VI

Presidential Reminiscences

Thomas E. Starzl

President, 1974-75

I believe that the idea of forming ASTS came originally from Aaron Bannett (Albert Einstein Medical Center, Philadelphia) and Fred Merkel of Chicago. Dr. Bannett approached me about one year before our first meeting and asked me to work with him and Fred in formulating a mission for this new organization. I gave the matter a great deal of thought, and the product of these introspections was my Presidential Address.

Included in my Presidential Address were some predictions and advice. I would probably give about the same talk today. Perhaps my most accurate prediction was that ASTS would quickly cease being a kidney transplant organization. The program in 1975 showed that 20 of 25 papers concerned the kidney, with 2 on the pancreas, 2 on basic immunology, and only 1 on extrarenal organs exclusive of the pancreas. In contrast, the program in 1993 contained 92 presentations: 23 kidney, 25 basic immunology, 8 pancreas, and 36 other extrarenal organs. The single most highly represented organ at the 1993 meeting was the liver.

Because I considered the primary purposes of ASTS to be research and development as well as the promulgation of information, my first priority was to obtain a responsible avenue for publication. I carried out lengthy negotiations with the editors of *Surgery* and eventually extracted from them an agreement to publish our proceedings. This was done at first (including publication of my Presidential Address), but ultimately the journal editors thought our field to be too specialized for this arrangement to continue. Everyone is aware that subsequently the publication responsibility was transferred to *Transplantation.*

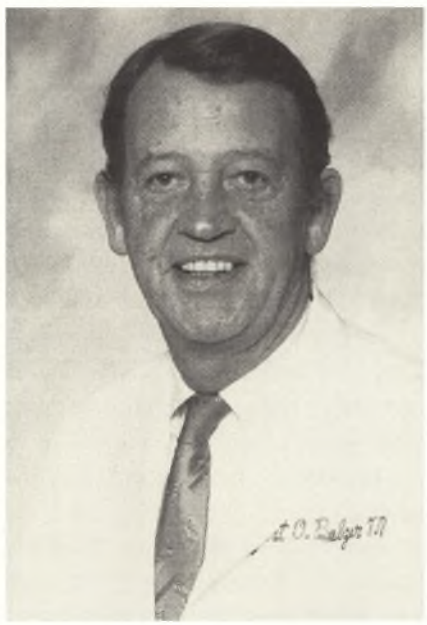
The nuts and bolts of the society were put in place by Aaron Bannett and Fred Merkel. Their achievements included the constitution and the incorporation process. I appointed the committees. Fred's efforts were rewarded later by his election to the presidency. I always thought it was an injustice not to have elevated Dr. Bannett to this important position, because he was more responsible than any other individual for the birth process.

Almost from the beginning, ASTS became the dominant voice of transplantation in North America, and soon the world. My advice to expand the presence of extrarenal organs at the yearly programs was followed. There was some attempt by advocates of the Transplantation Society to derail the American plans, out of fear of diluting the influence and power of the international organization. Of course, that fear proved unfounded, and soon the powerful linkage between ASTS and the Transplantation Society that exists today was firmly established.

Beyond regretting that ASTS has never acknowledged Dr. Bannett's role or formally thanked him for what he did, I would not change much about the neonatal process if I had it to do over again.

Folkert O. Belzer

President, 1975-76



In my Presidential Address I referred to ASTS as a 2-year-old child. My presidential tenure primarily focused on providing direction, firm guidance, and a clear perspective of our goals so that ASTS would prosper and improve. The child now is a mature 20-year-old, and many of the goals I suggested in 1976 have been accomplished.

By adhering to a critical review of increasing numbers of submitted abstracts, the scientific program in the past years has been of the highest quality. We have addressed the training of new transplant surgeons, and continue to train highly competent specialists whose expertise in multiorgan transplantation is unparalleled. We have joined forces and become friends with our colleagues in internal medicine and pediatrics, as exemplified by our joint meeting with the American Society of Transplant Physicians. We have improved our results in kidney transplantation, with acceptable low mortalities and one-year graft survival in the 90% range. Furthermore, the introduction of cyclosporine and OKT3 has allowed similar results in nonrenal organ transplants. For this reason, we are indeed now the American Society of Transplant Surgeons and not the American Society of *Renal* Transplant Surgeons. We have continued our social contacts, and should all be especially grateful to the members of

the local organizing committee in Chicago, who have served as host for us 18 times in the past 20 years.

My only concern at this time is that we have not continued our leadership in the field of organ procurement. In most instances, procurement is now under the leadership of independent organ procurement organizations (OPOs). Although many of these OPOs have done an outstanding job in the number of organs procured per million population, other OPOs fall far below an acceptable norm. We still have long waiting lists of patients — not only for kidneys but also for lifesaving organs such as the heart and the liver. I believe ASTS should provide a stronger leadership role in this area, first to increase organ donation, and then to decrease organ costs.

We are all proud of our bright, hard-working, mature 20-year-old; I hope we can work together to push this offspring to an even more illustrious career.

Thomas L. Marchioro

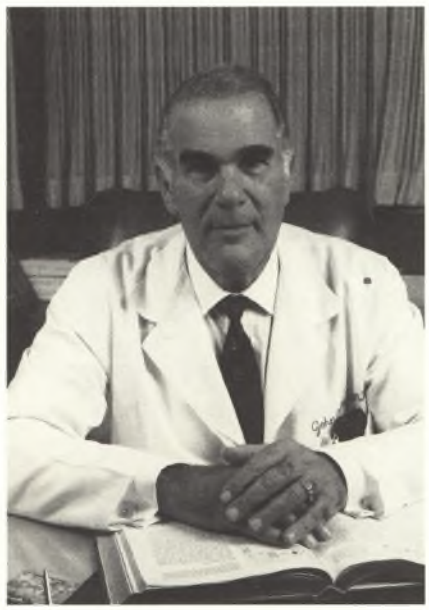
President, 1976-77

In the beginning of ASTS, there was a great deal of controversy over whether this organization should be political or scientific. Some wanted it to be a political arm primarily and scientific secondarily. However, those of us who strongly felt that we should be primarily, and almost exclusively, a scientific organization prevailed. I believe it was for this reason that we established our credibility as a scientific organization, and in turn have been granted an audience with the various federal agencies to which we appealed. Had we done it otherwise, it is my honest conviction we would have been completely ignored.

As far as important accomplishments during my presidential tenure, I believe that I helped to elevate the scientific stature of our organization. Basically, the Program Committee did an enormous job in improving our programs and in reaching out to the various transplant groups in the country. The work of the committee under Dr. Anthony Monaco was crucial during my tenure. In addition, Dr. Monaco indicated that the journal *Transplantation* would be willing to publish a group of ASTS papers, chosen by us and approved by *Transplantation.* Thus began our relationship with *Transplantation,* whereby presentations at the annual scientific meeting are published there after peer review of the manuscripts.

I would also like to acknowledge the work of our secretary, Russell Lawson, and that of other Council members during my year as president.

John S. Najarian
President, 1977-78



As the fourth president of ASTS, the most important goal I wished to achieve was to make known the need for, and help develop a concept and model for, the formal education and training of transplant surgeons. I focused on education as a foundation for the emerging clinical field of organ transplantation because, before that time, transplant surgeons were trained in a variety of ways — primarily on the job. I felt strongly that a formal training program, as we had developed at the University of Minnesota, would be important for our discipline's growth in quality and quantity. I also felt that if ASTS did not take leadership in determining what constituted appropriate training for transplant surgeons, then surely a national board would be developed and qualifications would be determined by the American Board of Medical Specialists. In addition, eventually, either a board certification or at least a certificate of advanced training (such as had been developed in the fields of vascular surgery and critical care surgery and is now being discussed for oncological surgery) would be required for individuals completing their transplant fellowship.

Thus, I first called for development of formal training programs in transplantation surgery and accreditation of transplant fellowships. I felt this was an extremely important move for our young society to make. I am happy that ASTS took this initial step in 1977 to avoid paternalism by the American Board of Medical Specialists.

It was my feeling that institutions seeking approval needed to submit a written application and undergo a site visit. Through this procedure, in the first year, 18 institutions applied and 15 were eventually approved to offer a one-year transplant fellowship. I continued as chair of the Education Committee through 1988. It is gratifying to see this process continue under Dr. Nancy Ascher's leadership; the committee is still approving new programs and reviewing previously approved programs every five years.

As time progressed, the Council came to feel that one year of formal training was no longer sufficient, particularly with the emergence of multiple-organ transplantation. The Education Committee recommended that, beginning in 1990, transplant fellows complete two years of training, along with their Boards in general surgery or urology. Our own program at the University of Minnesota has been expanded to two years: fellows spend four months as a donor doctor; four months as a kidney recipient doctor; four months as a liver recipient doctor; four months in pancreas and islet transplantation; and, if not already completed during their residency, eight months in transplant research.

Through the nationally approved fellowship program, the annual lecture in immunology, and now the postgraduate course, high-quality continuing education opportunities abound for transplant surgeons. The field has become one of the most respected and clinically successful new medical technologies of the 1990s.

The second suggestion I made with respect to education was to invite basic scientists in genetics or immunology to address our members. For the first lecture in immunology, I invited Sir Peter Medawar, 1960 Nobel laureate, who spoke on "The Wider Implications of Transplantation Surgery." He is arguably the father, if not the godfather, of transplantation. Since that time, each year, an immunologist has spoken to ASTS. This has served as a stimulus for our members to continue their involvement in immunology as the basic foundation for transplantation research. As an example, when ASTS began in 1975, only two papers were presented on basic immunology. By 1993, the number of papers dealing with basic immunology had increased tenfold.

In looking back over the past 20 years, I am delighted that — through the development of qualified transplant training fellowships — the field has grown not only quantitatively, but qualitatively. With the increasing number of organs now being transplanted, the demand for skilled, caring transplant surgeons continues. The eventual benefactor — the patient — remains our most important priority. As I told *The Cutting Edge* newsletter (December 1989), and have always felt, "Transplantation isn't what you see in the headlines or in the hospital immediately after surgery. It's the high school boy on a regular clinic visit asking me if he can play football. It's the woman with nothing else wrong who would've died as a teenager but is now living to a normal, active middle age."

Frederick K. Merkel

President, 1978-79

As president, I feel my major goals were well outlined in the Presidential Address of 1979. To summarize, I encouraged ASTS to be a society for all organ transplants, not just renal transplants. I encouraged better relations with the nephrologists, the expansion of transplant facilities throughout the U.S. so that more patients could be served, and the enhancement of kidney sharing. I also encouraged the development of better relations and contacts with the government and suggested that we obtain the services of a liaison between ASTS and Congress. This liaison came to pass very quickly; Jim Cerilli and Oscar Salvatierra then worked hard to make our impact felt in Washington. Finally, I will take the credit for suggesting that we publish a newsletter, now represented by *The Chimera.*

Jeremiah G. Turcotte

President, 1979-80

The year 1979-80 was one of continued growth and maturation leavened with the traditional hilarity and high jinks that seemed to always accompany the Council and annual meetings of the membership. ASTS was rapidly assuming a leadership role and becoming the spokesman for the transplantation community in the U.S. A grand sum of $56,000 had accumulated in the treasury. The membership roster and meeting attendance were ballooning. The Council found it necessary to meet twice a year. Help was needed!

Secretary Williams found us a new logo, and provided sufficient stationery for an entire year. The membership list would be updated and published annually. Arrangements were made to retain the Wright Organization, for a much debated fee of $300 per month, to assist with organizing our annual meeting. At the Council meeting, Cerilli maintained that "we are naive and uninformed" in our dealings with government. Consequently, the annual membership dues were increased to $100 so that we could seek assistance in Washington to spar with the administration and Congress. This later led to our association with Health Policy Alternatives. The bylaws were updated and expanded to accommodate our growing responsibilities. Standing committees of six members were established: Membership, Program and Publications, Education, Medical Data Review, and Scientific Studies. An Advisory Committee on Issues, whose membership would consist of all past presidents, was also established. Organ sharing was becoming a regional and national endeavor so an Ad Hoc Standards Committee on Organ Preservation was formed.

The scientific and educational activities of ASTS were also flourishing. Monaco reported for the Program and Publications Committee that the number of abstracts submitted had increased to 155 and the quality of the papers continued to improve. Members were urged to always submit a manuscript with their presentation. Monaco would urge the editors of *Transplantation* to publish all good papers. After much discussion Penn and his committee successfully drafted a statement of Special Requirements for Graduate Education in Renal Transplant Surgery that was acceptable to the Council and the membership. This formed the basis for ASTS approval of transplant surgery fellowships. Turcotte contacted the American College of Surgeons to seek official listing and an eventual governor position for ASTS, and requested that ASTS be added to the list of societies nominating a member to the American Board of Surgery.

The annual meeting was well attended and well received. Samuel Strober, Thomas Starzl, and Sir Roy Calne formed a panel of invited lecturers. They shared their exper-

tise and experience with promising new methods of immunosuppression with the membership. Nine new members were elected at the business meeting. Calne was made an honorary member. The annual banquet was its usual resounding success—no one was injured!! Clearly the discipline of transplantation and ASTS were enjoying their clinical and scientific success and their growing national prominence.

James Cerilli

President, 1980-81

My year as president saw ASTS achieve greater visibility as a scientific organization and as an advocate for transplant patients throughout the U.S. It was in that environment that I initiated the following:

1. *Liaison with Consulting Group in Washington, D.C.*—It became apparent that transplantation would become intimately involved with government regulation, more so than any other medical discipline. It also became apparent that these regulations would be changing frequently, and the field of transplantation needed to be kept informed of what was transpiring in Congress. Accordingly, I initiated a liaison with a consulting group in Washington on a paid basis. They kept us informed as to how we could proactively respond to contemplated changes. This liaison has continued and prospered, and has been the foundation for our continuing role in the legislative aspects of transplantation.

2. *Education*—It also became apparent that transplantation was becoming complex as a discipline and that, if it was to be a recognized discipline, it must have defined training programs. I, therefore, initiated an Education Committee to begin a certification process for all training programs and to set criteria so that the number of programs would be commensurate with need. The first of these objectives has been met and met well; the second remains to be accomplished. However, our program of site visits and program review has done much to standardize the educational process and to prevent the exploitation of trainees for service preferences only.

3. *Multicenter Report*—In early 1980, transplantation results in many centers were far better than previously reported in the literature. I, therefore, put together a multicenter report showing that, in better centers, transplantation results were indeed superior to the historical average, which had been much maligned by our nephrology colleagues. This report did much to change the image of transplantation and open the doors for patient referral.

4. *Congressional Testimony*—On several occasions, before major subcommittees in the House and Senate in Washington, I presented information demonstrating that

academic transplantation could be trusted to objectively assess the needs of transplantation. This significantly contributed to the credibility of the field of transplantation, showing legislative leaders that our requests were sound and were based on reasonable needs.

I should also mention an area in which I feel I was unsuccessful. It was my feeling back in 1980 that the biggest problem facing transplantation was the lack of available organs. I tried to get ASTS to focus on this issue as a major objective. I wanted to put all of our resources behind a program to increase organ donation, with the support of both local and national legislative bodies. To this end, I invited Philip Crane (U.S. House of Representatives, Illinois) to present the President's Lecture at our 1981 annual meeting. Congressman Crane was an advocate of some form of limited remuneration for organ donors. He authored the Crane Bill which, for lack of uniform support and enthusiasm, did not pass Congress. The failure to develop an effective program to increase organ donation led to the crisis in organ distribution and ultimately to the formation of the United Network for Organ Sharing (UNOS).

Richard L. Simmons

President, 1981-82

My year of presidency can be described as a period of peace and prosperity in ASTS. The Society had become established and was looking forward to growth and further scientific success in transplantation. ASTS required certain organizational modifications which occupied my interests as president, such as the establishment and consolidation of appropriate committees. We were totally unaware of the cost concerns that would soon arise and the change in medical health care delivery that was on the horizon. We were totally occupied with scientific issues and career development of people in academic transplantation surgery. I addressed, in my Presidential Address, the frustrations of investigative clinicians in transplantation surgery with respect to their expectations and funding opportunities.

Although my tour seems naive in retrospect, I think that the interruptions in scientific progress (imposed upon us by forcing us to concern ourselves with our livelihoods and with the livelihoods of patients potentially threatened by the putative health care crisis) forced us to focus on the essential meaningful issues in the scientific and clinical advances in transplantation. This shift in focus proved necessary in the years ahead and has been, to a large extent, achieved.

G. Melville Williams

President, 1982-83

The early 1980s marked the continuing struggle of ASTS to assume a leadership role in the organization of transplantation services, at a time when government leaders were beginning to realize something had to be done.

One of my first duties as president was to testify before Senator Albert Gore's oversight committee on transplantation. Norm Shumway was also there, as was Jim Williams. We were able to present our frustration over lack of support by insurance companies for lifesaving procedures with outcomes far surpassing those acceptable for reimbursement. Senator Gore and his colleagues were especially harsh in criticizing Champus for their failure to support liver transplantation in young patients with biliary atresia.

From a personal point of view, I was appalled by the waste of kidneys in the southeastern region of the U.S. where we kept very close track. At that time, 1 kidney of every 4 removed for transplantation was discarded or transported overseas. It certainly appeared to me that a larger pool of recipients able to receive kidneys having A, B, or AB blood types was essential. As you know, this was the time when personal appeals for donors were made via the news media. All of this public interest was promulgated by the excellent results achieved in nonrenal transplantation with cyclosporine. I think we established the need for some rational national policies.

The report of the Gore committee prompted debate in the Senate and House and led to the Transplantation Act, which established the task force and ultimately funding for the National Organ Procurement and Transplantation Network.

Not surprisingly, my Presidential Address in 1983 dealt with issues of organ sharing and distribution to avoid waste. In particular, I pointed out in the early development of transplantation the collaboration between David Hume (Medical College of Virginia) and Bernard Amos (Duke University). By 1968, both programs were stymied because a sizable proportion of patients sustained on dialysis had rejected their first transplants and were highly immunized. We could not use the few cadaver organs we recovered. A transfer of organs between the two centers enabled use of more of the kidneys and eventually led to a greater number of centers collaborating to avoid the catastrophe of waste. This early experience led to the foundation of the Southeastern Organ Procurement Foundation (SEOPF). Despite the best efforts of SEOPF, comprehensive data indicated continued organ waste, mandating a national system.

While a national system existed on paper, UNOS was simply an offshoot of

SEOPF. It consisted of a computer match program allowing any center in the U.S. to run the SEOPF match program. It led to very few transplants between SEOPF and the rest of the U.S.

I recommended that a transplant surgeon run a national network and appointed John McDonald as chairman of a blue ribbon committee to do this. It seemed fairly clear to me and others that there would be a national organization and that we had better be prepared for it.

It must be acknowledged that UNOS has had its organizational problems and that an operational consensus has not always been present. As Tom Starzl told me once, "Your organization of UNOS was either the best thing or the worst thing you have ever done." Looking back, I suspect it may well have been the best thing. UNOS was really us. Through its committee and regional structures, a system has emerged that represents transplantation and provides the most equitable distribution for organs while eliminating waste and shipment overseas.

Oscar Salvatierra, Jr.

President, 1983-84

My presidency marked the midpoint in the 20-year history of the ASTS. At its 10th Anniversary, ASTS had already witnessed incredible maturation, thanks to the purposeful dedication and unselfish efforts of the membership, the various committees, and the Council. The primary thrust of my presidency was both scientific and educational in addition to a genuine commitment to improve patient access to the increasingly successful option of transplantation (not only kidney, but also liver, heart, and pancreas).

As with previous years, the scientific program was outstanding. ASTS was becoming the primary forum for presentation of scientific papers on organ transplantation. It was becoming progressively more difficult to have abstracts accepted. The acceptance rate of abstracts in 1984 was 29.6%, which was in large part responsible for the excellent quality of the scientific papers at that meeting and foreshadowed the quality of future meetings.

Our scientific and educational progress could also be measured by the following:

1. An ongoing transplantation fellowship was established to encourage the training of transplant surgeons skilled not only in the clinical aspects of transplantation but also in the important immunobiology research techniques. This training grant was set up through the generosity of Sandoz Pharmaceuticals

Corporation. Each training grant was for $25,000 per year for a two-year period, with a competitive award to be made each year beginning in 1985.

2. The Upjohn Award was established to recognize the outstanding research paper by a transplant resident or fellow at each annual meeting. The first award was to be made at the 1985 annual meeting.
3. Given interest in workshops during the previous two years, a definitive decision was made to hold a yearly ongoing workshop on the Saturday morning after every scientific annual meeting. A different topic was to be discussed each year. This yearly workshop was a forerunner of the postgraduate course.

A number of patient care and ethical issues surfaced that needed to be confronted head on with a sense of concern and urgency. The organ shortage was worsening. If a kidney could not be placed regionally, it was easier to export it to a foreign country than to place it somewhere else in the U.S. The SEOPF report at the 10th annual scientific meeting showed that 575 kidneys from its region (over 1 1/2 years) were not transplanted in the U.S., primarily because of a lack of a national system. The importance of addressing the logistical and ethical problems of organ donation was further heightened when a would-be kidney broker from the International Kidney Exchange Ltd. in Reston, Virginia began offering his services all over the country. This individual was about to broker kidneys from paid donors to potential recipients willing to pay him a $5,000 fee per kidney. In addition, cyclosporine was released by the FDA; it became quickly apparent that all patients would not be able to afford the drug.

The following courses of action were taken by ASTS during my presidential term to facilitate an informed response:

1. The Ethics Committee was formulated to advise the Council and membership on a number of problems arising with the burgeoning of organ transplantation.
2. The Advisory Committee on Issues was restructured to consist of all past presidents plus three members at large. We needed the best available expertise to provide advice on the increasing number of issues surfacing with the rapid expansion of organ transplantation.
3. The Standards Committee, under the able chairmanship of Nicholas Feduska, advanced the concept of, and developed standards for, multiple-organ procurement in a very visible national effort. With the advent of cyclosporine and improved results with transplants of all organs, it was important to acquit ourselves of the then-current primary notion of consent for kidneys only. We wanted to actively present multiple-organ donation to families of potential cadaver donors. Encouraging multiple-organ donation as routine was one of the most rewarding long-term accomplishments of my presidency.
4. An Ad Hoc Committee on cyclosporine distribution was formulated to advise on equitable access of this drug to all patients.
5. Ever conscious to enhance the quality of our membership, we changed membership requirements by a bylaws amendment, which provided that every member must be Board-certified rather than Board-eligible, and that each member must be the author of three scientific papers published in peer-reviewed journals, with at least one as primary author.

6. At the suggestion of Education Committee chairman Dr. John Najarian, we decided to re-review certified training programs every five years to assure that competency in training was being maintained after initial certification.

Most notable was our response to HR 4080 and HR 5580, introduced by Representative Albert Gore (Tennessee) in mid-1983, and corresponding Senate bills S1728 and S2048 introduced by Senators Edward Kennedy (Massachusetts) and Orrin Hatch (Utah). These were the initial legislative forerunners of the National Organ Transplant Act of 1984. Our important involvement with this Act was probably the most recognized activity of my presidency, resulting in the most active year of Congressional testimony yet by ASTS members. The result was a national system for organ procurement and distribution, the National Organ Procurement and Transplantation Network (subsequently awarded to UNOS). The Act also provided for a national registry for all organ transplants, assistance for the development of organ procurement organizations (OPOs), and the designation of a task force to study the progress and needs of organ transplantation. It also made it unlawful to buy and sell organs.

Thus this was a conspicuous and noteworthy year. Through its members working together with unified purpose, ASTS achieved distinguished recognition in science and education. We also attained distinguished stature as well as credibility in forthrightly addressing the major issues confronting organ transplantation. This was all made possible by the very important groundwork laid by previous presidents and councils, in addition to the exemplary commitment and hard work of the Council and committees during my presidency. For their help, support, and collaboration I am extremely grateful. I am also grateful to the entire ASTS membership for the confidence they placed in me during my presidential year.

H.M. Lee

President, 1984-85

On October 19, 1984, efforts by ASTS to establish a national organ procurement and transplantation network culminated in the signing into law of the National Organ Transplant Act. In concert with the establishment of this new national network, the Standards Committee on Organ Procurement, chaired by Nicholas Feduska, and the Ethics Committee, chaired by James Cerilli, focused on important guidelines. The Standards Committee established guidelines for (1) prioritization of candidates for extrarenal organ transplants; (2) performance of cadaver kidney transplants involving foreign national patients in the U.S.; (3) criteria of acceptability for multiple-organ donors; and (4) a relationship between this committee and the UNOS Committee for Organ Preservation and Distribution. This committee also affirmed that cadaver kidneys should not be shipped out of the U.S. unless first cleared by the national network, which would verify that a suitable recipient could not be identified in this country.

ASTS affirmed the position of the Ethics Committee on four issues: (1) Solicitation of patients, particularly foreign patients, through advertising was deemed unacceptable; (2) American citizens or permanent residents of this country should be given verifiable preference for all transplantable organs; (3) Organs suitable for transplantation should not be sent abroad, unless no American citizens or permanent American residents were verified as suitable; (4) Itinerant surgery, as defined by the American College of Surgery, is unacceptable for transplant recipients.

A major event during our 1985 annual meeting was the presentation of the first two Sandoz fellowships. One was a one-year grant, the other a two-year grant. In subsequent years all fellowships would entail a two-year award of $25,000 per year, with one award made each year.

Anthony P. Monaco

President, 1985-86

During my tenure as ASTS president, the major problems facing the transplant community were the ethics of transplantation practice, especially procurement and distribution of organs; the education of transplant surgeons, particularly the maintenance of scientific education as well as clinical training; and the expansion of clinical organ transplantation services and facilities. I addressed all of these problems in my Presidential Address, reprinted from *Transplantation.*

I wish to also acknowledge the work of our various committees, both their chairmen and their members. Their effort was most invaluable to ASTS and to me as its president.

Robert J. Corry

President, 1986-87

During 1986-1987, ASTS was faced with developing positions on many critical issues involving the transplant community and, more important, the patients awaiting organ transplants. ASTS leadership worked closely with the office of organ transplantation and the United Network for Organ Sharing (UNOS) in establishing these policies. In fact, many ASTS leaders were also UNOS officers and board members during its incipient stages, which ensured our input into UNOS on national transplantation policies.

Organ distribution and sharing was a major issue, which had not been fully resolved and remained controversial. Sharing kidneys on a broad basis had been recommended by the National Task Force on Organ Transplantation, led by Olga Jonasson, who was also an officer and longtime contributing member of ASTS. We generally agreed with the recommendation that mandatory sharing of kidneys on a national basis should occur only in the case of 6-antigen-matched donor-recipient combinations — with the proviso that the data developed from this strategy should be analyzed expeditiously to

justify continuation of this policy. Otherwise, we felt kidneys should remain in the geographic region they were retrieved in, which might provide an incentive to promote regional educational programs and increase organ donation. On the other hand, most of us recommended sharing lifesaving organs on a national basis for critically ill patients dying of acute organ failure. This was generally accepted and formed the cornerstone of an organ distribution system for potential liver and heart recipients.

ASTS had been actively involved in approving training programs in qualified transplant institutions. It was now the designated task of UNOS, however, to approve centers where transplants could be performed. ASTS and UNOS, with several leaders in common, established a strong liaison, emphasizing standards for educational programs and certification of centers to assure quality patient care and optimal results. Thus, although a widespread proliferation of centers was taking place, members of ASTS through its Council and committees worked many painstaking hours to ensure high standards as a requirement for program approval and center certification. In addition, ASTS membership worked in a collegial way with the federal and state governments to provide the balance necessary for high-quality, affordable, and accessible patient care.

While we disagreed on some issues, solutions were nonetheless recommended that underscored high-quality patient care as well as scientific progress. It was clear that ASTS would continue to play a dominant role in establishing transplantation policies in the ensuing years and fostering scientific progress.

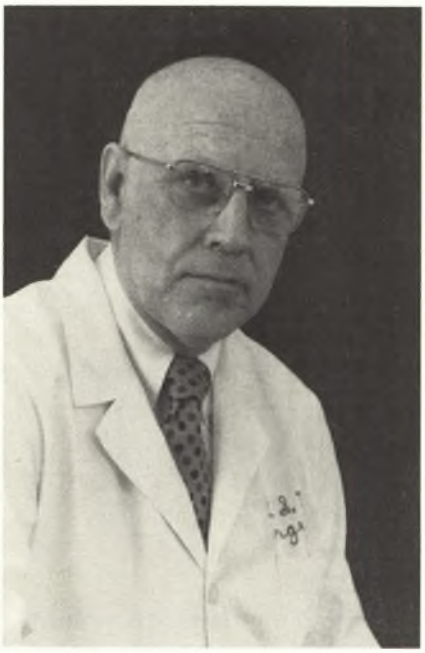
In addition, a number of important interactions took place with the Health Care Financing Administration, especially with regard to criteria for Medicare coverage of heart transplants. To this end, the Committee on Heart Transplantation strongly endorsed the concept of clear enunciation of criteria for center designation, in view of the recognized importance of concentrated experience in operative and postoperative care, the increased pressure on donor resources, and the need for centralization of the donor procurement process. Other interactions with government agencies were conducted under the auspices of the Advisory Committee, in concert with me as president.

During my term, Oscar Salvatierra was elected by the American College of Surgeons as the first governor to represent transplantation. ASTS had previously proposed three candidates to the college for this position. In addition, our Council approved the position of historian, and I named Oscar Salvatierra to fill this position with the Council's approval.

I would like to gratefully acknowledge the hard work of the Council and committee members during my presidency. They provided me with extraordinary guidance that made it a memorable year for me.

John C. McDonald

President, 1987-88



I had the honor of serving as the 14th president of ASTS.

The entire year of my presidency, as well as the year before and after, was a time of great political turmoil. For the first time in history, the federal government was trying to establish a national health care policy involving a single discipline of medicine. The entire transplantation community was awash with rumor and apprehension. I frequently told friends that I felt afloat in a sea of paranoia. During our joint 1987 meeting with the American Society of Transplant Physicians, I participated in a panel discussion on controversies concerning organ sharing. It was a very lively discussion with many opinions strongly expressed.

By coincidence, I was also president of the United Network for Organ Sharing (UNOS) at the same time (1986-88). UNOS, an initiative of ASTS led by our 9th president, Dr. G. Melville Williams, obtained the contract to organize the National Organ Procurement and Transplant Network (OPTN). By the end of 1987, a new three-year contract was obtained to actually implement the OPTN. The UNOS membership did not wish to change leadership at that particular juncture and reelected the entire Board of Directors and slate of officers.

A review of the minutes of the three 1987-88 ASTS Council meetings demonstrates the preoccupation with political affairs. A sample of some of the issues debated:

1. Support of legislation to change the credentials of histocompatibility laboratory directors
2. Constitution of advisory boards for organ procurement organizations
3. Support of mandatory sharing of 6-antigen-matched kidneys (later approved by the membership)
4. Possibility of a formal advisory board from ASTS to advise the UNOS Board
5. Concern regarding "conglomerates" of organ procurement organizations
6. Excessive transplantation of nonresident aliens
7. Relationship between ASTS and the American Council on Transplantation
8. A position paper providing ethical guidelines on cadaver organ and tissue procurement (later approved by the membership)
9. Support for UNOS to continue as the OPTN (later approved by the membership)
10. Standards for an organ procurement surgeon

These and many other issues were debated and brought to resolution.

I look back on that time with considerable pride in the performance of ASTS. Although the future was unclear, we forthrightly faced change and took courageous positions based on principle. In my opinion, time proved these positions wise.

At one time, I worried over the possibility that ASTS was becoming so occupied with political events that it was in danger of losing its primary role as a scholarly society. That concern proved unfounded. It was a strange time that called for special efforts, and it demonstrated what a small number of scholars (and political amateurs) could accomplish. In a purely voluntary effort, ASTS literally conceived, established, and implemented the national health care policy for transplantation. I do not believe this is too strong a statement. Although many other individuals and groups were involved, the driving force behind the whole movement was ASTS.

J. Wesley Alexander

President, 1988-89

With the passage of the National Organ Transplant Act in 1984, much of the Washington-directed political efforts of ASTS had diminished to manageable levels. Still, anticipating continued developments, we wisely retained our relationship with Health Policy Alternatives, Inc., although a new contract decreased our financial commitment for a Washington presence. It was later necessary for ASTS to become more involved in government affairs with the development of Medicare codes related specifically to transplantation and diagnostic related groups (DRGs) related to transplantation.

One of our successful activities was the development of a newsletter *(The Chimera)* for members, appropriate legislative bodies, and interested groups around the U.S. A subcommittee of the Advisory Committee headed by Dr. Kahan was appointed to look into the possibility of such a newsletter. At the May Council meeting, *The Chimera* was officially endorsed with a first year budget of $16,000 and Dr. Caliann Lum as editor. The newsletter, to be mailed quarterly, would replace about 10 or more intermittent mailings currently being sent.

Another important addition was development of the Ortho Academic Development Award. Ortho made an initial commitment for $15,000 in the first year with a target goal of $25,000 per year. A second check was to be disbursed in order to have $30,000 by the 1989 meeting. The Council decided to make the initial award in 1989 for $20,000, with subsequent awards in about that same amount. The award had these initial stipulations: To qualify, the applicant must be a junior faculty member with a rank of assistant professor or instructor in the first year on the faculty. The applicant

must have completed a transplant fellowship in an approved program. Recipients of the Sandoz Award would not be considered, and institutions having a Sandoz fellow could not apply. Awards would not be given to an institution in consecutive years. It was hoped that the awardee would use the funds to perform pilot projects that would form the background for National Institutes of Health (NIH) support for future years.

The proliferation of tissue and bone banks was of great concern during my presidency because of their lack of regulation. An ad hoc committee was appointed to study the relationships between ASTS, OPOs, and tissue and bone banks, particularly with regard to ethical standards.

The Bylaws Committee was charged with the issue of revising the Nominating Committee and the bylaws. As a result, one new councillor-at-large was elected, four councillors to each serve 4-year terms, instead of 3. One additional past president would become a member of the Council. The two new members of the Council would automatically become members of the Nominating Committee, thus extending the scope of the Nominating Committee. The term of the treasurer was extended from 2 to 3 years, providing additional continuity. These changes strengthened the stability of the Council and at the same time provided for broader representation by an increased number of members.

With the expanded transplantation of extrarenal organs after FDA approval of cyclosporine, there was concern that the training programs for fellows in extrarenal organ transplantation were not being sufficiently addressed or formalized. After very long periods of discussion by both the Education Committee and the Council, it was decided that a single-organ, 2-year clinical experience would be sufficient if preceded or succeeded by a year in the laboratory. However, programs desiring ASTS accreditation for training in multiple-organ transplantation would need to provide 2 years of clinical training, the first year in kidney and the second year in an organ of interest, most specifically the liver. Certification of pancreas transplant fellowship programs was not done at that time.

Fees for extrarenal organs were also of major concern. Both the president and several ASTS members made trips to Washington. Considerable correspondence took place with both Dr. Sullivan, head of Health and Human Services (HHS), and Bernadette Schumacher of HCFA regarding reevaluation of fees for organ procurement and transplantation.

Further efforts of the Council during this year increased the participation of cardiac transplant surgeons in ASTS meetings, developed relationships between ASTS and the transplantation program of the NIH's National Institutes of Allied Infectious Disease, and established better liaisons with UNOS and the American Society of Transplant Physicians (ASTP).

Our scientific meeting that year was the largest to date, with over 550 attendees. Despite an increase in dues, 44 new members were elected. A primary emphasis of my Presidential Address was that the organ donor shortage would not be alleviated n the foreseeable future, but that this shortage could best be addressed by ultimately improving the success rate through tolerance induction and, potentially, xenografts. A highlight of the meeting was an address by Dr. Herman Waldmann on "Monoclonal

Antibodies for Immunosuppression and Tolerance." Numerous excellent papers reflected the maturation of ASTS and the inexorable progression of the scientific foundation and clinical practicality of transplantation.

Barry D. Kahan

President, 1989-90

My presidency was abruptly shaken to life in early June 1989 by tight deadlines to respond to an American College of Surgeons (ACS) survey on professional fees. Indeed, the issue of appropriate reimbursement for transplant services dominated that year. The Physician Payment Review Commission (PPRC) had been formed by Congress to revise the Medicare fee schedule, using a resource-based relative value scale (RBRVS) within the context of an overall annual expenditure target. Concurrently, I had set a personal goal to investigate the necessity of fees being paid to a Washington-based organization, because of the large disbursements I had made as treasurer. In Washington in June I met with representatives of various organizations, and returned with the conviction that Health Policy Alternatives (HPA) remained our best advocate and that the issue of reimbursement could seriously affect the future of the transplant enterprise.

My concerns included not only the relative work values for transplant procedures, but also standardized definitions of global transplant surgical packages, identification of ancillary procedures integral to the surgical services, and the scope of pre- and postoperative visit services to be covered within the 90-day global fee. Because transplantation services were not among physician specialties surveyed during Phase I or II of the Harvard RBRVS study, our specialty had been relegated to a minor portion of the general surgery procedures to be considered by the college. The urgency of this matter demanded an August 1989 emergency meeting in Chicago of the Council, including past president Wes Alexander, previous president John McDonald, president-elect Dave Sutherland, treasurer Clyde Barker, secretary Gil Diethelm, and councillors Ron Ferguson and Hans Sollinger. After six hours of discussion, we decided to pursue the establishment of an RBRVS directly with the PPRC and the Health Care Financing Administration (HCFA), while keeping Paul Ebert, ACS director, informed of our plans, actions, and outcomes.

On September 28, 1989, Oscar Salvatierra and I met with Dr. Paul Ginsburg, executive director of the PPRC, to discuss appropriate valuation, historical irregularities in the setting of transplant fees, and possible mechanisms to establish the appropriate RBRVS. In addition, we later discussed with Dr. Roz Lasker of the PPRC staff the

options for defining global transplantation services covering the 90-day period as well as the pretransplant evaluation. At this same time we communicated our concerns to the health aides of Senators Kennedy, Fields, Bentsen, and Heinz, as well as Representatives Waxman and Leland. Via separate channels Len Perloff, Ingemar Dawidson, John Barry, and Jim Pierce wrote their Congressmen. The Council formed an ad hoc committee on reimbursement, which included Feduska, Sterioff, Moses, Delmonico, and Spees for kidney; Bollinger, Gordon, and Bussutiel for liver; Sutherland, Sollinger, Corry, and Ferguson for pancreas; and Baldwin, Reitz, Frazier, and Dyer for heart. Based on information supplied by this committee, we submitted to the PPRC and ACS an estimate of pre- and postoperative visits and intraoperative service information in December 1989.

On January 17, 1990, Jimmy Light and John Baldwin testified before the PPRC, emphasizing that renal transplantation was a unique surgical service because virtually all procedures were provided to Medicare beneficiaries. This was in accordance with special rules enacted 15 years previously and never updated, resulting in inadequate payment levels. Thus, Medicare's antiquated payment records did not reflect recent charge levels and could not be used for simple fee reduction by extrapolation. Furthermore, we asserted that Medicare fee data on extrarenal organ transplants were so fragmentary as to be not useful. We enumerated several unique aspects of transplantation, compared with general surgery practice: the use of a surgical team rather than a single operator, its emergency rather than elective nature, the travel demands, and the requirement for intense postoperative follow-up. We requested that the Harvard Group be commissioned to study transplantation services.

In February 1990, Ben Cosimi, Dave Sutherland, Jim Burdick, Henry Desmaris, and I met with William Hsiao and his colleagues at the Harvard School of Public Health, the investigators who formulated the RBRVS. This meeting revealed that their group had no knowledge of transplant services and no interest in the area in the absence of a federal award from the PPRC or a direct grant from ASTS. Because of the high price tag of such a study, the Council at its February meeting decided to perform its own survey, using the vignette methodology previously described by the Harvard investigators. The study included not only transplant procedures, but also pre- and post-service work, as well as comparative linkage to standardized procedures performed by these surgeons as families of services. The survey looked not only at the time involved in, but also the intensity of, the procedure. We sought also to establish a benchmark procedure for each type of transplant for comparison with every other service in that family.

The survey document to establish relative values and practice costs was largely designed by Jim Burdick and Henry Desmaris of HPA, after meetings with Dr. Nancy Cary, AFCA medical advisor, and Dr. Roz Lasker of the PPRC. The instrument included demographic/practice style and practice cost information, as well as nontransplant, reference, and transplant patient vignettes. A total sample of 182 members were questioned, including 132 randomly selected ASTS members and 50 members active in heart or lung transplantation. The response rate for the former group was 74%; for the latter group, 56.4%.

The analysis of the data performed by Janet Martin, M.S., R.Ph. revealed that the relative work values for transplantation services were higher than, but for nontransplant procedures were similar to, those proposed in the Federal Register. Practice costs and malpractice insurance fees were higher than for most surgical specialists. The document was submitted shortly after the end of my presidency in 1991 both to the HCFA and to the RBRVS. The end result was a relatively favorable fee schedule for renal transplantation. