MUSC's First Organ Transplant Oral History Project

Interview with Dr. Fletcher C. Derrick, Jr.
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Interviewers: Brooke Fox, MUSC University Archives
&
Dr. P.R. Rajagopalan, Department of Surgery

Location: Basic Sciences Building, Room 107

Brooke Fox: Give me a little background information on yourself, like where you went to school, how you got involved in medicine, et cetera.

Fletcher C. Derrick: I grew up in Edgefield County, Johnston, South Carolina, went to public schools there, then went to Clemson University, and after Clemson I came to MUSC. Interestingly enough, I actually started out in textile chemistry. In 1951 and the late '40s, early '50s, South Carolina was a leading textile manufacturing state, and I had several family and friends who were in the textile industry. But I had the notion that I wanted to go into medicine, so after I got to Clemson and had some friends who had made up their mind to go ahead and go into medicine, I slowly, gradually came to the point that I wanted to do medicine: plus, a little bit of encouragement from my mother.

So, I came to medical school at the Medical University of South Carolina and had a marvelous experience; as a matter of fact, I did much better academically in medical school than I did in college. I think sometimes that happens. I joined the Army Medical School Program as a senior student and did my internship at Fort Benning. At that time, we had to have a voluntary service, so I felt that the third year would be good and my wife and could probably travel abroad. So, I did my internship at Fort Benning, and when we arrived, the head of the intern program said, okay, you've got 11 months all planned, now you have one month if you'd like to do an elective, and we had a list of electives.

I chose urology, and interestingly enough, had a marvelous chief of urology, and he started me out quite well. It was interesting, too, he got deathly ill about the end of my month rotation, and the chief of surgery came to me and said, "Would you mind running the clinic another month while Colonel Campbell recovers?" And I said, well, I suppose so, and my good friend in the internship wanted another month

of internal medicine, so it was an easy swap; I had the other month of surgery. And that stood me in good stead and got me started in Urology.

Fox: When did you join MUSC on faculty?

Derrick: After my residency at MUSC. After my internship, I spent one year with the troops, an 8th Division Artillery and then I went to a fixed installation which was The Second General Hospital in Germany, which is in Landstuhl, and that's the referral center, the consulting center of Europe. At that time, I also got assigned to urology.

So, I had two years of urological training under three board certified urologists while I was in the Army, and knowing I wanted to do a residency, I began to apply and check around. To make a rather long story short, we decided to come back to Charleston and to do my residency here at the Medical University under Dr. Kenneth Lynch.

Fox: Were you involved in any of the research activities focusing on anti-rejection methods, the lymphocyte depletion process?

Derrick: No, that was not my role; others were doing that, I was aware as we talked about transplantation, and aware of the necessity for the rejection program, but I was not directly involved in any of the research.

Fox: So, how did you get involved with the operation itself?

Derrick: Well, at that time, it was a learning process for all of us, so I think as we were looking and deciding, the most qualified person to remove a kidney and to also reimplant the ureter was a urologist. So, that was the role that as Dr. C. Thomas Fitts and Curtis P. Artz and I began to talk about doing

the first transplant, then they asked me to join the team as a urologist, and I did.

P.R. Rajagopalan: What can you tell us about the selection process that went into picking the donor, for example? What was your role, and in those days, how did that actually occur? What were the processes involved in selecting that particular donor?

Derrick: Well, of course we all knew that you had to have as good a match as possible, and at that time, if my memory serves me correctly, we didn't have much more than blood match. There were some experimental things that were going on, so that's when Billy [William Roy] Ashley, who was our first recipient, our first transplant patient, his sister came forward, and it turned out that she was a good match as far as our matching laboratory procedures were concerned at that time. And also at that time, as we were trying to get kidneys from other places and so forth, it certainly was not nearly as organized as you, of course, know about now, Raja.

Rajagopalan: Was there any discussion about the ethics of a healthy person donating an organ and undergoing a procedure? What kind of discussions took place?

