall, five station, one session a day, chronic dialysis program in the hospital. At that stage clearly there were limited resources and this was like the Seattle days, if you will. I wasn't in Seattle at that time we had to go through a very complex selection process for the patients coming into the chronic dialysis program. I recall that at some time within that window, the late 60s, when we still had the very small chronic dialysis program treating a very small number of patients, no home dialysis and no peritoneal dialysis. I was still attached to the team. At this stage I was on the faculty, the junior faculty. Chris Barnard returned to South Africa having spent about six months in the States working with Shumway and some other folks on transplantation. He was a very kind of dynamic guy. He was a vascular surgeon, doing a lot of research in general vascular surgery. When I say vascular surgery, I mean aortic aneurysms and that kind of stuff, general vascular surgery as I recall. He came back and announced that he was going to set up a transplant program, a kidney transplant program. I remember meeting with him, not me personally but I was part of the group that met with him, and him announcing

that he was going to set up this program. He was a very kind of dynamic guy even in small groups. I was then working with my mentor who actually got me into nephrology, a guy called Lennox Eales who was a senior professor at the school of medicine running the nephrology group in the metabolic unit and the dialysis program. Then the discussion evolved around this is a wonderful idea, we are all supportive of it but we need a dialysis program to support the transplant program and literally, not in so many words, but literally he said something to the effect, as I recall, we don't need a dialysis program because we're going to transplant these patients. It was really, just like, remarkable. I mean it demonstrated at one level that, and this is not meant to be disrespectful to the guy, that he basically had no insight into what he was getting involved in. The bottom line is that he gave up on the kidney transplant scenario and rapidly moved into, I'm going to do heart transplants. That's how it evolved. Then he started running around the hospital looking for a donor and most people kind of didn't take it seriously because we didn't have a research… I mean we had research committees but he didn't submit protocols or anything. I'll stop in a moment because it's actually a wonderful story at one level. He eventually found a recipient and did the first heart transplant. I was actually not physically in the operating room when they did it, because I was then on the junior faculty at the Department of Medicine, when they did the transplant but the story is from people who told it to me, that as they were ending the procedure he said something to the effect, we need to send, I think his name was _____ he was a dentist, we need to send the patient to the isolation unit because in those days we used to isolate the patients post transplant. The people kind of said to him, well Professor Barnard, well you know we don't have an isolation unit. So what they did was we had a hospital, which was the _____ Hospital, which had two wings and a kind of big corridor between the two wings where there were units. So there was a urology unit as I recall and they just cleaned out the urology unit in the middle of the hospital and made it into a, it was like a 10-bed unit or something I don't remember, and converted it into an isolation unit which wasn't obviously an isolation unit. Then they started treating the patient obviously. They used to have meetings twice a day with this team of consultants who were brought in to treat the patient and every day the team got bigger because the complications occurred.

DWM: _____

LD: And I remember the patient developed diabetes, as I recall, _____ not diabetes, you know, high blood sugar from the steroids so they brought in an endocrinologist. I can see the room today. It was not one of these big, like four-bed, patient units, they were open units that had been cleaned out and converted into "a conference room" with chairs around the end and the room just got bigger and bigger and bigger. I don't remember exactly what day it was but it was around day, maybe, 7 or 10, I don't remember exactly. They had now tried everything because there was no protocol, I mean there was just _____ immunosuppressive, double dose, I mean it was a circus. So they decided, he said, we need to treat him with radiotherapy; radiation, which was part of the armamentarium that you could do. So they kind of said, you

know, that's a good idea. So he says well bring the machine in and let's radiate the heart. They said, well, it's the same kind of story as in the operating room, that's not kind of going to be possible because the machine is like the size of a building and it's in Building 9. You know, three … It was a big campus. It was literally in Building 9. That was a revelation to him so what they then did was; I mean I couldn't make this up, right. They then brought in the police force. They didn't have a hospital security force because they didn't need it in those days. They actually brought in the police force to kind of cordon off the route that we had to go from the unit that was in the middle of the hospital, down some elevators, through a corridor, an underground tunnel, as I recall, to this other building where the radiotherapy department was with this big massive radiotherapy machine and they radiated the heart. So that was the story of my own personal reflections on that story. So I guess, you know, the interesting part about it is he did it without any planning, which was obvious, and that's not meant to be a totally negative comment, but he did it without any planning. It's possible to argue if he had not done it…

DWM: Right.

LD: Under those kind of circumstances or under circumstances where all sorts of reviews would have gone on, that doing that procedure may have been delayed by X-years and it could have been a long period of time.

DWM: And I think that's been actually an interesting theme as I've talked to people about dialysis. I mean on a smaller scale, obviously, you know this heart transplant I'm sure was quite an event. But dialysis, also on a smaller scale, I mean, people were doing things, responding to problems that they could see without any preplanning or anticipation or review and that that was an important part of the innovation that came along for dialysis as well.

LD: Right. So without getting on too serious of a note, that raises a very important issue that we currently are grappling with in the current environment which has to do with the clear recognition that clinical research and related activities have to be subjected to appropriate review by research committees to protect patients and all sorts of other legitimate issues. But the complication is that the way the federal government have defined research, without getting into all the details, it flips over into putting all quality improvement programs into the research bucket. Because it essentially says that if you systematically are collecting data and if you have an intent to develop generalizable knowledge and thirdly if you have an intent to publish and/or publish, that those three sets of activity pushes an activity into a research environment requiring IRB approval and that is a quality improvement program. That creates all sorts of challenges, actually incapacitating challenges, that a lot of people are currently debating and _____ get involved in trying to figure out how to deal with this. If we had to subject all quality improvement programs to a research review that would basically paralyze that activity and, in addition, would eliminate this whole ability to innovate within some kind of boundaries. I'm

not totally in favor of what Barnard did because I think he wasn't doing quality improvement he was actually doing research and in the current climate we ought to be doing that under research protocols. But there are all sorts of minor innovating activities that we do during practice improvement activities that if we had to subject that to vigorous systematic review by research committees we'd be paralyzed and we'd kind of wipe out innovation in a significant way. So, you know, it's an interesting hangover from those kind of activities.

DWM: Absolutely.

LD: Yeah.

DWM: Well before we leave the late 1960s I want to actually have you think back to that time when you were taking care of acute renal failure and tell me what machines you were using, what dialyzers you were using, what access you were using. What diseases did the patients have that you were actually treating?

LD: I'm not sure I can remember all of that; that's a long time ago. You know, the diseases were mostly acute renal failure resulting from trauma. I remember gentamicin being and drug-induced acute renal failure and general shock and sepsis renal failure. So I think those were the causes of the renal failure. I don't recall, but I could stand corrected, but I don't recall dealing with chronic conditions that slipped into renal failure. They would not have been dialyzed in that kind of a setting.

DWM: Everybody would just have understood that you weren't going to go there.

LD: These were all acute; you know well patients post surgery, shock, etc., drug induced, sepsis, antibiotics, acute renal failure, you know. And I can only tell you that it is my recollection that as a general internist and treating these patients that we all feared acute renal failure for a number of different reasons; large numbers of patients died, probably as a result of their primary condition but also by the complications of acute renal failure because this was a learning experience for us. This was in the middle to late 60s and even when I got to the States in the early 70s dialyzing acute renal failure was an innovative activity.

DWM: So your success rate was not very good.

LD: It was not very good. So we feared it for that reason. I want to come back to connect it to coming to Washington, D.C. which is the world's capital. Well, I'll say it now. I came to Georgetown and the only people doing dialysis for acute renal failure were the universities, period. We used to send people with machines out into the suburbs to do dialysis or ship the patient back to Georgetown. Now, almost every hospital in the metropolitan area, 30 or 40 of them, all do acute dialysis and many of them do chronic dialysis as well. The second reason we

feared it was it was an incredibly "time consuming resource intensive activity" because we had to get the vascular surgeon in to put in a shunt which was a big deal.

DWM: What was the shunt like? Were they doing a true AV shunt?

LD: No. No.

DWM: _____ Scribner ?

LD: These were all external shunts. These were all external…

DWM: Were they a Scribner-type shunt?

LD: You know, I don't know exactly what the names were but, yeah, they were probably Scribner-type shunts. I mean, big clunky stuff that was put into them, you know, by the surgeon. There were only a couple of surgeons who could and were prepared to do it.

DWM: So getting the access in was …

LD: Was a big deal and it took, like, hours you know because there was a delay in getting them, they had to come in and do a consult. It wasn't like an automatic thing. Then they had to do the surgery. Then we had to set up these big dialysis drums. I don't remember exactly what dialyzers were used; the actual dialyzer, but the water was in like a big barrel as I recall. I can visualize in that room. We were doing dialysis when I was a resident actually so we used to have two residents on duty plus one or two nurses doing this dialysis for six hours. Now that was the dialysis for plus or minus six hours, it wasn't a four-hour treatment, and the preparation prior to that so it was like a 12-hour deal for the first dialysis.

DWM: And you had people; I mean you had people sitting at the bedside…

LD: Oh absolutely. Two physicians, as I recall, sitting at the bedside and then, you know, we had to empty that drum, as I recall, of water with like a… siphon it off.

DWM: In the middle of treatment?

LD: In the middle of treatment because that's the way this antiquated piece of equipment worked. One of the episodes I remember was one of my colleagues, who was an English guy with a deep English accent, who had completed a Ph.D. He was a M.D. and Ph. D. in all sorts of complicated science and everything. He had come back to do his residency in South Africa and he was a couple of years older than all of us. We doing this particular dialysis together and as we were emptying out the drum of this, you know, massive amount of water, which was now

impure water; something happened to the connection and it spilt all over on the floor. Now we're filling up the drum and now we're mopping up the floor and I remember him saying to me, this is what I did all my training for. It was just the funniest thing to see this guy with his accent. So it was a big procedure and it was then that we evolved some years later into developing a chronic dialysis program as well where things became a little smoother and it was innovative to the extent that I think we may have been the first … Firstly, we were the only hospital in the Cape Town area doing acute dialysis and that was for a long period of time and then we started the chronic dialysis program probably in the late, like '67 or '68, as I recall, I don't remember the exact date. We were then probably the only… And this was all with state funding. We were the only program in the entire state doing it and we may have been one of two programs in the entire of South Africa. The university program at _____ probably had a unit at the same time, in that kind of general time. So it was a very different time.

DWM: Yeah.

LD: Limited resources. A privilege to get dialysis. We went through this whole business, you know, of family significance and all that sort of stuff.

DWM: Now in talking about that early chronic program, did you have a formal selection committee?

LD: Yes.

DWM: I mean at that time in Seattle they had this committee.

LD: Yes.

DWM: So what would it have been like?

LD: Yeah, we had a selection committee made up of a couple of; the Chief Lennox Eales.

DWM: Spell his last name.

LD: Eales and his first name was Lennox.

DWM: Okay.

LD: He was a very innovative guy. He was a general internist trained in nephrology and metabolic disease. He was a porphyria expert.

DWM: Hmm.

LD: Actually when I did that research here that's what I did my research on, some aspects of porphyria. Yes, we had a selection committee. I don't know that we had an explicit point system with criteria but it had to do with the patient had to have chronic renal failure. I believe at the time, and I don't want to hold to this, but I believe at the time in the early days, comorbid conditions was an excluding factor. We didn't treat diabetics.

DWM: Right.

LD: We didn't treat the very elderly. There was an age limit. I don't remember exactly what it was but there was an age limit, probably in the early to middle 60s. There were no people of 70 or 80 being dialyzed chronically. Then there was a very complex, and I don't remember all the details of it, a very complex family situation issue. To the extent that, you know, we would give preference to a mother or father in a family situation rather than a single person. Those kind of criteria. Yes, we had a selection committee. Now I don't know exactly whether it worked the same way that it did in Seattle. You know we only had, my recollection is, we had limited information about what was going on outside of South Africa. Not that they were closing down, but there was no television at that time. Yes, we had newspapers and yes, we had peer review journals so we got most of our information from the peer review journal situation, which is fine so we knew what was going on scientifically. In fact, at that time, going on sabbatical was going to England. That was going on sabbatical. We used to send faculty to England and I think, in fact when I came to the States, I think they thought I was coming to the States on sabbatical because in fact they offered me a job a year later. But that's where information was accrued by actually visiting these other countries. That's why, you know, the story I told you earlier about Chris Barnard he spent six months here or four months, a long period of time, to kind of learn because there was a limited ability to learn from the peer review journals and there was no comparable laypress around that. We had newspapers but you know it wasn't the same as today. So we didn't really know what was going on Seattle although we had some idea I guess.

DWM: So there would have been people that were qualified to dialyze; for example they didn't have comorbid disease, they were the right age, but maybe, like you say, they were single. They were socially somehow not as important as somebody who had a family and that's a pretty difficult decision to make. Were people agonizing over that or did people just say well that's just the fact; I mean without dialysis everyone would have died anyway. I mean, what was sort of the thinking about having to make those decisions?

