

Commissioner James L. Goddard, who will head the task force for the President, believes equivalency can be established for some 50 drugs in an 18-month span.

The message, by and large, is a message for the future; budgetary exigencies prevent the immediate start of any bold, new and expensive programs. The sum total would increase the Federal health budget from 1968's \$14 billion to \$15.6 billion for fiscal 1969. This, however, is largely the increased costs of existing programs.

Five major new goals, including the reduction of infant mortality; meeting the need for more doctors, nurses and other health workers; dealing with the soaring cost of medical care; lowering the toll of accidental deaths; and launching a nationwide volunteer effort to improve the health of all Americans, will take "years to achieve."

A notable omission from the message—reportedly deleted less than a week before its delivery—was the long-expected reorganization of the health part of the sprawling Department of Health, Education and Welfare (SN: 3/9, p. 231).

Acting Secretary of Health, Education and Welfare Wilbur J. Cohen, who was, with Former Secretary John W. Gardner, the architect of a plan to reorganize the Public Health Service so the National Institutes of Health would be independent, says the reorganization is being held up from 30 to 60 days until a study is completed embracing the health activities of the entire Federal Government.

CARDIOLOGY I

A plea for a transplant moratorium

To transplant or not to transplant? The question dominated the 17th Annual Scientific Session of the American College of Cardiology which ended in San Francisco last week; it is a riddle with several answers, none of them final.

Dr. Christiaan Barnard, 44, the South African surgeon whose pioneering efforts made the issue more than an academic question, said yes.

But three of America's top cardiac specialists begged for a moratorium on transplants until the results of the first six are exhaustively evaluated and the results published in the medical press.

They are Dr. George E. Burch of Tulane University, New Orleans, president-elect of the college; Dr. Eliot Corday of the University of California at Los Angeles, a past president, and Dr. Simon Dack of Mt. Sinai Medical School in New York, another.

Even though Dr. Barnard's second transplant patient, dentist Philip Blaiberg of Cape Town, was still alive, two full months after his surgery, the three Americans said they are not satisfied that the enormously complicated problems of tissue rejection have been solved.

Dr. Burch was especially emphatic in his views. "I would not select any patient for a cardiac transplant, because once you take his own heart out, you know he's going to die," he said. "His new heart will be rejected by his body because we are still unable to suppress the immune reaction."

Dr. Corday echoed the sentiments. "Until we overcome the fantastic problem of immunity, we'll have a tremendous mortality rate from transplants," he said. "So, until we improve the state of the art, I say the risk is too great."

Dr. Barnard defended his historic operations with equal vigor. "A doctor has one duty and one duty only, and that is to treat his patient until he has no means left," he declared. "If we feel a heart transplant is a method for helping a patient, we must do it."

Nor does he hold with the theory that heart transplants should be viewed as only a last-ditch resort in a life or death situation.

"It is not how long the patient is going to live, but how he is going to live," he said.

Dr. Barnard described the condition of both his transplant patients as miserable in the extreme before they underwent the operations. He said they were unable to eat or sleep, and suffered constantly from complications to their liver, brains and kidneys as the result of poor blood flow from faltering hearts.

Under these circumstances, he said, he felt more than justified in attempting operations that might restore them to some semblance of good health.

But even though Dr. Barnard said his conscience is clear and he will undertake a third transplant soon, the American physicians are approaching the whole problem with extreme caution. They foresee a multitude of agonizing problems arising because of the peculiar nature of the heart transplant.

For this reason, the American College of Cardiology will sponsor a national conference in April in Bethesda, Md., in an attempt to clear the air of the moral and ethical questions which are clouding the American transplant picture now.

The organization will ask for delegates from the nation's major religious denominations, the American Bar Association, medical societies, and a number of other groups.

Dr. William Likoff, president of the

ACC, says the major hurdle to be overcome is to establish firm guidelines as to what constitutes the moment of death.

At present, American physicians generally consider the time of a patient's death as the moment his heart stops beating. But physicians know that a heart can continue to beat for eight hours or more after the brain is irretrievably dead, especially under artificial stimulus.

"But it is no longer true that a person is dead only when there is an arrest of the cardiovascular system," Dr. Likoff says. "Physicians can sometimes start the heart beating again after it has stopped."

For transplant purposes, it might be more practical to consider the moment of death as some specified time after all electrical activity has stopped in the brain, he adds.

The Bethesda meeting will also consider the proper involvement of donors, recipients and their families from a legal as well as medical standpoint.

The size of the problem can be understood in the light of figures produced by Dr. Likoff: "If this surgery were applied to all who need it, it is estimated that there would be 1,000 heart transplants a week," he says.

CARDIOLOGY II

Advance in mitral valves

While the controversy continued to rage over the transplants, another surgeon brought news to the cardiologists that another operation, considered to be a life or death gamble a few years ago, has now become comparatively safe and commonplace.

Dr. Albert Starr, chief of cardiovascular surgery at the University of Oregon in Portland, led the team which installed the first mechanical mitral valve in a human heart less than eight years ago.

Dr. Starr's team lost four out of its first five patients, a mortality roughly equivalent to that of the heart transplants.

The Oregon surgeon reported that there are now approximately 50,000 people walking around with artificial mitral and aortic valves, most of whom would be dead without them.

Refinements in technique and materials used for the valves has chopped the mortality rate down to about five percent and it continues to get better.

The valve improvements have been so great that Dr. Starr believes that some 15 percent of the people equipped with the older type valves should come in and have them replaced with the new ones.