Derrick: Yes, we did have -- there was actually formed an ethics committee, and we had had numerous meetings about how to select donors, -- and also a lot of work was done as to even when we were going to get a cadaveric organ, when was that patient, or when was that person actually pronounced dead so we could then harvest organs. But the living donor did create some problems, but after we worked with it awhile, we felt that at least family members would be highly acceptable because of the relatively ease of matching the person.

Rajagopalan: What confidentiality options were the donors given, in terms of were there any elements of coercion? What kind of discussion do you recall took place between your team and the potential donor's family to come to the conclusion of the transplant process?

Derrick: Well, I do distinctly remember sitting down and talking with the donor, which in this case was a family member, a sister [Velma Jean Madden] of Billy Ashley, and we went over things very carefully with her. She, of course, had had extensive testing to be sure that both of her kidneys were working nicely and that also she had a good creatinine clearance and good renal function. And we explained to her that there are many, many people who come to us as a urologist who have to have a kidney removed for possibly cancer or trauma, and that there are also many, many people out there who are living with one kidney. Some people are only born with one kidney.

So, we went through all of this process in telling the patient that losing one kidney was, aside from the risk of surgery and recovery, not such a big problem being that she was healthy at the outset.

Rajagopalan: Do you recall any hurdles, objections, support that you see from the University itself? What was the atmosphere like in your team and the institution in doing the very first transplant that had not been done here before?

Derrick: Well, I think we all had a degree of apprehension, but everyone on the team, to the best of my knowledge, had already spent time at another center that had done transplantation. I had personally been to Richmond with Dr. David Hume, Dr. George Prout and Dr. H.M. Lee and others, so that we had some hands-on experience at other institutions. We were obviously a little bit apprehensive, but then again, we all felt we had

sufficient training in order to make this happen, and others were making it happen. We did have lots of discussions about timing and working together and getting everything precisely just right. We had a good game plan, as we would say in modern language.

Rajagopalan: Was the institution generally supportive of the early effort?

Derrick: As a matter of fact, I think the institution in general was very delighted that a team had been formed and that we had discussed it and then brought it to the institutional review committee and went over everything very carefully at that time. So, we had a great support from the Medical University and from the rest of the staff.

Rajagopalan: What can you tell us about the procedure itself, the organization that went into setting up two operating rooms and donor-recipient? Is there anything we can learn from that experience?

Derrick: You know, we certainly had to block out the time and had to get the patients properly prepared, and get the two operating rooms. I remember distinctly that we had a sort of timing as to when I would start to remove the kidney, to harvest the kidney, and then also there was a timing when we would be ready to implant the kidney. So, we started not simultaneously, but there was a delay, if I remember correctly, in which I started and said, okay, now I have the anatomy dissected out, and we actually waited until Dr. Fitts had the implantation area ready, so that we'd have a minimal profusion time, and of course bringing the kidney right over and transferring it to one operating room to another.

Yes, there was a lot of planning and talking back and forth as we moved through the operation, so that when we were ready to clamp, cut and remove the kidney, that it was done quickly, handed off to a team who

was going to do the profusion. I finished the donor nephrectomy to close the wound.

Fox: How did the idea of a kidney transplant come about in that time?

Derrick: You know, I don't recall specifically as to when we really had the first idea, but unless I'm mistaken, I think Dr. Artz actually presented this to the department of surgery and to urology and said, we need to get into the transplant business. And at that time, myself, Dr. Fitts, Dr. Artz, Dr. Lynch, Dr. Arthur Williams who was running the nephrology program, we all sat down and just began to talk about it and to decide, okay, how could we do it, and then I think we began to try to identify a patient.

Fox: How did you go about identifying William Ashley as a patient?

Derrick: I must say, I thought maybe that question might come up, and I really don't specifically remember how Billy was particularly chosen. He was already in the nephrology program, so I believe that Dr. Williams had actually presented him and selected him in saying, okay, this would possibly make a good transplantation patient, and he was willing, and then of course he had the living, related donor.