LD: My recollection, you know, we came from a different… there was a different mindset. When I say different, it's different to what it is today. I'll answer the question in a minute but I remember after coming to the States, somewhere around '93, George Schreiner ran some conferences on an annualized basis called Controversies in Nephrology where he brought two parties together on a given subject and spoke about, you know, they discussed … I think it ran

for three or four years, as I recall, I don't remember. It was very well attended, etc. and the reason I'm telling you that is I did a presentation at one of those conferences about limiting dialysis therapy and got into some of the technicalities of my interpretation, at least, of the Medicare statute which was fundamentally different from the interpretation of my colleagues, and probably still is, to the extent that my interpretation was that what the statute essentially said in plain English was; that if you're eligible for chronic dialysis based on medical criteria that we, the federal government, will cover you under certain circumstances for the coverage of your therapy. The circumstances being you had to pay into Social Security because, as you know, if you don't pay into Social Security you're not covered by Medicare. It's a lot of federal workers that are not covered. A lot of my colleagues believed that it was absolutely mandatory that every patient who had chronic dialysis receive dialysis irrespective of any consideration because they were "entitled". Because Medicare, they interpreted, said that you are entitled, that there was a like a knight's move; a knight being on the chessboard going from A to C without going through B. But that's not what the federal government said. They said we will pay for it if you are medically eligible. So we came from a different setting; that no one was entitled to these therapies and people were dying all the time. I don't mean to sound callous but people were dying all the time. You know, when I was in medical school I used to attend at a clinic in what is loosely called the ghetto, a place just outside of Cape Town. You know kids were dying from malnutrition, you know, and we were seeing it in front of our eyes and kids were dying from dehydration. So it wasn't that we became callous to death as much as kind of a recognition at one level that death sometimes occurs. You know what I mean. And it is, in fact, a natural end point. When I used to talk about this and I don't talk about this much on the public circuit in any more but I used to talk about it in those days. Reflecting on the difference between an English person and an American; English people at the age of 45 and 50 and those kind of ages begin to plan for death; Americans of all ages consider death an option. So, I'm trying to give you a sense that, yes we battled and I remember working with Eales, Lennox Eales, and other people and putting position papers together to present to the state government to put more money into it and what the need was and how many people we were turning down, etc. But at one level it was agonizing but it was within a context of an understanding that there were limited resources and even as we made the case for extending the chronic dialysis program, we kind of understood that people were dying from dehydration around us, you know; from Kwashiorkor which some of us don't see any more. It was just a different environment. But they ended up with a chronic dialysis program in the middle 70s and then a transplant program they moved into.

DWM: All fully state supported?

LD: It's all fully state supported although there is a private; yes, all fully state supported, yes.

DWM: Because they still have the issue; well certainly very early on in dialysis in the United States that in order to be accepted you had to have some personal funds or community funds. I

mean it was partially paid for by the individual, not supported… of course before the Medicare law in 1972. I mean it was fully supported by some funds coming from…

LD: In the 60s and 70s and still to a large extent I believe in South Africa the entire delivery system, it's a combination of state and, what we would call, federal support.

DWM: Uh hmm.

LD: It is a province. So it was all state supported. Now there is a private sector healthcare industry in South Africa that has grown up in the late 70s and beyond but in those days it was all state supported.

DWM: Yeah.

LD: Yeah.

DWM: We've sort of zipped over how you got interested in kidney disease anyway. I mean you were sort of in this residency. How did you end up with Dr. Eales in metabolic nephrology territory?

LD: Yeah, I don't really know actually. I think it was probably the fact that he and I connected. I mean I connected at a different level, you know he was a professor and in those days we were not on first name terms. This was an English system and at one level very formal but friendly and professionally interactive. I've thought about this a little but my guess is that I moved into nephrology in large part because of him and the mentoring that he provided and the opportunity he gave me because I did my residency with him and then the fellowship, etc. So there was an opportunity there. I guess the other reason is I wasn't particularly drawn to dialysis per se or chronic dialysis because it wasn't even on our screen at the time or even kidney transplant, which was clearly not on our screen. But it did strike me that nephrology was a pretty broadly based specialty. It covered a lot of ground for the patient. Dermatology was not an option for me; you know what I mean. Cardiology, for me, was a little bit too technical and electrical, if you will. I was comfortable with physiology. I was not comfortable with physics and related activities. So I think that's how I drifted into nephrology. I don't recall considering anything else. But I would say something else and that is even as I introduce myself today, when I'm at meetings and stuff and small group meetings, I always introduce myself as a general internist and nephrologist. As you will hear later I drifted very rapidly back into general internal medicine after being in nephrology for a long period of time when I became chairman of medicine. I mean I have a lot of affection and connections to nephrology and still do but I'm basically a general internist and I'm basically a generalist. It came out in some of the public policy stuff I did with nephrology because I resist, for instance, the notion of nephrologists just doing dialysis.

DWM: Right.

LD: I mean it just makes no sense to me.

DWM: Sure.

LD: And there are, you know, a lot of people in the same space on that issue but for me it comes from a kind of a patient-focused approach, a general approach and dealing with the whole patient. So it's a complicated way of saying I'm not sure how I got into nephrology. I think it was opportunity, which is probably…

DWM: And a mentor.

LD: And a mentor. Yeah. And he, in fact, helped me get my job in the States. He knew George Schreiner. George Schreiner had met me…I'm not even sure that he met me when he visited South Africa. But George actually ended up offering me a job unseen, un-interviewed, on the faculty at Georgetown based on the recommendations of Lennox Eales; the two of them knew each other quite well through, you know, international contacts.

DWM: A lot of folks who got started in nephrology in the late 1960s were, you know, at the beginning of dialysis doing some dialysis but also were doing a lot of renal physiology, electrolytes and all that. Was that part of your work that you were doing at all?

LD: No. No.

DWM: Yeah, so it was mostly renal failure care?

LD: You mean in South Africa?

DWM: In South Africa, yes, in the late 1960s.

LD: Mostly renal failure and general consultative nephrology; stone disease, any number of other nephrology problems. So we didn't only deal with renal failure, we dealt mostly with, you know, electrolyte imbalance, high sodiums, low sodiums. I mean that kind of shock syndromes where we dealt with that. But I was never drawn to the… I understood the physiology part but I was never drawn to that per se. It's clear to me now that I was drawn to the public policy stuff kind of very early on.

DWM: Yeah.

LD: The kind of general population management stuff early on.

DWM: So how and why did you come to the United States?

LD: Yeah. I mean we left South Africa for political reasons. We left in 1971. This was at the height and strength of the apartheid regime. In the late 60s it really escalated. We were involved quite actively politically. It escalated in general and it escalated into the university. In fact going back to the Barnard heart transplant issue, that came at a very bad time from a political point of view because around about that time, one member of our senior faculty, a guy called Bill _____ was banned. Banning in South Africa at that stage was an executive branch activity that allowed them, by their own statements, allowed them to incarcerate people without trial, without charge, with nothing. This guy was essentially not incarcerated but he could also be subjected to home confinement so he was essentially prevented from teaching, visiting the library, treating patients and all that sort of stuff.

DWM: Why?

LD: Well there's no why. Well, he was active politically in an open way. He may or may not have been doing stuff behind the scenes because at that stage the ANC was becoming increasingly active in terms of undermining, protesting and there was some violence occurring, mostly to military and government targets, not to civilians. He may have been providing them…who knows. But the fact is that the situation escalated and we were becoming more and more active. I was very active at the university and did a whole bunch of things that I don't think the faculty appreciated. But the bottom line is we had two kids, age two and four, and we just saw no hope. The world was silent; had done nothing except, at that stage, beginning to isolate South Africa in the sports world; kicking them out of the Olympics and all that sort of stuff, which I think had an effect eventually. I don't think at that stage the economic boycotts had started although they were never very serious. So we saw the rest of the world basically hands off, unending power being attained and we saw no hope of any change. We kind of said we didn't want to bring up our kids in that environment. I think there was an unsaid but clear understanding that we were getting more and more sucked in, in terms of the protest movement and the question is, where would that take us. We never actually spoke about that. Then there were a couple of elections which really put the nail in the coffin where in a relatively progressive area that we lived in, a lot of promises, it's almost like the Bradley effect, a lot of promises on voting a second member into parliament from the Progressive Party totally floundered. I remember coming back from the election results that night and in the mail was a traveling scholarship to come to the States for the equivalent of $700 which was a hell of a lot of money and I just looked at Esther, that's my wife, and she looked and me and I said, this is a sign. We've got to get out of here. Another part of the story was our car was badly damaged which clearly was an act of vandalism, I think, directed at us. Anyhow, so we left. I looked at four jobs; two in the States with George Schreiner at D.C. and a guy called David Earle at

Northwestern offered me a job and I had two job offers, one in University of Sydney, I think it was, in Australia and one in Auckland, New Zealand. We were not big on sheep so we didn't go to New Zealand and I love beer but we decided not to go to… We had these choices and in fact the obvious place for us to have gone might have been New Zealand or Australia because they play rugby there and cricket, you know.

DWM: Were you big into rugby and cricket?

LD: Yeah, sure, I mean rugby and cricket.

DWM: Were you playing or just watching them?

LD: Yeah sure. No. At school I was a competitive swimmer through college but certainly rugby and cricket, but rugby…

DWM: How about football?

LD: Yeah, football wasn't… Soccer was the game. But anyhow, so…

DWM: That's what I mean, soccer.

LD: Yeah, yeah, soccer. So yes. But I didn't play soccer. Soccer only became big…they didn't play it at school actually; they didn't play it intramurally.

DWM: So they were playing rugby?

LD: Rugby, yes, rugby was the big game. I played rugby and, you know, it's a lovely game. So the reason I'm saying that; I mean the culture in those two countries…

DWM: Would have been much…

LD: Well you know, part of the British Empire and all that sort of stuff. But we decided not to go there; we decided to go to the States. It was kind of a sense that it was a much more open community and maybe more opportunity here. Now we only came out on a year's…although I got a faculty appointment the initial visa was only for a…it was a H-1 or something, I don't remember exactly what it was. But we didn't land here as landed immigrants, we came here on a student pass of some sort.

DWM: And you came to George Schreiner's program?

LD: Correct, on the faculty.

DWM: And didn't really know him and he didn't know you.

LD: Yeah, never met him. Never met him. I remember the day we came; I think it was the 21st of January 1971. We stayed in London for a couple of days. Do you want this kind of stuff?

DWM: Yes, absolutely.

LD: So we stayed in London for a couple of days, about a week as I recall, with two kids age four and two. Now you've got to understand that we came from a climate where Black Beauty, the book, had been banned. That was the environment. So they banned the book _____ what they were talking about. They banned a lot of books. But they banned Black Beauty. Why? Because it's black. We came from a climate where movies and other things were also not accessible and where, prior to our departure in the two-year window, movies like The Graduate were seen with embargoed newsreels. We used to go into a house of 10 of us and watch the movie. I remember watching The Graduate and I remember watching…which was not permissible in South Africa for reasons that totally escape me. But the one that didn't escape me was Guess Who's Coming to Dinner.

DWM: Yes.

LD: Which was also banned. So we went to London for a week, as I recall, and stayed there just on _____ Avenue and one of the greatest experiences we had was to go and see Hair. Which was about that time. This was like a catharsis. You know what I mean. And we saw some other shows as well obviously. So we came through London and then we flew into Dulles, as I recall, and the youngest one, now Gregory, was on a papoose on my back. We checked into a hotel. We had a friend who was working at the World Band and they got us a place out in the suburbs. But we checked into a hotel downtown in D.C., it was called Albert Pick Hotel and was on 14th and K Street. Now, this is 1971. In 1969, as I recall, I don't know the exact dates; there was sort of rioting in Washington, D.C. So we checked into the hotel, went to bed and as is my still routine, I don't sleep very much. I get up early. So I got up early and I started walking around that area. You're not going to really understand…that was the red light area; there were prostitutes all over the place, number 1, they've cleaned it up since then. This was 14th and K Street, right downtown, and it looked liked Berlin 1945. The place was, like, bombed out. I mean, you know, shuttered up here and buildings because they'd had major riots down there less than a year or year and a half and they hadn't rebuilt it. I remember saying to myself, what have you done. I eventually said to Esther, Esther, you know, we're here, we're just going to have to see, maybe it's better outside this area. So anyhow, so, yes then when I got to Georgetown the entire faculty were at the Young Turks Meeting in Atlantic City or New Orleans, as I recall.

DWM: The Young Turks Meeting?

LD: Yeah. They used to have a meeting called the Young Turks Meeting. My recollection is it was a research group that did…at this stage Georgetown was very heavily into kind of basic research and stuff. So it was an interesting experience driving on the wrong side of the road and trying to integrate oneself into this high-powered nephrology group. I mean by that stage I knew this was, at that stage, that was a big, big nephrology group.

DWM: What job did they hire you for?

LD: Everybody has a title in America so I was the second faculty person; so I was the assistant chief.

DWM: Ah.

LD: There's the chief and the assistant chief, no, at D.C. General Hospital, which was the city hospital affiliated with…not just affiliated, affiliated and integrated with the nephrology division. So I had a faculty appointment and an administrative position but I actually did not have a license. I was paid a resident's salary and it took me about a year, plus or minus, so a year and a half, I can't remember exactly how long, to actually get a license because I had to write exams and everything.

DWM: Sure.

LD: I eventually got a license by reciprocity in New York which only helped me a little bit because D.C. General was a government agency so it was something that allowed you to function in a government agency. Then I got a license in Virginia and D.C. by examination but I think that was sometime in '92. It took me about a year because you had to apply for it and you couldn't…

DWM: In '72?

LD: Sorry, in '72. Excuse me, '72.

DWM: '72, yeah. Okay. All right.

LD: In '72. _____

DWM: I was like, whoa, that was a long time.

LD: _____ Then I got a license by reciprocity after getting it by exam in Maryland.

DWM: So what activities; what clinical activities did you have to do?

LD: Well I initially started at D.C. General Hospital, which was a straight consultative nephrology program so we did mostly consultative nephrology, acute renal failure. We had an acute dialysis unit at the hospital. It's my recollection that the acute dialysis program ran much better at that stage at D.C. General than it did in Cape Town. I mean they had a unit. In Cape Town we didn't have a unit; we just dialyzed people wherever we could find a room, there was no specific unit. At that stage, this is 1971, we were also doing acute dialysis and consultative nephrology at the university hospital and it was at this stage that National Medical Care, as I recall, I don't think it was '71 but it may have been, but certainly in '72, opened up the first chronic dialysis unit in the D.C. area. I think simultaneous with one that G.W. opened. The NMC unit, National Medical Care unit, was down the road here in Bethesda and the unit is still there; they've renovated it since but it's still there. That program was affiliated under very complicated circumstances with overlapping faculty with George Schreiner's unit at the University Hospital. We were not involved as full-time faculty at that stage. I subsequently became involved, which I'll tell you later, in chronic dialysis. So all we did was…

DWM: In-hospital acute dialysis.

LD: In-hospital acute dialysis and the back up from the patients...

DWM: You know when we talked about acute dialysis in Cape Town just a few years earlier you were talking about, you know, physicians sitting at the bedside for six hours…

LD: Right.

