



The New Zealand Liver Transplant Unit

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The splendid performance of the New Zealand Liver Transplant Unit (NZLTU) and its associated surgical and hepatology specialists outlined in this issue of the NZMJ gives cause for both celebration and reflection. Celebration, because the NZLTU is delivering, no exceeding, the services we all hoped for. Reflection, because its establishment was a triumph of shared clinical and political vision in spite of intervening ideological and government changes, financial constraints, periods of profound calm in the Sargasso Sea of bureaucracy, PR blundering and local rivalries.

In December 1993, the Ministry of Health requested the NZ Society of Gastroenterology (NZSGE) provide national guidelines on liver transplantation. Their primary concern in doing so was to systematically prioritise categories of patients, and to limit transplantation to “those...most likely to benefit regardless of how many transplants are available”. The NZSGE President at the time, Philip Bagshaw, and I consulted with international experts. It is fair to say that the directors of the overseas units (Strong-Brisbane; McMaster-Birmingham; Krom-Mayo, Toouli & Padbury-Flinders; Turcotte-Ann Arbor) were bemused by the tenor of the request, suggesting that it had little to do with liver disease or transplantation as they understood it. Nevertheless, we examined policy documents, reports and articles from overseas liver transplant centres, surveyed all members of the NZSGE, and produced guidelines by March of 1994 that supported the establishment of a single, nationally-funded liver transplant unit. Society members suggested that the unit should maintain close relationships with their Australian colleagues, establish its own clinical criteria, and be subject to regular informed monitoring and annual public and peer audit.

The Ministry of Health (MOH) remained keen on criteria and priority, and members of the NZSGE (Bagshaw, Nigel Stace, Cliff Tasman-Jones, John Wyeth, Mark Lane, Randall Allardyce) drafted a suitably flexible document. The first meeting to discuss patient prioritisation and guidelines was held with Colin Feek, Andrew Holmes, Peter Hunter and Ingrid Ward on 1 June 1994. Shortly thereafter, the NZSGE were contracted by the MOH to further develop criteria for patient selection and a system of prioritisation. Thanks primarily to Tasman-Jones and Stace, another suitably flexible document resulted. In September, the MOH, Core Health Services and Regional Health Authorities (RHAs) facilitated the establishment of a group to take responsibility for liver transplantation, and progress toward a national unit began with the inclusion of Ray Naden (Northern RHA) to the group. In November 1994, Bagshaw, Stace, Peter Johnson, Tasman-Jones, Tony Smith, and Allardyce were appointed to the New Zealand Liver Transplantation Advisory Group (NZLTAG) by NZSGE. They were to work with the RHAs to manage the existing demand and funding, as well as to advise on the selection of tenders for an NZLTU should that be decided. Other members of NZLTAG have included Martin Schlup, Allison Wesley, Dawn Kelly, Ross Wilson and Mike Strettell.

Later in 1994, Paul McMaster and James Neuberger from Birmingham were invited to address the clinical demands of liver transplantation at the annual NZSGE meeting organised in Christchurch by Bagshaw and Allardyce. In mid-1995, we visited the Birmingham Liver Transplant Unit to ask McMaster, Neuberger and Elwyn Elias if they would assess the circumstances in Auckland and Wellington for siting, staffing and resourcing an NZ unit and prepare a written submission. They agreed and McMaster agreed to help establish an NZLTU for its first three to six months should that be necessary.

Ray Naden resigned from the Northern RHA and Maryanne Boyd took over. The project languished until 1996, when the CEOs of the four RHAs set up a Liver Transplant Purchasing Project Team under the chairmanship of Barry Taylor (Central RHA) and coordinated by Marion Clark. The other members were Colin Feek, Paul Malpass (Midland RHA), Waseem Niazi (North Health), Ron Craft (Southern RHA), Bagshaw and Allardyce. In May 1996, a Request for Interest was issued and, later that year, service specifications, a Request for Proposals and tenders from Australian and New Zealand hospitals were produced and considered, and the show was once again on the road. Or so it seemed until an over-enthusiastic manager in Auckland prematurely announced to a journalist that they had won the contract for the national liver transplant unit. The Commerce Commission also became involved because – wait for it – a single liver transplant provider would not fit into the competitive model. The Wellington clinicians and managers were justifiably upset and responded strongly. There was no alternative but to go through the entire tendering process a second time.

Auckland did win the three year contract in June 1997 and quickly attracted the wealth of clinical and management talent that is represented by the articles in this issue. Notably, Steve Munn returned from leading transplant surgery at the Mayo Clinic to head the Unit. Ed Gane (hepatologist) returned from King's College Hospital, London. John McCall and Jonathan Koea developed specialist hepatobiliary and transplant surgery. Stephen Streat (intensivist) did much of the initial costing and protocols. Kerry Gunn came back from Seattle to head the anaesthetic team. Mee Ling Yeong brought extraordinary histopathology expertise. Kay Hyman, Manager of Surgical Services at Auckland Healthcare, was always supportive. Dawn Kelly (nurse) came from King's to be the first liver transplant coordinator. Numerous people from Auckland Healthcare went overseas to upskill. Teams included OR nurses, ICU nurses, a clinical nurse specialist, ward nurses, radiologists, pathologists, dieticians, anaesthetists, technicians and surgeons. The Unit opened in December 1997, and two years later, with major support from the New Zealand Lions Clubs, it commissioned its associated local accommodation, Transplant House.

The opening of the NZLTU has brought many emotional, financial and clinical benefits to patients and their families. In addition, the inevitable growth in specialist hepatology associated with the Unit has occurred at a time when those services are rapidly becoming necessary to deal with hepatitis B and C. Under Bagshaw's chairmanship, the NZLTAG still reviews annual reports from the Unit and oversees decisions relating to difficult paediatric cases. Despite the high clinical and economic performance of the NZLTU, there are still two problems that must be solved. The first is to find political and managerial solutions to provide national or shared financial support for the Unit in the wake of regionalised and population-based DHB healthcare

funding. The second relates to reducing the waiting-list mortality by adopting new, more effective donor pool strategies.

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