Fox Could you describe the actual preparations, not the day of the operation itself, but other kinds of preparations were involved? I guess research.

Derrick: As we normally would, and to the extent of our knowledge at that time, which was pretty good, we of course wanted to be sure that the donor was healthy and that that person could also live with one kidney. The recipient also went through a series of tests to be sure that he had the strength to go through with an operation of this sort; he was already on dialysis, so we had to time that so that everything would be done right. We also had to be

sure that in preparation for transplanting the ureter, (reimplanting the ureter into the bladder), we had to be sure that his bladder was within normal range and would be able to accept a reimplantation of a ureter.

There were some x-rays and testing that was done to be sure that all the bases were covered, all the aspects of the surgery were covered, and the patient could, of course, go through with the surgery. Those are the things that I think we really were concerned about, was to be sure that he was able to stand the anesthesia and two or three hours of surgery.

Fox: Do you have any remembrances of the involvement of several of the doctors in the operation, such as Dr. Curtis Artz, Dr. Charles Graber, James Harvin, Dr. Arthur Williams?

Derrick: Dr. Artz was chief of surgery, and he was a dynamic person; he was very active, very outspoken. He was able to get things moving, and if I remember correctly, he and Dr. Fitts actually performed the preparation of the bed for the kidney to be transplanted. I also was trying to think who had assisted me with the nephrectomy, and I cannot remember exactly. I'd have to go look at the op report to see who assisted me with removing the kidney.

But we also, and part of the preparation as I was mentioning to you, we did something which I don't think you do these days, Raja, we did an arteriogram to be sure we had sufficient length for the artery and the vein and so on and so forth. So, that was one thing in preparation.

As far as Dr. Harvin was concerned, I just don't remember specifically his role. Dr. Williams was a nephrologist, and of course he was going to be the one to primarily take care of the patient after surgery when it came to the renal function, as far as that was concerned. It was a team effort; we

were all watching and keeping our eyes on the patient from various circumstances.

Rajagopalan: One interesting thing in this institution was the practice of lymph depletion that Artz and Dr. Fitts -- lymph deletion, thoracic duct cannulation; do you recall any of those efforts? Because Billy Ashley did go through almost a month of lymph depletion prior to transplantation.

Derrick: Dr. Raja, I really don't recall any specific data in regards to lymph depletion in his case.

Rajagopalan: Did it pose any problems in the surgical procedure? Was there any special care that needed to be taken?

Derrick: As well as I remember, I think Billy Ashley did very well. I think he recovered nicely from surgery, was up walking, and also he made urine immediately; the kidney functioned. We all joined the pee-watchers club, as we say, because we all have our eye on the bag on the side of the bed. As well as I remember, he went right to functioning properly and was alert and then got up and started moving around.

Now, of course we had to watch out for the rejection phenomenon, and we didn't have all of the drugs that we have now, but as well as I remember, he did very well for awhile. For a long time.

Rajagopalan: What can you tell us about the donor, her post-operative course?

Derrick: As well as I remember, she had a very uneventful course and was probably out of the hospital in five or six days, and also I think did well immediately following.

Fox: She's still alive, just for your information. We've been in touch. Besides the surgeons working on the transplant, do you recall any of the OR nurses or the lab technicians who were involved in the operation? Do you remember anybody specifically and what they did?

Derrick: Well, as was very usual, my scrub nurse was Kathleen Johnson. She was the head urology nurse, she was in on everything we did, and I'm sure that we asked her to scrub on that particular case as we did. And Kathleen is still here, she's retired and she lives in Charleston. She may be a source of information. She's a friend and a patient; I see her periodically and talk to her from time to time. As a matter of fact, I see her walking when I'm riding my bicycle at Hampton Park. She lives in that area.

As far as any other technicians, I don't recall specifically, but I do know Kathleen was our head urology nurses and scrubbed with us a great deal. So, I'm certain she was probably there.

Fox: You left in MUSC in 1970, so you really don't have any remembrances of the transplant program here at MUSC after the first operation?

Derrick: You know, I don't recall; we did maybe three or four more during my tenure here, then I went to George Washington University to head that department, and we started a transplantation program there And then when I came back to Charleston, the team was going very well. Raja, when did you come to Charleston? '74. And that's about the time that I came back from Washington, so that Raja was here at that time, and the program was sort of ongoing at that time. I may have participated in another one or two after I came back, just to help the program keep going, and then subsequently I think you pretty much had your own program and own ideas, because then we got into the national pool and were receiving kidneys from other places.

Rajagopalan: What lessons have you learned, or we can learn, from that initial experience of doing something new, developing and putting a team together and working with a team?

Derrick: I really think that the important aspect of getting something together the first time is cooperation, and I would say that first of all, the University, as well as I remember, the administration was quite happy that we wanted to do this. And then I think all of the folks involved with their areas of expertise were able to contribute, and when you put a team together like that doing the first one, then I think it went very well. As time has gone along, the team may have changed, but you still have a marvelous teamwork. So, I think the idea of cooperation and teamwork, and then understanding from the administration that we needed to stay abreast of our times and to move along. I think they showed lots of courage, and also lots of understanding of the future to go ahead and actually bring someone in like you who would then be full-time associated with the program and continue it.

Fox: Are there any final thoughts you want to share about the operation or preparation that I have not asked about?

Derrick: As far as we are concerned here, I think that the program was certainly just far reaching and also visionary in the eyes of those who wanted to do it. I distinctly remember Dr. Lynch, my chief, he asked me if I wanted to be part of the program, because they had come to him, and I told him I would, and so he was very generous in time and effort to allow me to go to go to Richmond and to work with a program that was a highly respected program and was doing well. So, I think that was something that also showed the cooperation of the University and the faculty and administration, that they wanted to get something going.

That stands out in my mind. If he had not maybe pushed me, or at least given me that opportunity, then I may have said, well, let somebody else do it, or somebody else might have done it. But I think it was a grand time, and I had an opportunity to participate not only in their program, but in our program and then at George Washington while I was there to help get a program started.

Rajagopalan: Were there any reservations in any quarter about doing something new and innovative?

Derrick: I think there's always somebody who is -- even on our ethics committee, I might say that there was one person who had some, you might say minor reservations about, well, you're going to operate on a perfectly healthy individual and remove a perfectly healthy organ, and so forth, and then give it to someone else. Of course, it's commonplace today, but at that time there was one person who had a lot of reservation about it. I think the rest of us on that ethics committee and the institutional review board at that time, I don't think we had any real reservations. We thought we could do the surgery. It was the rejection phenomena that we knew would be the biggest part of caring for the patient and getting him through.

Rajagopalan: Was there any consideration given to the financial and social commitment at that time?

Derrick: That was a very important consideration, because I do remember specifically discussing this in part of our planning in terms of okay, who's going to pay for it? And I do remember specifically, actually not myself but the administration talking to the insurance carrier. And unless I am mistaken -- I'd have to go back -- I believe that the insurance carriers for Billy Ashley and his sister were able to help out on this particular time.

Later on, I'm not sure that all of them participated or would participate, but I think on this particular one, I really think that we had participation from the insurance carriers. But that was a real consideration, and subsequently, I think it's relatively common now for the insurance carriers to support you in this, isn't it?

Rajagopalan: What lessons would you like to impart to future surgeons?

Derrick: I think it's always a matter of good preparation. All of my teachers as I was coming along and then as I tried to impart on the residents that I taught through the years and still teach, you know, you learn everything you can about what you're fixing to do and go back to your freshman anatomy and be well prepared. Because you never know, and particularly in dealing with the kidney and bladder situation, there can be embryonic changes that will make things slightly difficult, so that if you're well prepared, that's the main thing. I think I would impart that to the surgeons. Be prepared. Know where you're going, what you're going to do, and what you're going to do in case something goes wrong, if it does.

End of recording.