DWM: Big open drums…

LD: Yes.

DWM: What was it like for acute dialysis in '71?

LD: In '71, as is my recollection, we then had a unit. There was a physical location with maybe two or three stations at both D.C. General Hospital and at the University Hospital staffed by nurses with a head nurse; fully structured if you will, and with us as attending physicians with fellows rounding on those patients during the acute dialysis period. It was much further developed, the whole technology, etc. The dialysis machine as well as the dialyzer were clearly of a different era.

DWM: Maybe you were using central water. So were you using individual machines or centralized machines?

LD: No, I don't recall using centralized machines initially in the acute dialysis units.

DWM: So you were using an individual machine.

LD: Correct.

DWM: Do you remember at all what…and were you using plate dialyzers, what were you using at the time?

LD: Yeah, now you remind me of the distinction of plate. My recollection is that we were using both plate and hollow fiber. By the way, I think in South Africa we were using mostly plate; we were not using hollow fiber, now I remember that. You know I've been out of nephrology for sometime now _____.

DWM: Some of the early machines that we were talking about with the big open drum were using the big flat Kiil dialyzers too.

LD: Yes, we certainly used Kiil dialyzers in South Africa.

DWM: Yeah.

LD: And it's my recollection in the early days in the acute units we were using Kiil dialyzers. It's my recollection that we moved very rapidly, especially at the University Hospital in the acute setting, to the coil dialyzer.

DWM: Coil, yeah the coil.

LD: Yes. Yes.

DWM: Which is definitely much more, you know, easy to set up kind of event.

LD: Yeah. Yes. So now you remind me why we had so much difficulty in South Africa; we were not using coils.

DWM: Right.

LD: That was not even on the high horizon. They were probably too expensive; I don't remember exactly what the reasons were but you know taking back a long time, that's 40 years ago. But you remind me now that, yes, we were using the Kiil dialyzers initially.

DWM: Now the Kiil dialyzers, it sounds like part of the issue was you had to remake them.

LD: Correct.

DWM: I mean you had cellophane sheets that had to be stacked up.

LD: Yes.

DWM: The Kiil frame.

LD: And we had technicians that did that.

DWM: Yeah.

LD: There was a whole technician cadre that did that. And certainly in South Africa those technicians did other stuff as well because, you know, acute dialysis wasn't that frequent, it was an infrequent event. But going back into at Georgetown in the early 70s, I mean, by that stage we had a well-functioning acute dialysis program.

DWM: Patients were more stable.

LD: Patients were more stable. Yes, we were the only ballgame in town other than G.W., which is the other university but the nurses were competent, some of them remained around for long periods of time in terms of being committed to the program. And the size of the acute program grew to the extent that the physical size grew into legitimate units with staff, etc., etc. In fact, now that you mention it, I started at D.C. General but by '72 or '73, as I recall, I became Co-Director of the Acute Dialysis Program at the University Hospital and simultaneously Director of the Transplant Program. That must have been like '73 or '74 and at that stage we began the transplant program at Georgetown; began it with a vascular access surgeon part time with total dissociation between the nephrologists and the surgeon. I mean we were in two different worlds. We were dealing with a very difficult political situation because George Schreiner was a top dog internationally and nationally and had a very prestigious nephrology unit, doing all sorts of research and stuff, running the acute dialysis program and having this association with the chronic dialysis program and then starting; not starting because he didn't start it, but facilitating the starting of the transplant program. He had, on the other side of the fence, a guy called Hufnagel who was Chairman of Surgery who was in the same, a little older than George, but of the same ilk, an icon, you know what I mean. He had done the first open heart surgery,

you know, he was an innovative guy but very difficult to work with. He was a cardiac surgeon and he assigned this guy who I had a lot of respect for, a guy called Goames, who was a vascular surgeon who was then assigned to do vascular access like in his spare time and do the transplants, which he did actually in his spare. spare time, you know what I mean. So I became Chief of the Nephrology Group, kind of Co-Director of the Transplant Program and within, I don't remember how long, not a long a period of time, wasn't years, may have been just in excess of a year, I remember August of maybe the first year that I took over the transplant program. George Schreiner used to go down to Kitty Hawk every August for the entire month; he was Chief of Nephrology but he was down at Kitty Hawk, in his home down there which I visited a couple of times. He was just a wonderful guy. Sorry, he's still alive. I remember having to write him a…it must have been a five or six-page letter, describing the current state of the transplant program which we discussed before but at that stage, that August, myself and a couple of colleagues, I remember Jim Baylor was then a fellow, and the bottom line was recommending that we close the program which we actually ended up doing. We closed the program. The basis was we were not functioning as a team. We needed a transplant surgeon. Without getting into all the details, this guy was doing a terrific job but within a very confined space, and we were not rounding together. We were not talking. It was just chaos. We'd worked through all sorts of ways, I was very young then so I probably didn't use all of the techniques I could have used, but even in retrospect I could not have salvaged the program absent bringing in someone who was going to be dedicated to transplantation.

DWM: Right.

LD: It had to do with not just the functioning of the program but it had to do with our ability to grow the program. We made the judgment, or I made the judgment together with a couple of my local colleagues, that it was never going to grow absent a formal commitment and a real understanding; understanding first and a commitment of what you needed to run a program. So we ended up closing the program and then they, some six months later, recruited a transplant surgeon.

DWM: So were you doing just a handful of transplants?

LD: Yeah, we did a handful, yes and it wasn't working and our success rate was creating a problem for us and we were running into all sorts of complications. The communication was not functioning. You know, you can imagine the kind of problems you had with a part-time, not a part-time transplant surgeon, a part-time surgeon who had a full-time job.

DWM: Right.

LD: In fact, as I recall, we had a good personal relationship but it became a little fractured in the end. I mean, he was clear when he and I spoke privately that he didn't really want to do

this. You know and I was trying to get him to help me close the program, which he couldn't really do because he couldn't buck his chairman so that ended up creating friction. But he was just being pushed into this and it was hopeless. So the bottom line is we ended up closing the program. I didn't remain there for much longer as Chief of the Transplant Program.

DWM: When you were in South Africa you talked about being pretty isolated, you know, from the rest of the world as far as just sort of interaction, physical interaction, meetings perhaps and things like that. When you came to the United States did you start to go visit places where they were doing dialysis? Did you go to meetings? Did you become more connected with what sort of was happening in the dialysis world in particular?

LD: Oh yes. Yes, I mean I became very connected very rapidly. Yes.

DWM: Who were you listening to? Who was making sense to you at that time?

LD: Well it all depends what the question is because I was clearly much more exposed coming to the States because of the nature and, you know, you had these, as I recall, these two big meetings on an annualized basis, the ASN Meeting and the ASAIO Meeting. I can't remember exactly when, but it may have been as early as '72 or '73, George Schreiner who was then editor of the transactions of the ASAIO.

DWM: Yes.

LD: Appointed me as editor; he was the editor and I was probably the co-editor, I can't remember exactly what my…I've got some of the stuff in here. So I became the editor of the ASAIO proceedings which, as I recall, were extended abstracts; I'd have to go back and look, I've got them sitting in my office here, and did some work in that area. So that connected me to a lot of people and I became quite visible personally obviously. I don't want to sound self-serving but I'm always interested in new ideas so I was reaching out to a lot of people in a general kind of way. At this stage I didn't have a real specific interest other than, as I recall, my big interest at that stage in the early stages was teaching. I mean I was obviously committed to teaching. I was interested in doing some clinical research. I was totally uninterested in doing any basic research, that was not my want _____. So teaching and clinical research was something I was particularly interested in. So, yes, I was exposed to a lot of different people through these various connections and did attend a number of different meetings, as I recall those two big meetings. There were some other peripheral meetings that I probably attended. The only organizations that I visited or academic centers that I visited were under two circumstances. One is during the stage of redesigning and reconfiguring the transplant program when it became clear both by the hospital administration and George had bought into the fact that we needed a kind of fundamental change, they sent me to a number of programs. Actually, this was before we closed the program and the surgeon came with me. Because what I persuaded

them to do, now I remember, I persuaded them; I said if you don't believe me about what we need to do and how we need to structure it, let's go and visit some units that are actually functioning. We went to Denver and I can't remember who was exactly there and we went to visit Starzl in Pittsburgh, as the two that I recall. We may have visited some others as well.

DWM: How about Boston?

LD: I don't remember going to Boston.

DWM: Because they, of course, were the big transplant advocates at that time.

LD: Yes. Well Starzl was clearly big.

DWM: Yes, of course, yes.

LD: And there was somebody down in Denver. There was a nephrologist down there and I can't remember who the surgeon was. But they clearly had functioning transplant programs. I don't remember going to Boston but we may have. The idea was we would go there and visit them and we'd come back and put together written reports and stuff like that. So that certainly occurred. In '75 I do recall looking for a job; considering moving and I visited Detroit. What's that hospital?

DWM: Henry Ford?

LD: Yeah, Henry Ford.

DWM: Yeah.

LD: I visited Henry Ford and I visited Jefferson, as I recall.

DWM: Um hmm.

LD: And I think those are the only two that I visited. By that stage the Chief of Nephrology; I was now full time at Georgetown University Hospital, resigned and went into… I'll come back to that in a minute. But he resigned his position at Georgetown and at D.C. General and George offered me the Chief of Nephrology at D.C. General Hospital, which I accepted. What this guy did is he went full time into the chronic dialysis program in Bethesda. At that stage they had a terrible system. We had a system whereby the full-time faculty were full time and two or three of them were also running the chronic dialysis program on a "deal" that they cut with George. He and I had unending debates about how unacceptable that was etc., etc. I could never really convince him that it was not good for the nephrology department to have that kind of

mishmash of relationships. I was in favor of a relationship but not that kind of one. So he left and that's when I went back to D. C. General full time. So there was clearly an exposure then but very soon after that it became…I got more and more sucked into public policy stuff which is obviously my…

DWM: Well I want to talk about that in just a minute and how that happened. But also before we leave the early 1970s, in the United States there was a lot of discussion that in the late 60s and early 70s there was sort of an East/West split about dialysis. The West being Scribner and his group who are really committed to chronic dialysis on a larger scale, beginning home dialysis therapies, not really doing much with transplant and the East Coast being more; well dialysis is a means to keep people alive until you can transplant them which was, sort of, what they thought was the best solution. Did you have any of that feeling that there was a, you know, two schools of thought or ambivalence about commitment to chronic dialysis in some fashion?

LD: You know I don't recall the split as you've described it; so called East/West split.

DWM: Right.

LD: But I do recall a specific split; not a split, a specific tension related to the ability to mount a transplant program and the kind of lack of commitment to do that. Part of that, I think, was related to the fact that there was a shortage of transplant surgeons and it was going to be difficult to secure organs and put programs in place and I think there was a bias towards chronic dialysis because at this stage this National Medical Care group started; I don't remember exactly when but it must have been 1971.

DWM: Right.

LD: As I arrived in the country.

DWM: Right.

LD: And it was clear to some people who got involved in that that it was a big money_____ for them going forward and they got sucked into that. Similarly there was clearly a home dialysis lack of interest. Now I personally was kind of neutral to all this; I was less than neutral I was actually in favor of transplantation. I don't recall being strongly in favor of home dialysis; I was kind of neutral to home dialysis. I can't remember exactly why but I was clearly, a little later in that cycle, deep committed to peritoneal dialysis as an alterative. I remember explicitly having long debates and tension at Georgetown about opening up a peritoneal dialysis program. From my perspective it just seemed like a reasonable thing to do. It wasn't that I was in favor of peritoneal dialysis, I just wanted to give the patients the option and it was clear that some patients were going to do very well on peritoneal dialysis and would do better than either

home hemo or in-center peritoneal dialysis. But again I wasn't sophisticated enough to understand all the nuances of…

DWM: What was the debate? Why would people not have been _____

LD: Well that's what I'm saying, I'm not sure I fully understood the debate excepting it was going to be difficult to do, you know what I mean. You know you had to set up another program. You know it wasn't just that you had to set up another program but then you had to go through a complicated process of offering the patient the options, which created, you know…well this is 1970 and different people had different concepts. I came from a different background. I'm not trying to pat myself on the back. I had a different thought process about this. So that was part of it I think. It was a very complicated dynamic. I'm sure in retrospect now that you've pushed me on this that there was something related to the financial relationship with the chronic dialysis program because in the early days, and I think less so today, there was a lot of money flowing from chronic dialysis, the chronic dialysis programs, to individuals who were the medical directors, etc. as well as to the institutions that gave them some kind of blessing. I mean the program in D.C., without being disrespectful to them although I had a lot of conflicts with them, they got the blessing of George to put that program in place and they were the first in the city to do that and for a long period of time they had the…essentially to be frank with you I brokered middle 80s and the very difficult circumstances; we can talk about it, the very complex circumstances later on. But they had the franchise for the entire metropolitan area. I mean, think about that. Nobody could open up a dialysis unit without joining them. I mean it's like, what is this? The mafia. They used to be called the three musketeers. I got along very well with the personally but we didn't see eye to eye on a number of kind of organizational things, etc.

DWM: Who were the three musketeers?

LD: It was a guy called Jim_____, Bill _____, Michael _____, Larry _____; there were initially three and a guy called Barry _____. There eventually became five. So the initial was Bill _____, Jim _____ and Larry _____ who subsequently died about five years ago. Then Barry _____ was brought in and Michael _____. I mean Michael _____ actually worked at the chronic dialysis unit as a partner, if you will, helping them open it etc, etc. while getting credit for his fellowship program. I mean the kind of stuff that went on was just remarkable and this is all under the umbrella of a deal that had been cut with the University and money was flowing to support the nephrology group.

DWM: You know it is the big issue that a lot of people have had with the for-profit dialysis is that all of a sudden mixed in with caring for patients and the best interest of patients is this financial gain.

LD: Right. Right.

DWM: Even in those early days in the early 1970s did you think, well, maybe for-profit dialysis is not such a good thing? I mean did you have a problem with that?

LD: Well, yes I did. I had a problem day one with it because I came from a nonprofit background and I never understood it. I never understood the for-profit concept. I change later, which I will explain in a moment. But more than that I didn't accept, which was a much stronger feeling than I had, I didn't accept the relationships that were being cut with these for-profit groups and academic medical centers across the country. And it wasn't just Georgetown, it was across the country. I didn't accept the deals that they were cutting with the medical directors. In fact, some years later, when I (which I can discuss in a moment) got National Medical Care to open up a unit where I would be the medical director under very complex circumstances, which was the first one in the D.C. area, they tried to write a contract with me that had to do with the volume of patients, which is the standard contract at that time. I can't remember exactly but it had to do with the volume of patients and the profit margin of the unit. So I remember Ernie Lowrie was the chief operating officer; she was the wife of Ed Lowrie who was the medical director.

DWM: Yes. Ernie Lowrie.

LD: She said to me, you know, this is the deal. I said, _____ it's just not necessary, you know, I don't need that and I'm not going to accept that. She said something to me about that, this is the only way we can control you, or words to that effect. I remember saying to her, I said, _____ you've given me a job description, I've read the job description, I understand there is stuff I need to do in lieu of being medical director, pay me a salary. Let's pick a figure. I'm not even going to ask for, you know, $500,000. It was a very small sum of money then and it was a reasonable figure. But they couldn't. So those are the things that I couldn't accept at the time. On the for-profit story I was strongly opposed to for-profit in healthcare although I always recognized that, you know, fee-for-service and the physicians were in the profit business. I mean, not in the same sense. But then I got involved with some research. I then got involved with a guy called Phil Held, an economist.

DWM: Oh, Phil Held. Yes.

LD: Yes. At the Urban Institute and a guy called _____ ; it must have been in the early 80s so it was a long time after having arrived here in '71. I was a collaborator with him on a whole bunch of research that was done like _____ research looking at various characteristics of dialysis units and outcomes and all that kind of stuff in the early days. This was in the 80s as I recall. The bottom line, Dugan, is we couldn't find any difference between how the for-profits performed and how the nonprofits performed. I remember, kind of, turning neutral to the

question of for-profits. It then became illogical for me to opposing for-profits. And then I remember about the same, maybe a little later, there was a big debate going on in the country that for-profits were under-dialyzing their patients. I remember speaking publicly about it. I said, I don't know what you guys are talking about. Leaving aside the moral question of why they would do this, what is the business case that you can make for under-dialyzing your patients in a chronic dialysis unit if you're for-profit. I said these guys are not stupid. If you under-dialyze the patient you've got a couple of events that will occur. The patient will die; that's like a big loss of income. And I spoke to the people up there. Secondly, the other thing that will occur is the patients will be under-dialyzed and they'll get complications and need hospitalization. Unless the chronic dialysis unit happens to have the contract for the acute setting, they're going to lose revenue. They're going to have an empty station sitting in the dialysis unit with all sorts of overhead, etc. and unless they're, you know, 120%. I said, I don't understand what you're talking about. But that argument didn't seem to kind of carry any weight. Everybody still believed these guys are under-dialyzing their patients, which actually made no sense whatsoever. So, I mean, the data just said to me we couldn't distinguish the two and it didn't make any difference. Then something else happened and that is I became aware of…which is also not rocket science…I became aware of the inefficiency of the nonprofit systems. Some of them are just like, dysfunctional. They don't seem to recognize that, although they are in the nonprofit, so-called nonprofit business, that they need to make more money, more revenue, more income than their expenses. You know it's not rocket science but when you say that but they weren't doing that. They were like, in another world. They weren't looking at the financials. They were running deficits. They were running lousy programs. I don't mean the dialysis unit, I'm talking about generally, that nonprofits. The biggest example I had was the University Hospital, which was like totally dysfunctional. As you know, they subsequently, shortly after I left which had nothing to do with my departure, they were running a $350 million deficits and they eventually sold out to the Washington Hospital Center because they couldn't function. They couldn't administer themselves. So I changed very rapidly and I'm just now neutral. Whoever you are, you've got to function, have to have a value and bring in more money than your expenses and you'll be okay. Profit, nonprofit, it doesn't make a difference. So that's how I evolved in that.

DWM: And also before we leave those early1970s, George Schreiner was pretty involved, as I gather, with the political effort to get Medicare to amend the law and to cover ESRD. Do you recall any of the events around that?

LD: Oh, it was before I came.

DWM: Okay.

LD: That was in the…

DWM: ’71 _____

LD: See I arrived in January ’71 and I think that had already been consummated in the 70s and the late 60s.

DWM: It passed in ’72.

LD: Yes.

DWM: And they did the dialysis in Congress right around that time.

LD: Correct. Yes.

DWM: But I’m sure that the efforts… I mean they had the Gottschalk Committee in the late 1960s.

LD: Correct. Yes. I was not that involved… I was only vaguely…I mean this was… I’m driving on the wrong side of the road, you know what I mean.

DWM: It’s confusing enough without being in Congress…

LD: You know I was still trying to figure out all sorts of stuff through the 70s. I was battling to get my license, etc. Obviously I had some understanding but it was all very strange to me.

DWM: Sure.

LD: And, you know, I was getting my license. We made a decision very rapidly within the first year that we were going to convert to landed immigrant so I had to go through that process, I think, in ’72 we converted our thing. So it wasn’t until a little later, around the time that the RPA got formed, that I became politically involved.

DWM: Yes.

LD: I wasn’t involved. I recall being at the first meeting. In fact, now that I remember, I recall being at the first …

DWM: Are we talking about the RPA?

LD: Yes.

DWM: Let’s talk about that first meeting. Let’s talk about the RPA.

LD: Yes. I don't know if it was the first meeting but I recall a meeting at the ASN in a big auditorium, must have been a thousand people in the room or something. I remember John Sadler on the stage and I remember Capelli and I remember Chris Blagg. I remember one topic of the meeting had to do with the composition of the Board of Directors. This is obviously very personal because I remember actually even though I considered myself a semi-foreigner and not really knowing what was going on, I got up and spoke and strongly recommended that they put a transplant surgeon on the Board of Directors. Now I'm not sure that that carried weight but they eventually did put a transplant surgeon.

DWM: Who did they put?

LD: Ah, ah, we'll have to find the name.

DWM: Okay. I can.

LD: I know who it was. It was a surgeon from Buffalo, New York, as I recall. He subsequently died.

DWM: Okay.

LD: I'm block on his name. A terrific guy. He died from, I think, laryngeal cancer.

DWM: Okay. But they did do that?

LD: I can't tell you whether it was the first board but by the time I got on to the board in '77 there was a transplant surgeon on the board. But I remember speaking about the transplant surgeon at that meeting which was electrifying.

DWM: Why?

LD: It was because it was obviously a rump group. You know, it was at 5 o'clock in the afternoon, it had nothing to do with the ASN. It was at the ASN meeting, but it clearly it didn't have the blessing of the ASN because it was… you know… and there were a lot of people in the room. There just appeared to be a lot of energy and excitement because the statute had just been passed some time before that; I don't know exactly now. I didn't really have any idea what that really meant. You know what I mean. I mean I knew what the words were but I didn't really have an understanding of what it kind of meant going forward excepting I obviously recognized that it was big. I obviously recognized at some level, in retrospect, that going to the meeting was important otherwise I wouldn't have been there. I mean I was drifting around. I had obviously heard about this meeting and the idea attracted me; that

physicians would get together collectively to do something on the behalf of their patients. You know what I mean. Which was different from what the ASN was doing. The ASN was clearly…I had a lot of respect for them. It was clearly a scientific group furthering science, without being disrespectful to them, but it'll show my bias about science in general. Furthering in science with no end in mind, you know what I mean. Just like a general end in mind but there's no real end in mind. These guys are not thinking about…so how are we going to translate this into something that is actually going to help a patient. It's so far off…. So this group kind of attracted me otherwise I wouldn't have gone I guess. I don't remember exactly seeing the notice or anything but I remember the meeting. I can visualize it as we speak. It was a conference room with a long hall packed, standing room only.

DWM: And a lot of these folks who were early on involved in the RPA, Chris Blagg and John Sadler, have talked about the fact that they were also pretty involved in ASAIO.

LD: Yes.

DWM: And in dialysis.

LD: Yes.

DWM: And in patient care.

LD: Yes.

DWM: And that that really was…

LD: Yes.

DWM: And that the folks who were at the ASN who were the science folks, sort of looked askance at that.

LD: Oh, absolutely.

DWM: That they were not as good as the true science folks.

LD: Oh, absolutely. And I don't think that has changed. I really don't think that has changed. I'm serious. I don't think it's changed. I don't want to get out of sequence here but I was President at RPA at some stage later, I'll have to figure out when, and one of the things I did was to kind of reach out to other organizations. In the American Society of Internal Medicine, we became a delegate, and in the AMA we became a delegate, when I was president, and ASN was a group that I wanted to reach out to and form some kind of coalition. It was clear to me

then, as it is clear to me today, that we are living in different worlds but there is only one world that we should be living in which is a connection between the science and the economics of practice. These guys are in the science, loosely, and RPA was in the economics. Long story short, we had a big issue during my term as president, which had to do with eliminating the acute dialysis code. I don't know if you recall that. They were going to eliminate it and just make it an EMM code, which we may be drifting back to again. I essentially, for the entire term, in addition to doing other stuff, which we can talk about in a moment, was able to negotiate with HCFA to, in fact, maintain the code. A guy called _____ was the administrator of HCFA, he's now down at Duke. I see him a lot because he's President of the National Quality Forum. He's still actively involved. In fact when he called me that December to say that the deal had been cut that we will maintain the code, I hope this won't seem like an off color comment, I was at the AMA meeting in Atlanta at the Marriott in my hotel room waiting for the call where he was going to tell me the decision and I was literally naked. I was in my room; I had just come back from a full day. I actually was lying in bed and when he called I stood up; because you've got to stand up he's an important guy. I remember saying to myself, he should know _____. But the reason I'm telling the story…so I had arranged, prior to that even before we cut the deal; we cut the deal about 48 hours before the ASN meeting, as I recall, I came back to D.C. or wherever. I think the meeting was in D.C. I had previously arranged to meet with the ASN Council to speak to them about some kind of collaboration going forward and Natey Levine who was the then president elect came with me. So we go to this meeting and the council is sitting there and, firstly, it's only half the council because they don't show up because it's like, you know, kind of disrespectful. The fact is we just did a major deal for nephrology, which they kind of appreciated. So I had a presentation. I made a presentation, and I knew that I didn't have a lot of time so it was a brief presentation about what we were doing. In fact we had actually started the first… we had initiated the first clinical practice guideline during my term, which was the first clinical practice guideline in nephrology which we pushed during that period of time. So we were doing some innovative stuff. So after my presentation there was a guy called Tom Ferris.

DWM: Um hmm.

LD: Who subsequently became president and he was sitting on my right, the president was at the head of the table. This is a true story, I mean, I couldn't make this up. His feet were actually on the table; you know what I mean. He's leaning back with his feet on the table. You know, I mean, my opinion of them was; I was there to cut a deal I wasn't going to… and see whether we could actually advance a relationship. So at the end of this presentation he said something to me to the effect, you know Lou, or something like that, you guys are doing just terrific work and we really appreciate it and you've saved, you know, the inpatient dialysis procedure; a little bit of a speech in the thing. Then he says something to the effect, the words were something like, how would RPA like to become the Dialysis Council for the ASN? You know, they had a Transplant Council, it's like a committee. I mean it was just like a

stunning…like mind boggling that he could even think about saying such a thing. You know what I mean. I remember saying, you know, sometimes you just kind of… you're able to react appropriately and not react inappropriately and somehow or other "rise to the occasion". Right. Which is, without being too self-serving. Because I never expected it. It was so maddening that I was like almost speechless, but I just as quick as a flash, I came up with the following comment. Which I think I can repeat now, if I remember it correctly. I said to him, Tom that's a terrific idea, or words to that effect, but I've got a better idea. I said, why don't we form a new organization called the American Society (ASN) of Renal Physicians. I mean I couldn't have done it better. And his feet dropped to the floor, as I recall, and he leaned across and says, I get your point Lou, or words to that effect. So it speaks to their arrogance. I mean it speaks to their arrogance. I mean, and I think they've still got it. And, unfortunately, some time later we did … it was during Derrick Latos' term as president, as I recall, I was still medical director of RPA, we did cut a deal with them to collaborate. We had a number of meetings, one of which was at O'Hare Airport, as I recall, at the Hilton there. There was a guy who was then the ASN President from Arkansas. I'm blocking on his name. But he actually saw the value. We had some kind of a triangle, a diagram, talking about the expertise of the two organizations and the fact that there was very little overlap, which is true, and the fact that there was some overlap in the middle and we agreed that RPA would do the public policy stuff and the reimbursement stuff and we'd form joint committees and stuff like that. I had actually hoped that that would be the forerunner of further merging of the two organizations but it never occurred.

DWM: _____

LD: Never occurred. You know, I was on the Board of Trustees of the American Society of Internal Medicine (ASIM) which is the essentially the same as RPA; the Board of Trustees, I think they were called, for eight years when there was a freestanding organization. We had the same conflicts then with ACP, two different worlds, etc. But, as you know, they subsequently did merge.

DWM: Right.

LD: And the new organization has been a great success and brought in the values of both groups and fostered them and the culture and the focus on the economic and the quality issues from ASIM and it's a tragedy that's not occurred at the level of ASN and RPA. I didn't push it… I did try a little bit after the recent breakdown a couple of years ago. I'd kind of cautiously hoped that _____

DWM: Yes.

LD: Who probably has the stature to have pulled something off but you need a partner and I don't think there was any partner…

DWM: From the other side.

LD: From the other side. The ASIM and ACP were very lucky to the extent that there were two executive directors who were very strong people, Alan Nelson on the ASIM and previous President of AMA, and Walt McDonald who's just a terrific guy from the Oregon area and now living in Washington, who were at the end of their tenures as CEOs of the two organizations and some leadership at the voluntary level in both organizations that were able to do it over a two-year time frame. Unfortunately, it's not occurred at the ASN level, you know.

DWM: The RPA has been a remarkable organization.

LD: Yes.

DWM: Your enthusiasm from that first meeting at the ASN, was it justified? I mean has the RPA done what you thought it would do even in those early days?

LD: Yes. Yes. Yes. I mean I couldn't be more pleased where they are. I joined them in '71, sorry, '77 as I recall. Again, you know, you visualize certain episodes in your life and you don't remember all the details. But I remember sitting in my office at D.C. General and getting a call from John Sadler asking me to serve on the Board of Directors of the RPA. I remember putting down the phone and saying to myself, what are these guys thinking…why did they take me. You know what I mean. It was totally out of the blue. The RPA, this was in '77 so I don't remember exactly when they were formed but it must have been like '74 so it was like three years into the …

DWM: Right, in '73.

LD: You know I'd been at some of the meetings but I don't remember being particularly visible, etc. So, you know, just in those days the board were incredibly dedicated under, you know, John Sadler and John Capelli and Chris Blagg, as the initial, kind of, leadership. It was all volunteer. There was no staff. We paid for our own travel. We went into meetings with no agendas. I mean, there was the agenda in, you know, Capelli's head but there was no, like, background material or anything. We had guys like John DePalma who was a character, I don't know if you remember him, at the meeting. In fact at many meetings we had multiple meetings at the same meeting because there was no kind of decorum. You know. They used to break up into little groups. As I recall, food and sometimes beer and wine was served during the day. It wasn't that they were parties or anything but, you know, it was kind of a free for all. Everything was done out of the back pockets of the initial leaders. So I can't remember who came after

the first three but I know John Bower was there and Dick Friedman who, I think, has subsequently died. Actually Dick was before John Bower; I came after John Bower, as I recall. I think that was the sequence, I can't remember, there may have been someone before me. I don't remember. Literally when I became president in, whenever it was, I can go and look at my resume, in the early 80s I guess it was; we didn't have any staff. We had files, which I can visualize in a filing cabinet in my garage. I mean this is a true story. That was about the same time that I began to… so I'll just speak about kind of what I was trying to get done. I became involved with ASIM for reasons that I can't remember. But I became involved with the ASIM and just learned a lot from them. They had an annual meeting, which was like a House of Delegates, so I learned a lot about policy and policy development. I'd been there for a couple of years before I became President of RPA. So they had a formal House of Delegates with resolutions and motions and, you know, tightly constricted statements of support for this and support for that and they had annual leadership development meetings for two or three days.

DWM: Um hmm.

LD: In various parts of the country which I ended up attending for three or four years. Then they taught you all sorts of things that I hadn't even thought about. Like how to construct an agenda for a meeting. Kind of basic stuff but, you know, how to manage the time, how to secure, what's it called again, volunteers. How to do public speaking. How to speak to the press. I mean all sorts of things that obviously became…are very helpful tools when you're trying to live in that kind of space. Oh, and how to charge committees.

DWM: Um hmm.

LD: And set up committees and how important committees are and the relative role of committees versus boards of trustees. All this sounds kind of basic for some of us who've now lived it for a period of time but none of that was in place; I think this would be confirmed, at RPA. We were functioning as 12 members talking with each other, conference calls, showing up at three times a year, as I recall. meetings, having this annual meeting at various places and just kind of driving it through the enthusiasm of the group but we had no structure in place.

DWM: Wouldn't that be so true though of physicians.

LD: Yes.

DWM: I mean smart people who know what they want but as part of their education would not have had any, you know, ability to develop these skills.

LD: Absolutely. And I recall learning those skills and I recall beginning the process of driving them into RPA and speaking in terms of, you know, this is not in our DNA guys. You know and

we were not taught this in medical school. It was a tough sell at one level. It wasn't that they were hostile or anything; that wasn't the point. The point is, you know, most physicians think they know everything and it was clear to me that we didn't know everything about a lot of things. So we began, at that stage, to put in place some committees; different charges and so, but that became a very important function. Agendas. And it was at this stage that I think it's fair to say that we began to evolve, from the RPAs point of view, of a focus only on something called the socioeconomic financial issues into the quality issues.

DWM: Ah. Sure.

LD: And I remember having discussions with John Sadler and John Bower. I remember the one discussion down in… what's that island just outside of Miami? There's like a…

DWM: Key West?

LD: Yeah, Key West _____. About the need for us to do this and the debate about how we're going to do it and what the importance was. It was clear at that time that the discussion we were having about the quality issue and expanding the scope of what we would do had to do with some clear recognition that we had some limitations on our resources. We had only so much time. Although we didn't have as clear an understanding as some of us have now about the need to focus and all that sort of stuff but it was clear that, you know, we had some limitations. Secondly, it was clear it was the right thing to do so there was no debate about that. But there was also the discussion that the credibility of our message on the socioeconomic issues becomes enhanced if we have a much broader, not totally expansive but a broader scope that we were going to be dealing with. That's how we eventually landed, during that time frame, on the need for something called a clinical practice guideline, which was kind of, you know, totally new stuff. How to do this, etc. And, as you know, we eventually wrote a contract with some group at Georgetown and put together the first clinical practice guideline with, what's his name? Jimmy Roberts, doing a lot of background work. He was a very smart guy. He became president at a later stage. So that was all part of the discussion then and then the other part was we needed to not be isolated within the nephrology community. That kind of came out of my own belief that there was a lot to learn from groups such as the ASIM. So we became a member of the House of Delegates of ASIM; the first and only nephrology group to do that. And simultaneously, that same year, applied for membership to the AMA under the aegis that we needed to be part of the House of Medicine and we needed to find a way to leverage what they were doing so we didn't stand alone and learn from what they were doing. That's been a really big, big issue for us going forward. I can't remember exactly how I got involved in the ASIM but I recall, this was before I was President so it must have been '75 or something. Actually, yes, it was Dick Friedman was the President. And ASIM convened a meeting of the various specialty groups, who were not even members of the ASIM House of Delegates, and we were invited, the RPA was invited. Dick asked me to attend the

meeting because they didn't want to send anybody because they didn't even know what it was about. It had to do with something called cognitive services. I don't know if you recall this?

DWM: No. Cognitive services.

LD: Yes. Cognitive services. It was the Cognitive Services Taskforce. This eventually became the evaluation and management payment system and was the forerunner of the RBRBS and the forerunner of recalibrating payment for primary care services versus procedures. I remember going to this meeting in northern Virginia and there was a guy called _____ who was a previous president and a guy called _____ who managed the meeting. There were about 10 specialty groups there. They made this presentation of this concept that ASIM had put on the table which was to fundamentally change the payment system from the usual and customary to some kind of basis; a resource based value based system, which has to be changed again now but the fact is it was the right thing to do at the right time. I remember coming back from that meeting and calling up Dick and there was a whole lot of background material. Calling up Dick Friedman and saying to him, Dick I've just come back from this meeting. This is exactly what I said to him, as I recall, I don't fully understand what these guys are talking about but I think it's important and I recommend that you put together a taskforce to work on this going forward so that the RPA can be involved because I think these guys have got legs. The taskforce that we appointed was myself, to work on this project. What they had asked for was we need your input. What do you guys actually do; was the question they posed to us. What does a nephrologist do? So we can figure out how to pay them.

DWM: Right.

LD: It seemed to me like an important issue. You know what I mean. What we did was not that clear.

DWM: Right.

LD: Yeah. It was more complexly posed than that. So the taskforce was myself, Dick Hamburger who, as you know, is still around.

DWM: Yep. I've interviewed him.

LD: And still active. I saw that yesterday. And still active with this whole CPT2, etc.

DWM: Yep.

LD: He's done a terrific job.

DWM: Yep.

LD: And made a terrific contribution. And the third member was Jordy Cohen. Jordan Cohen was a nephrologist in, I don't remember how we selected him, but he was a well-known nephrologist. He was out of Harvard. Then working in the New York area somewhere, I don't remember exactly where at the time. But he was well respected as a researcher and scholar, if you will. He subsequently went to run the nephrology group or even the Department of Medicine up in Chicago somewhere; I'm not sure exactly what school. But became, for a long period of time, the President of AAMC; it's the premiere lobbying group for the academic medical centers.

DWM: Okay.

LD: Association of American Medical Colleges (AAMC). He retired about, maybe, two years ago. So the three of us were the taskforce working with the researchers at Harvard; a guy called _____, I recall his name, who developed this whole resource-based work-related relative value scale.

DWM: Right.

LD: A very complicated formula, etc. etc. So we had to, you know, do all sorts of scenario development for them and file back reports to them at Harvard so that they could come up with a fee schedule, which was attached to, eventually, the MCP and the acute dialysis service thing.

DWM: So this was around 1975?

LD: Some time around that time. Yes. It was before I was…

DWM: So is this the beginning of your quality career?

LD: Yeah probably. Yeah. Yes. You know, you asked me stuff that I haven't thought about before. I guess, you know, the other reason, I don't know about a reason but the other thing that I think drove me was I started at Georgetown at D.C. General Hospital, which is a city hospital with all its problems, and then went back to Georgetown for a couple of years to run the transplant program and the dialysis program and then went back, as I reflected, to D.C. General as Chief of Nephrology. This must have been the late 70s. Now D.C. General, at that time, had two universities affiliated with it, Howard and Georgetown. We had a fully-fledged Department of Medicine there with faculty in each of the subspecialty areas plus a very strong nephrology group, which was well supported by George Schreiner and the nephrology group. All credit to him; he put a lot of money into that group and really integrated, as I indicated, well

to the program at the University Hospital. We weren't just a peripheral group. The other specialty sections were not well, if at all, integrated with the university. They all had faculty appointments, etc. but it was not well integrated and we had students rotating, etc. So that's a long winded way of saying, so now I'm at D.C. General and D.C. General is, let me put it kindly, university affiliated but totally dysfunctional as a hospital. This is now in the late 70s. Totally dysfunctional. I become more and more involved because I'm there so I'm dealing with… what am I dealing with? I'm dealing with… So what is dysfunctional? The dysfunction is the quality level. It's not providing basic services and the basic resources are not available. Some time during that timeframe we run into all sorts of issues in regards to the Joint Commission and the hospital administration, which is run out of the mayor's office, kind of, doesn't want to release information to the physicians. You know, it's like just anarchy. I remember some time during that timeframe a private sector group filing a class action suit against the hospital charging them with not providing basic services. There is a judge called Barrington Parker who was the judge and I end up, because I'm obviously getting sucked into this, I end up testifying against the hospital as one of only two physicians that actually testifies; another, Dr. Taylor, who used to work in the emergency room. So I'm becoming not that popular with the administration. But I think all this is kind of driven by the recognition that, yes there's a financial problem at the hospital and yes there's an administrative problem but it's all resulting in lousy care to patients. They're not getting kind of basic services. You know, in addition, the Georgetown Department of Medicine is not functioning that well because we actually are using, what I would loosely call, an old model of the attending physician. The attending physician is not responsible for the patient; it's the resident. The attending physician sits in his or her office and does rounds; this is what I'm finding there. I'm doing rounds on nephrology patients because you can't sit in your office and do rounds. And that becomes relevant a little later. So I think that's how I get sucked in to this quality issue and it all relates to the environment I'm sitting in. I'm sitting in an environment where these patients are not getting, kind of, reasonable care. Then I think I start searching for, you know, how can you impact on what's going on in the hospital. And how much do you need to reach outside of the hospital to find solutions. And I remember somehow or other finding out about Baltimore City Hospital which is just around the corner, which is also a city hospital.

DWM: Right.

LD: Which is totally dysfunctional but actually gets fully integrated with Johns Hopkins and where the salaried physicians develop a practice plan and they begin to succeed and move themselves into a new era. So I am now concluding that the salaried physicians… By the way, the Georgetown faculty are all salaried physicians, salaried by the hospital (I happen to be jointly salaried by the hospital and the university) as are the entire rest of the medical staff. Almost the entire rest of the medical staff also have private practices, not the Georgetown faculty which is somehow or other not permissible although that kind of gets undermined a little later. So I conclude that the only way we can deal with this issue is to build a different

model. So I work on, for a period of years, a practice plan proposal and I get the Board of Trustees to conceptually buy off on; the Board of Trustees of the hospital on a pilot basis for Georgetown. So it's all within the concept of how can we improve practice and how can we improve the accountability. I then become President of the Medical/Dental Staff.

DWM: The American Dental…

LD: Sorry, the Medical/Dental Staff.

DWM: The Medical/Dental Staff.

LD: Yeah, the Medical/Dental Staff. Within six months while I'm negotiating they essentially impeach me. Excuse me, they don't essentially impeach me, they impeach me. They have a vote of no confidence directed at me because I am in open discussions; these are not private discussions, with the Board of Trustees about a practice plan to move the physicians from salaried physicians (with appropriate guarantees, etc., etc.) to a practice model where we would run a practice at the hospital and in addition reach out and set up some clinics in the community.

DWM: What was the opposition to that?

LD: Oh, everybody was drawing a salary and participating in private practice simultaneously and some general opposition to change and some philosophical opposition to the notion that, which is very complex because a lot of the physicians were in private practice; that some how or another in a city hospital care has to be delivered by physicians who are salaried. It's a very complex kind of situation. It might be also that the rest of the hospital… and I'm totally neutral on the black/white issue, that I was clearly white as was most of the Georgetown faculty so there was obviously tension there about, you know, were these guys coming here to rape the city hospital and the city coffers. But it was an opposition to fundamental change, the inability to see the future. The hospital subsequently closed two years after I left with nothing to do with my departure. In '93 the hospital closed because they couldn't function any more. They were running major deficits. They couldn't collect any money from even the insured because they were so inefficient. The physicians continued to bleed into the community while maintaining full-time positions at the hospital and full-time salaries and the place just completely imploded as has many other city hospitals that have not gone through the change mode. See I came from the perspective, you know I'm talking about myself here, but I came from the perspective that it had to do with the way to deal with the uninsured at one level was to integrate their activities with the insured. It was kind of self-evident to me. I'm sitting at a city hospital and, you know, 30% of the people have got Medicare so they are insured so why would we not maximize the reimbursement coming from the Medicare program and from the Medicaid program to cover those who have no insurance. Then we had a small number of

people who… So it made no ethical sense to me, leaving aside economic sense, and it goes back to my earlier comment, not to have a well-functioning system that maximized what you legitimately accrues to you which is, if you provide services to those with insurance you ought to get reimbursed for it. They couldn't put in place a billing system so we couldn't get any money in to do anything. And the physicians wouldn't complete billing forms. Why? Because there was no incentive for them to do it.

DWM: Right.

LD: And in addition they didn't want to be held accountable to somebody figuring out how many services they actually rendered. God forbid you should have to fill out the billing system and somebody can count how many visits you actually did. So when I became Chairman of Medicine, not the first thing because I eventually became Chairman of Medicine, which gets back to, you know, I was always wanting to be a general internist. I held both positions for a period of time and then I gave up the nephrology position. But when I became Chairman of Medicine I changed, with a lot of resistance, the model of the attending physician. I said to these guys, you've got to go and see those patients; they are your patients. And in addition, even if you don't think they're your patients, if you want to be a teacher you've got to demonstrate a model of teaching. You can't do that sitting behind a desk. You've got to demonstrate; how do you talk to … you know, I mean it's not rocket science. It was just unacceptable to me. So we changed the model and that was also resisted by the rest of the faculty. I had support from the Georgetown faculty to do what I was doing but the rest of the departments and _____ Department of Medicine were totally out of sync with what we were trying to do. We never got it off the ground; never happened. Never happened.

DWM: Early on, I mean you know, just listening to you talk about this it's clear that, you know, you're advocating for quality, quality of care, services provided and yet it's very wrapped up in the economics of medicine as well.

LD: Yes.

DWM: I mean was that very apparent to you early on that they were just so tightly integrated?

LD: Yes. Yes. Yes. And by the way that battle is still being fought today, the battle of the recognition that quality and cost of care are connected. The majority of the physicians in this country will not buy into that notion. If you can get them to buy into the notion that we ought to be committed to the quality dimension and that we have some responsibility to pursue quality for individual patients and populations. That population issue is a big no-no for most physicians. I'll come back to that in a moment. They do not buy into the notion that we ought to deal simultaneously with the financial dimension. And it's very complex. It's got to do with some level of arrogance and some level of this belief that services accrue to patients on an

unending basis with no limits attached to it. It has to do with this question of the individual patient and a patient population because most physicians… When I speak to physicians about it, for instance, and when I say to them, after you go through a couple of iterations; you know what I'm talking about, I'm just talking about your patient population. They say, what do you mean Lou. I said, it's your patient population; you need to know how many females you have in your patient population as a primary care physician, what the age distribution is and how many females over the age of 55 have had a mammogram and, you know, can go through that list of… Oh, is that what you're talking about. I thought you were talking about, like, the whole nation. I said well that's a different issue. And some of them say, you know, don't bring this communist stuff to me. They generally say this to me; you know that's socialist stuff. So there's a lot of tension related to that and we're still debating it, as you know. You know there's beginning recognition, and I'm not totally comfortable with it, but there's beginning recognition by physicians that we ought to measure the quality of the services they provide and make the information public. It's beginning to sink in. I'll come back to my position on that in a moment. But we are a long way from dealing with it. So the other part of the dimension, namely the financial dimension, ought to also be measured and ought to also be made public. I've had discussions in public forums about this and some recent discussions where I've pushed with some others and succeeded in getting the two to be linked. For instance there was recent discussion at the national level that we needed to measure quality and one of the things that some of us put on the table is we said; we need to link that to the financial dimension. I said I'm saying that for a number of reasons. One is, they are in fact linked, period.

DWM: Whether you like it or not.

LD: Whether you like it or not. That's number one. And number two, I'm now talking personally, I said I've got to be consistent. They said, what do you mean by that? I said, well I opposed economic credentialing when done on an isolated basis without measuring quality. In other words I'm not a supporter of measuring the financial dimension without measuring the quality dimension. I said, I've got to be consistent so now when we measure the quality dimension, you've got to be able to measure the financial dimension so there's a consistence there that I'm trying to speak to. But it's also that they are, in fact, linked so you're correct that the recognition that those two are linked and we needed to take both into account was not there and that goes back to some extent to our earlier discussion on the ASN and RPA. Because the ASN, the predominant group for nephrologists, and there were other organizations similar to them, you know, ACP, etc., did not want to deal with the financial issue at all. They paid lip service to the quality issue but all within the context of basic sciences but they could kind of say, yeah we're committed to quality but they could never commit to the … because the financial stuff was like dirty stuff.

DWM: Do you think that's because the ASN is so heavy academic and I think academic institutions have never really been wanting to deal with the economic… look at it like it's not _____.

LD: Absolutely, and that has to do with the arrogance of academic centers and their lack of understanding of what nonprofit corporations are all about.

DWM: Yeah.

LD: That they need to be able to deal with economic issue.

DWM: To be accountable.

LD: Be accountable. And, you know, somehow they're not accountable. And that's why RPA was formed. Right? To deal with the economic issues because nobody else would deal with them. That's why ASIM was formed 30 years ago; it was the same story. The ACPs didn't want to deal with the financial issue or the practice-related issues and so RPA started with the economic issue and then evolved to the economic quality issue and has not drifted back into the basic science issues, which is appropriate for them. So I think it's a very complex issue. And, by the way, I think this patient and population schism is a big one that it's going to take a generation and a half to deal with.

DWM: I want to talk about patient population schism also but we were talking about academic institutions who have sort of shunned away from talking about money but also in that early for-profit/nonprofit dialysis unit there were physicians, there are maybe still physicians, who don't think they ought to be talking about money when they talk about patient care.

LD: Correct.

DWM: Why? Why is that you think? I mean, you know, physicians need to be paid for the work they do and when you're taking care of patients there needs to be financial reimbursement for that and patients ought to have good quality of care so I don't know why physicians have not been particularly good business people, not educated in business skills and not willing, always, to really talk about reimbursement money.

LD: I mean, Dugan, I find it inexplicable. You know, here you're talking to a guy who is kind of very much interested in the quality dimension but links it explicitly to the financial dimension.

DWM: Economic_____

LD: Without any, like, hesitation.

DWM: Yeah. Yeah. Yeah.

LD: It's, like, automatic to me and I can't comprehend why it is. I'd have a little difficulty answering the question except there is a complex emotional thought process and it has to do with this issue of my responsibility is to the individual patient, to the patient sitting in front of me. And, as you know, the AMA and others have continued to articulate what the ethical, and rearticulate because there is need to, the ethical responsibilities of physicians that has to do with this broader relationship to society. But certainly in the States… I don't know what the feeling is in the U.K. for instance or other Western countries, which is I think a little bit more perhaps balanced. There is this kind of _____ individualism issue that may be overriding some of this thought process. It doesn't make a lot of sense to me and I can't explain it.

DWM: There is a U.S. society issue too of individualism.

LD: Yes.

DWM: Yes. I am the patient, you know, care for me versus what is good for our community, what our healthcare needs are of the community.

LD: And, you know, it's the rescue phenomenon. You know, rescue a kid out of a hole, kind of a situation. You've got to rescue the patient. But I actually can't explain it very well.

DWM: I don't want to lose our quality trail but maybe we can pick up again just talk a minute about when you got involved with the Networks and what you think their role has been in quality care?

LD: I first got involved in the Networks when they got reorganized down from whatever the number was 40 to 18 Networks when we merged the D.C. Network with West Virginia, Virginia and…

DWM: Maryland.

LD: And Maryland, yes. So that must have been about 15 years ago, whenever it was, we'd have to check on the exact date. I was then obviously heavily involved with the RPA and a lot of public policy stuff and I became involved in the group that kind of facilitated the merger of these groups. Some of us believed at the time; this is kind of relevant to what happened afterwards, that the only way that CMS would write a contract with a Network with these new

organizations was if the boards were self-perpetuating accountable entities versus what most of the Networks are which are essentially a rotating board coming out of the community. So the notion that some how or other the community that were being monitored and being the subject of oversight would form the oversight boards didn't make a lot of sense to certainly me, and a couple of other members of the group, so we actually are the only Network that is a "self-perpetuating board". Now we have changed board members and we have changed; our first president was a guy called Fred Westervelt.

DWM: Yeah.

LD: You remember him?

DWM: Yeah.

LD: I became the second president and obviously they've kept me there for an extended period of time. So the question of the Networks… So I'm troubled by the Networks. I'm involved with them. I'm not troubled by them, I'm troubled by the situation we're in because we are relatively small organizations with contracts to do the work that we do which is to somehow either facilitate quality improvement in the dialysis units, don't do much of any work in the transplant area.

DWM: Right.

LD: And I'm part of the Network so, and I'm in a leadership position, but having said that…because I've served as President of the local Network for an extended period of time and I've been President of the National Forum which is the organization of Networks and I'm still serving on that Board as an ex-officio member but we are troubled. So let me get to you the basis of the trouble. We're a troubled set of organizations because we've not grown and matured in terms of the way we do our work going forward. We've remained… and this is the responsibility of CMS and I would put the onus on CMS and the rest of the community, not the Networks per se because I think they have a difficulty in fostering change because of the nature of Networks; they are the contractors to CMS and there's a perception of conflict of interest and they don't have a lot of … But the rest of the community have failed, in my judgment, and this is not the first time I've said this. They've failed in fostering this program. So where have we failed? We've failed across almost every front that I can think of, to be frank with you. We are stuck with the same measures that we were measuring 45 or 100 years ago. I mean, it's enough already with dose of dialysis, you know what I mean. I mean and you know, anemia. What are we doing? Anemia, you know… So we're stuck with a very small focus and set of measures and then we move from that… You think about this. We move from that to this Fistula First Project, which is obviously a needed area of repair. Right? And then so what do we do there as like a fundamental question. Fistula First is essentially; it's more complicated than

this but, at one level it's the need to change the surgical procedure. _____ change … but the end result is we're going to change the surgical procedure. We're going to change what surgeons actually do with the two patients in terms of putting an internal shunt in versus external, etc. So you would think that by this stage, I don't know five years into the program, that some how or other we would have been able to secure anonymous data on surgical practice patterns so we could share it with the surgeons. Not make it public. So we could share it with the surgeons and show them; hey, you know, this is what you're doing and this is what you're doing compared to your peers and this is what you're doing compared to the… so let's figure out, can we change it. Maybe we can't change it but, you know, at least look at the data. So you know it's failed on that front. We failed to kind of deal with… When I say, we, I'm talking generically we now. …deal with the patient. Because all we deal with is this like dialysis procedure. The dose of dialysis, anemia, a little bit of phosphorus, you know, in terms of the measurement system and stuff. We've been unable to mount any kind of patient safety programs despite the fact that there is abundant evidence that safety is a problem across the board and in dialysis units in particular; we've got data to support that. We've not expanded into any kind of real look at the co-morbid conditions that these patients have in terms of quality improvement, quality measurement and quality improvement. So there's no vision of going forward. In fact, as of today, today, today, there is no plan to develop more measures that I'm aware of at least. You know, and certainly the LDOs are doing some innovative stuff but they're all functioning in silos. And in addition to that, the end-stage renal disease program is one of the few programs, disease-specific programs on a national level, that has some element, some dimensions of a health information database. We've got this whole database out there and what have we done. We haven't even developed it to any extent. I'm exchanging emails this morning with Nancy Armistead from Network 5 because, you know, something called CROWN is coming down the pike. Everybody that knows anything about it says it's going to be a total disaster. The NRAA has somehow or other persuaded CMS to delay its implementation because it's not implementable. And, in addition, people like Nancy who are well up on this, is in favor of not implementing but she has no idea whether the existing system will continue the legacy system will be extended. So, you know, everybody's running around in a vacuum there. So there's total dysfunction. There's no vision of building out a health information infrastructure although there's abundant opportunities to do all sorts of stuff, not the least of which is create a personal health record with pre-population of the data from CMS data which they're piloting in other patient populations but have done nothing. Overriding all of that we have got specific legislative restrictions that speak about the Networks only dealing with the dialysis unit. So we're not actually dealing with the patient, as they move from site to site, that's what the statute says. It's not beneficiary focused. Say if I was advising Obama, I would tell them to redo the program totally. And, by the way, I think it would be inescapable and that's why I don't know why the ESRD community is asleep at this including the LDOs; that if they're going to redo it the easiest way of redoing it is just merger into the QIOs, period. Instead of trying to recreate another whole system. That's what they're going to do, I think. That's what they probably should do. If they wanted my recommendation that's

probably what I would recommend except that I would probably prostitute myself just a little bit and say given my long legacy with the ESRD program, let's give them a break and let's create a legitimate program within the ESRD program to cover ESRD and some element of CKD but cut across settings. So give them the right to deal with the patient across settings, etc., etc., put an agenda together for a measurement system and then build a health information infrastructure to support that measurement system as well as to support practice. So, you know, drive built on the national stuff and I know Frank's doing a lot of work in this area. But, you know, he will be the first to admit that he's futzing around at the margins, right. I mean he's not getting… You know what I mean; he's not going to get any national ….he's not going to get, you know, 30% of the market in the next three years. We need penetration. We need adoption…

DWM: Right.

LD: Of something; not necessarily the chronic health record but you could start with a personal health record which would include a medication record which would be a big, big gain and begin to do some kind of coordination. So that's a long-winded way of saying, I don't know where they're going. And another time I could talk to you about where they're really going but…. And in addition, what was I going to say? Oh, the comment I wanted to make was that CMS has also, in addition to being _____ with the rest of the community, have made it particularly difficult for the Networks to function. They have functioned in a very autocratic way and they've essentially precluded the forum from functioning by putting all sorts of restrictions on them about what monies they can or cannot use. So for the last two years, plus or minus, the forum has attempted to remake itself based on a whole new configuration of how they're going to function and where they're going to get their funds from, which is not a lot of funds in the first place.

DWM: Right.

LD: By the way, I include the LDOs in the community. You know I don't know exactly what the thinking is of the LDOs. I haven't spent time with the senior people out there but my sense is they would sooner have the Networks go away. The problem with that is I don't think they understand the alternative. There's got to be an alternative. It's just not going to go away and nothing's going to happen. The whole system we're involved in is based on; we want more and more accountability, more and more transparency and all of that is, kind of, very complicated. I'd forgotten to make a comment earlier about my lack of support for public reporting because I think the LDOs, some of the folks that I've met with without naming names, their senior staff, are "strong and passionate believers" of something called public reporting of measurement. And the problem with that is I don't think they understand the implications of it. I don't think they understand the complexity of measures and I don't think they understand; and I'm not being disrespectful to them totally because it's widespread, I don't think they understand the complicated nature of measurement and the need to build infrastructure to facilitate

improvement which is not driven by measurement alone. And you know the literature that's now surfacing, not just in end-stage renal disease but across the board, is that we're not achieving the quality improvement that we ought to and that clearly public reporting in and of itself appears not to be working the way we had hoped it. We know for a fact that patients are not using the information, which was one of the premises of public reporting. We have some soft evidence that it may be changing behavior but that's not strong at the moment. What I think is the problem is that we don't have a balanced approach of public reporting with some flexibility because measures change, with the building of infrastructure. What I mean by the infrastructure is; build a healthy information infrastructure to support the measures but that's only one piece. But build educational opportunities for professionals and for patient engagement and change the culture within the institutions that we are talking about which is absolutely fundamental to change within institutions. And by institutions I mean the doctor's office, the dialysis unit, the hospital; that's with institution being kind of broadly spoken. So I'm not trying to make this more complex than it really is but it is complex.

DWM: It is very complex.

LD: And it's not just simple, you know, we're going to put these measures out. And you know the fascinating thing about all of this Dugan is that the people are pushing this… well firstly they're desperate. You know, the private sector purchases and CMS, they're desperate to facilitate change so they're grabbing onto anything they can. But all of them purport to be interested and committed to something called evidence-based medicine and evidence-based policy making but they totally ignore the evidence. There is no evidence to support what they're doing but they keep doing it. It's just, like, fascinating. I mean, it's absolutely incredible. So, I'm pessimistic about the Networks going forward and I'm afraid, you know, it may not reach the threshold of interest because of all the other issues.

DWM: Right. It may just lay at the bottom.

LD: Yeah. It may just kind of drift along there but you know there is going to be an interest. So I don't know whether it's going to attract attention but I'm surely convinced myself that organizations such as the LDOs and RPA and NRAA and the stakeholders will find themselves asleep at the switch if it does come down the pike.

DWM: Yeah.

LD: Yeah.

DWM: It brings up a couple of issues. These may not be related but just as, you know, you're talking, I'm thinking about a couple of things. One is, you know, I've talked to people about the early days in dialysis. Thinking about quality and quality improvement in its very rudimentary

form in the early days of dialysis when none of these, you know, tools were in place. There was this culture though that people were trying things and when they didn't work they were announcing it to everybody; don't try this, this does not work. And you know, everyone understood; meaning providers and patients, that nobody really knew what would work and so they were willing to accept that there would be mistakes made but that opened up the opportunity for improvement. And it seems to me that one of the things that is in our culture today is nobody wants to talk about mistakes and without the ability to, in a healthy way, talk about mistakes you can't talk about improvement.

LD: Right. And I agree with you on that. I think we do not spend enough time. And I think it's partly a cultural issue, it's partly the malpractice environment that we're living under.

DWM: Right.

LD: And I think, I don't know this for certain for obvious reasons, I think it's partly the competitive environment we're living in.

DWM: Sure.

LD: You know it's not totally… I don't think it's totally a happy situation and I haven't studied this because I'm not that involved in nephrology any more, but the concentration of the dialysis units can't be a totally happy situation. And every time I hear of one of the LDOs buying out another group of dialysis units, but more importantly buying up the supply chain.

DWM: Um hmm.

LD: You know, buying dialyzers and buying…I think I saw some stuff recently they were buying some of the drugs.

DWM: Yes.

LD: So pharmaceuticals.

DWM: Yes. Yeah.

LD: So this gets back to my old roots I guess. I'm not sure that that kind of concentration of market power is good for us and I think there's probably some economic theory behind that as well. I guess it's not totally clear to me what's driving this other than profits. I don't want to be disrespectful to the leadership of those organizations.

DWM: Well, but in their defense, I'm not sure, for example, that CMS would be unhappy with that type of vertical integration in the sense that CMS wants to pay less money for a treatment and if there is vertical integration perhaps that treatment can be provided.

LD: Right.

DWM: Meaning they can buy the dialyzers, they own the dialyzer company, they own the machine company.

LD: Right.

DWM: They can provide the treatment for less money.

LD: Right.

DWM: You know, that CMS may not be unhappy about that.

LD: Well you may be right and I guess the question is …

DWM: CMS has, you know, in fact driven some independent people out of the market.

LD: Correct.

DWM: Whether it's manufacturers or whether its…

LD: No, you're right.

DWM: Because there's such price pressure.

LD: No, you're right. As an example, I don't know all the details about this whole CROWN Web rollout. The independents were given a raw deal on that question. I don't know if you know what I'm talking about.

DWM: I don't know the details of it.

LD: It has to do with the data dump and whether batched data dumping…

DWM: Yeah.

LD: Can be done.

DWM: Yeah. Yeah. Right.

LD: And the independents are restricted from doing that, etc.

DWM: Right.

LD: So they're really making it difficult for the independents…

DWM: It's just one more thing that, you know, you can't quite manage.

LD: Yeah. Very difficult. Yes. Yeah. So, you know, I would be less concerned about it, what, if I knew there was; not knew with certainty necessarily but that there was a somewhat more robust oversight system in place.

DWM: Sure.

LD: And a measurement system.

DWM: Right.

LD: That could allow for a lot of this integration going forward.

DWM: Are quality and outcomes the same thing? A good outcome and quality care, are they the same thing? I mean, we measure…one of the things that we've been able to measure a lot are outcomes. Are they the same thing?

LD: Well the way I think about it at least, Dugan, outcome is one metric under the quality broad definition. So the way I think about quality at least; quality has multiple dimensions attached to it, outcomes being one. Outcome being, by definition, a change in the patient's status. So my own personal way I think about quality is I like the definition that the IOM have articulated which says something to the effect of; achieving the desired outcomes of patients and populations within the context of available knowledge, or words to that effect. So, what that captures is the word desired which speaks to desired by whom. So it has to do with going back to the patient focus and asking what does the patient actually want. So the way I think about quality is within that broad definition there are multiple dimensions that we need to review when we're thinking about how do we actually measure quality. _____dimensions. One way of thinking about it is measure structure, process and outcome so you've got to measure all three. And all three of them in some kind of way give you a look at the picture of quality. A structural measure would be, you know, a dirty room without a fire escape, is not a quality room in a hospital, as a crude example. A process would be a process measure, something you do to the patient. So patients deserve to either receive

or not receive certain therapies so process becomes a dimension and then outcome being some kind of desired outcome. So that's the one set. Then another look at, which is not mutually exclusive, is to speak about what does or does not occur with patients and to patients along the dimensions of under-use, overuse and misuse. So under-use is pretty straightforward. Overuse, which is less straightforward because we're not sure how to measure that, although there's going to be a lot of interest going forward. Then the misuse is errors and related stuff. So that's, in my mind at least, the second structure _____. Then a third dimension, as I think about it, is speaking about the patient's perspective because that becomes a dimension that speaks to the quality. So getting input from the patient about their perspective becomes an important consideration as we think about it. So this is not a simple construct because there are multiple dimensions.

DWM: Yeah. I mean you're talking about a three-dimensional model and most of us…you know, we want a simple answer. You're not helping us here _____

LD: No. I understand that. I understand. But I mean the problem is it's not that simple.

DWM: And if you talk…

LD: There's a fourth dimension that has to do with, which is kind of covered by the other two, which is covered by something called a flaw of performance. What do I mean by that? Cutting off the wrong leg is a no-no so that becomes a kind of flaw of performance. Then you have something driven by something called evidence; what we do or do not do with and to patients based on evidence, which is obviously an imprecise science. Then the third bucket in that dimension becomes the patient's preference. So overriding all of this, I think if you had to push me and say, so give me one answer. You know what I mean. I would say it has to do with the patient. It has to do with, what does the patient desire, period. So at one level you could say that offering the patient something is a dimension that is absolutely required but whether they receive it or not based on their choice becomes an open ended question. The best example I can give, not the best but one of the examples I can give, is the mammogram story. You know, you could say that, you know, recommending a mammogram because the evidence says that women over the age of 55 appears to be a reasonable standard of practice. Actually getting the mammogram is a separate question because there are females, because this is a female issue, who don't want a mammogram for whatever reason. Some of them are religious, some them just don't want to know or… so that becomes attention about what do you actually measure. So it comes back to the patient in the end. Right? About what the do and do not want. So I don't have an easy answer. I happen to be one that believes, Dugan, that we can measure quality and we need to do it across multiple dimensions and we need to measure it based on the best tools that we have available today and then improve the tools going forward and not wait for the better tool.

DWM: You're also sharing the responsibility of the provider offering the service or the care but then laying some responsibility on the patient to accept or not accept it.

LD: Correct.

DWM: And that's a very difficult for some patients. Some patients don't want or can't assume that responsibility for saying yes or no; well I don't know, you know best, tell me what to do.

LD: But that's fine. In my paradigm that's fine.

DWM: But in the current climate it leads the provider to do everything.

LD: Correct; and that's part of the problem.

DWM: Yes. And you get overuse of _____

LD: And we're going to see more and more of that being dealt with because there is a big national push now to… and I don't think we've fully thought through all the implications of…

DWM: Right.

LD: Of dealing with something called shared decision-making.

DWM: Yes.

LD: And I think, you know, we're going to see an evolution; I'm overstating the case a little bit, an evolution away from something called informed consent to something called shared decision-making. Now this is complex. It's going to take a decade to deal with but it does deal with what you're speaking about and that gets to my point earlier about that one of the imperfections of measuring performance has to do with that issue.

DWM: Right.

LD: That performance becomes, to some extent, dependent upon the patient. There is a tension there about what the patient does or doesn't accept. That's even just at the fundamental question of whether to accept a treatment or not that doesn't even talk about, you know, taking medication over an annual basis four times a day.

DWM: Yeah. But it does then leave physicians with performance being measured and yet they are…to some extent their performance is influenced and changed by their patient population.

LD: Correct. Yes. So I mean it's a…

DWM: It's a difficult…

LD: It's a terrible dilemma. I'm doing some speaking on the circuit and one of the current talks I'm talking about is measuring physician performance and talking about the challenges of measuring physicians and there are a lot of them but I start off the talk by, kind of, trying to protect myself a little bit by saying that I am committed to professionalism and I am committed to professionalism which implies, specifically, ongoing learning as part of our professional responsibility, measuring our own performance which is part of the professionalism ethic and reporting to the public. Because that's part of the professional notion that we've taken it upon ourselves, as physicians, that responsibility and now we're going to be held accountable to the public. So having that I'm committed to those, I then make the point that I don't know what to report because, for the reasons I just mentioned, because I mean I know what we're reporting but it's all kind of garbage at the moment. We're going to have to figure that out going forward. What are we actually going to report to fulfill our leaving aside employers want it and CMS wants it, we have a responsibility to do something and we can't just report that we're licensed; that's nonsense. I mean I haven't practiced since the early 90s and I'm licensed in Maryland. I could open an office across the road here. I couldn't get privileges at a hospital but I could open up an office and nobody would know the difference. When you think about that, that's a dangerous event. Since 1991 I haven't practiced out of, you know, my own choice.

DWM: _____. Good luck with that.

LD: Yes.

DWM: As we just wind up here I just want to make sure; I know we've talked about a couple of your mentors. We talked about Dr. Eales.

LD: Right.

DWM: Are there other people that you really look at and say, yeah, you know, these are people that really influenced me or I respected what they did, they changed, you know, they made progress in what we're doing today in medicine.

LD: In medicine generally?

DWM: Yeah, sure. Nephrology in particular. I mean I would certainly say as a collective group we're talking about the RPA, I mean this early group of people who really recognized the need for the RPA. I mean that made a difference in what's happened for reimbursement and to some extent…

LD: As I think about that, it's a little bit more emotional than that. I do think about my parents. My late father was a family practitioner and he actually graduated at Cape Town and went to Edinburgh and came back to Cape Town. He was the first in his family to go to college. He then opened up a practice in an elite area, the beachfront that we lived in, as well as in the ghetto. The first doctor to go actually into the ghetto. And my mother was a real strong individual and had a lot of influence on me. So I'm guessing that they had a lot of influence in me. I mean given my bent in public policy, I'm not sure how many people actually influenced me…

DWM: Yeah.

LD: Per se… at the kind of way you've raised the question but I certainly had, and still have, a lot of respect for the folks in the nephrology community who lead the RPA in the early days. I mean I obviously have a lot of relationships with the RPA. It's just not the RPA, it's what they stand for and what they've done. So those guys, you know, Chris and John Sadler and Capelli and Dick Friedman who was just a terrific guy but unfortunately he's gone. There was a guy called Norman Dean _____. They were all interesting folks and all innovators. You know there are a lot of people, not a lot of people, but there are people at the ASIM that were involved in the public policy arena. There was guy called Joe Boyle who was the Executive Director of ASIM who was just as smart as a whip and as ethical as hell and did a terrific job at fostering the membership and the leadership of ASIM. There were a number of leaders there in the early days that I was there that were really, kind of, shining lights going forward. I guess those would be the people that I have a lot of respect for and obviously there are some current people. Who do I think about? You know, I think about people _____ is someone one kind of looks up to, this guy Don _____ who I know quite well and has done a lot of work in the quality area, has been knighted in England. I mean he's not a personal friend of mine but we know each other and speak to each other. And just watching these people kind of drive change and do the innovate work that they've done, you know, continues to influence me. I think the bottom line is… You know George Schreiner, he and I had a very interesting relationship. I would hope that he thought it was a close one and a professionally stimulating one. We disagreed on a number of things on a lot of these public policy issues, etc. I mean they were disagreements but they were always done in a professional way so I've always had a lot of affection and respect for him over the years. I haven't seen him for some time. So those would be the kind of people that I think are out there. But I guess, you know not getting too emotional and personal, there's something inside that drives me. I'm not sure how much I'm driven by… I'm driven by external events but I'm not sure about driven specifically by people.

DWM: Well you certainly blazed your own trail. I mean you…

LD: I did what I wanted to do and, I mean, I've had a terrific run. I've enjoyed every moment of it.

DWM: Right.

LD: I've just enjoyed every moment of it.

DWM: You've had a lot of, you know, role with government and CMS and do you think that government has actually been helpful in the progress in healthcare over the last 30 years?

LD: You talking about federal government?

DWM: Yeah.

LD: Yeah.

DWM: Is it a good thing or a bad thing?

LD: You know I think in general, you know, change is very difficult and dealing with culture and existing systems. I don't mean to be defensive of… but I think that the federal government at the CMS level and the Medicare program; I'm not sure about the Medicaid program, but the Medicare program has in fact been quite innovative in some of the stuff that they've done. I think some people would conclude, and I conclude, that of all the programs we have out there of various private sector health plans, etc., that Medicare is still the shining light out there in terms of the way it functions. Now I understand the cost escalations and I understand the notion that there is significant quality problems exist but they've made significant advances. So I would be unable to choose between something called the private sector and something called the government right now. But if you forced me, I think I would go with the government's system. We might have a better shot, I'm not specifically pushing for something called the single payer system, I think we might have a better shot at getting stuff done than we have with the current fragmented private sector system which appears to be unable to do any kind of collaboration.

DWM: Yeah.

LD: I think of the private sector plans and think about how can they get anything done and how can they work with physicians when most physicians are signed up with, you know, 20 plans, unless they do some kind of collaboration. It isn't a patient-focused system. So that's a long-winded way of saying unless we can get collaboration I would probably end up going with a federal government system.

DWM: Yeah. And a patient focus which has really not been…

LD: Oh, it's got to be patient-focused otherwise it's not going to work. You can't continue to do _____.

DWM: No.

LD: Dialysis units and nursing homes. You've got to move faster than you're currently moving and you've got to make some tough decisions. You know and we're moving in that direction, as you know. I think it's going to take a little time. This whole comparative effectiveness initiative, which is getting support from the federal government, namely to compare therapies against each other. Which we're not doing right now, as you know.

DWM: Right.

LD: We compare therapies against nothing; drugs and other procedures, etc. So doing this comparative effectiveness stuff is going to be important. But you know I was reading an article in the BMJ recently; they've had a comparative effectiveness project there for some years. They've got a national institute called NICE that stands for, something clinical excellence; the National Institute for Clinical Excellence, I guess it's called. So you know they've made decisions on rationing and restricting stuff and the political system just doesn't allow them to do that because it's the rescue phenomenon. So that's a long-winded way of saying in my lifetime we're not going to solve a lot of these problems. It's just too complex right now.

DWM: Right.

LD: Yeah.

DWM: Well, and you may have answered this already, but what do you think will be the innovations and the improvements that we'll see in the next 10 to 15 years? What are you hoping for? Even if you don't believe we may actually see it.

LD: I don't want to talk about what I'm hoping for but I can tell you, because that's too idealistic, but I think what we will see is more use of information technology with the ability to connect providers to each other and to connect the patients to providers. From that I think we'll see much more, which I'm hoping will come, home monitoring of patients of all sorts of stuff; I don't just mean dialysis, I mean blood pressure, weight, etc., etc. with downloading of the stuff into their own personal databases and back to physicians. I think we'll see much more care being delivered by physician extenders either as part of a team or on a freestanding basis. We're already seeing that to a large extent and the public are beginning to flock to that. It's becoming increasingly evident that a lot of the conditions that are currently receiving care don't need high-powered physicians.

DWM: Are practice guidelines an important part of that?

LD: Yeah. I think practice guidelines will become a part of that and what I'm hoping; now I want to express a hope. What I'm hoping is that we will have a much more robust system of generating the evidence which we converted into the guidelines which get used, which then get modified and we move the cycle of 10 years down to some reasonable figure. And that's going to require what is called a learning system to allow that to occur. So for instance, you know, if I could attract the attention and hope that the dialysis units, the LDOs, would get off their high horses and the three of them sit down together and say, what can we do together without damaging our competitive advantage. Let's see what we can do about building a health information infrastructure that we can innovate on top of but has some standard features that we can all use across the system and we can then merge some data and build the capacity to learn from what's going on. And not only be trapped with, you know, the 10 measures that we've currently got. Have a much more robust mining and analysis of the data. So I think we'll see a much more robust national measurement system to measure performance. I'm hoping, so I'm going to throw hopes in here, that the personal health record will take off because I'm a big proponent of the personal health record, which is different from the electronic health record. It's something owned and operated by the patient but then shared with the practitioners and inputed by their professional team and if we could get that done I think we'd have a big movement in the right direction. It's almost certain that we're going to see payment systems that cut across settings. We're going to see episode-based payment systems as the, if you will, the next iteration of payment reform. What do I mean by that? I mean hospitalizations plus 90 days or 160 days for X conditions where it makes sense and some forcing of the coordination that needs to occur as patients are discharged and treated in the community. I'm not optimistic about the consolidation of practices. As you may know the small practice setting has not changed in the last decade.

DWM: Right.

LD: In terms of the number of physicians doing it in onsies and twosies. So the question is, can we actually drive a virtual consolidation of physician practices? And what I mean by that is, some community of activity where there's a lot of sharing of information and this requires an information infrastructure to do, and some relationship between the physicians in a given community that looks like a group practice but isn't a group practice.

DWM: Business wise it's not a group practice.

LD: Correct. No governance.

DWM: But patient care wise.

LD: Correct.

DWM: Yeah.

LD: And you know where the standard becomes the standard that I was used to. You know we've got data out there today that says; and I can show you the data, that large numbers of patients don't get results shared with them, either negative or positive results. That something like, you know, 50% of specialists who see patients don't send reports back to the primary care physician. That's what the data shows on a national level. I mean the figures are stunning. If you want I can send you some of the data. It's just, like, stunning. And I keep saying to people, you know, I don't want to keep going back to where I was before but when I was in practice in Cape Town working with my father on locums and stuff. I was a primary care physician. Sending a patient to a sub-specialist or specialist for a consultation and not getting a report back would only occur once. Would only occur once because that guy or that gal would never; there weren't a lot of gals then, but the guy would never get another referral. I mean I'm overstating the case a little bit but it, like, never happened. You know what I mean. It was, like, just doesn't happen. They pick up a phone, they tell you or they send you… I mean. But here it's like common practice. So I'm just hoping that that kind of problem will be beginning to be eaten into where it becomes the norm that coordination occurs.

DWM: And communication.

LD: And communication. Yeah.

DWM: _____.

LD: And that's why to some extent I'm beginning to speak at some level in opposition to something called the advanced medical home. I don't know if you know what I'm talking about. The advanced medical home is the new iteration of the American College of Physicians and American Academy of Family Practitioners to articulate how to rejuvenate primary care. What they're saying is that patients have to have a medical home.

DWM: Ah.

LD: A medical home. And the medical home has to be…

DWM: A primary care coordinating physician.

LD: A primary care coordinating physician, etc., etc.

DWM: Hmm.

LD: So it's called the advanced medical home and there are all sorts of demonstrations occurring funded by CMS and pushed by these two groups and clearly there would be payment. You know, like $40 a month.

DWM: For oversight and coordination _____.

LD: For oversight and related activities. So what are some of the problems with it? The first problem was they actually, I mean it's remarkable, they actually rolled out the program over a long period of discussion and internal futzing around with the criteria. They never really engaged the patient and consumer community in any kind of significant meaningful way and when they eventually did the patient groups kind of said, you know, we don't like this term; medical home. Which is interesting because it sounds like it's like the deathbed. It's like, you know, the medical home. You know. But it's a different perception. But the more substantive point that I'm concerned about is that is that, and I'm obviously not opposed to the medical home, I'm in favor of it, is the kind of perception that it will give. Namely, that there's this one physician, or this physician group, that's responsible for the coordination because that then translates into all the other physicians; for Medicare patients could be as many as six or seven other physicians, that they have no responsibility for coordination. You see and I'm saying some how or other you've got to put in place an accountability system that everybody's playing, not just the person who's getting the $40. It was designated as the advanced medical home. So that's the long-winded way of saying we've got a long way to go to deal with this kind of change in culture but I'm hopeful that this question of coordination of care will be dealt with; that we'll see substantial improvement with this coordination of care issue. I think that's really one of the big issues. I guess I'm cautiously optimistic that we'll deal with the uninsured issue.

DWM: Yeah.

LD: Yeah. I'm not sure about it. And, sorry, there's one other issue. I think, and I've already said this, but this comparative effectiveness initiative as well as another initiative at the National Quality Forum, which is dealing with the six national initiatives that they want to drive. One of which is overuse. I think as we move down this debate of overuse, which we are now starting for the first time in a meaningful kind of way, I think that's going to fundamentally change thinking and perhaps move us over a decade; so it's going to take a long time, over a long period of time to deal with this question of, so how do we deal with these resources and how do we deal with individual physician judgment and patient preference within the context of, you know, not everything works and not everything needs to be done for patients. So, yeah, that's what I think is going to happen. Unfortunately, I'm not optimistic about the end-stage renal disease program and the CKD program because I just have a sense that the leadership has gone. What do I mean by that? I don't want to keep picking on the LDOs but the LDOs are functioning in silos.

DWM: Yes.

LD: And they want to get control of the dollars and push a bundle where they can control more. You know, the big other player, Amgen, is kind of lost in a big problem with their drug and they've made a lot of profits. The other major player, and I've got a lot of respect for RPA, but they've got so many problems that they're dealing with at the fundamental practice level and the reimbursement level for physicians and demonstrating value to their patients, you know, on behalf of the physicians. They're going to have a tough time dealing with the big picture question of, how they are going to reorganize this program.

DWM: True. And then having said that, I mean, the end-stage renal disease program and population; we do have the opportunity that, I mean, our data is very amenable to electronic health records and sharing of data.

LD: Yeah.

DWM: And we do at least begin now because we're talking about CKD stages, we're beginning to have this vision that it's not just dialysis but it's the care of the patient, you know, who from the moment they have diabetes and hypertension. So ESRD has had the opportunity to see, sort of the more global care, the lifetime care of the patient and the sharing of data and the ability to report and look at data.

LD: Yeah.

DWM: I mean we do have those advantages over some other…

LD: Terrific advantages. So, say, if you do push me on my hope; I think if I had to give you one hope for the end-stage renal disease program and I've tried this a couple of times with the forum and with RPA but not succeeded in getting them to deal with the question. It builds off what you've just said. There is a fundamental health information infrastructure, a floor that has been created, within the end-stage renal disease program; starting with just the end-stage renal disease program and what I would have hoped that they would've done, given that there are massive significant efforts occurring at the national level to go through a process on a coalition basis, a multi-stakeholder group that's the RPA, the patients, you know, the full spectrum, NQF, the LDOs, etc., going through a process of actually informing themselves, maybe it's a two-day conference, informing themselves day one of what's going on at a national level with regard to health information infrastructure, the build out. Because significant stuff is going on. And then simultaneously having conducted a structured inventory of what's going on in the end-stage renal disease program. What does it look like, the health information

infrastructure? What is the penetration of the electronic health records? What is going on in the LDOs? Describe it and then figure out what the gaps are.

DWM: Yeah.

LD: And then figure up what a road map would like for building out what we need to build out and build off what's going on nationally and build on what the current state looks like. And use this as a, and starting with the end-stage renal disease program, not the CKD program which is a step more complicated, but you could then rapidly jump to the CKD program which means integrating various activities with the rest of the healthcare delivery system. But I think you've got to _____ start with the ESRD program and then build a road map for building it out and then move it into the CKD program. But, you know, nobody's kind of… I mean maybe the message was not well put, you know, maybe there are just too many other problems that they're dealing with. Who knows? I don't know, you know. I just find it remarkable that the majority of people, given what you've indicated that there's this fundamental framework that _____ the majority of people have no idea what's going on outside their world. I mean you talk to Frank and he knows what's going on. He'll tell you the same story; that the majority of them don't know what the hell's going on. And I think that's a big mistake for them because they lost it and they're losing a big opportunity

DWM: Right.

LD: So that's why I'm saying I'm not that optimistic of fundamental change in the ESRD program although a couple of leaders standing up could make it happen. It's not going to be me but… You know, I'm passed… I will try, but it's not going to happen from me. I don't have the credibility any more.

DWM: Is there anything else; something we have not talked about today that you think is really important to make sure we record today? I've kept you a long time. I know.

LD: You know, I don't think so.

DWM: We've covered a lot of ground.

LD: I think we've covered a lot of ground.

DWM: We can always come back.

LD: Yes. I understand.

DWM: If you think we need to spend 20 minutes talking about this I mean I can bring my recorder anytime and we can do that.

LD: You know, Dugan, I don't think so. You've asked some good questions and I've spoken more about a lot of different things. I'm sure there are other events out there that have slipped through my memory but, you know, I think I have a sense that we've captured a lot of the history of what's occurring and certainly the evolution as I passed through the system. And, as you know, I've moved out of the end-stage renal disease program.

DWM: Sure.

LD: Yeah.

DWM: But I mean I think all the quality stuff is definitely relevant and was born out of that for sure.

LD: Yes. Yes.

DWM: Well, you know, again as I finish and put this together and if you listen to it and say, ah, we should've spent…we can always do it, it's very easy to do that.

LD: Sure. I understand that. Yeah.

DWM: I really appreciate you letting me come today to talk with you.

LD: No problem. No problem.

DWM: Good.

LD: Good to speak to you.

END OF DICTATION

Dugan W. Maddux, MD
DWM/dlb
T: 01/17/09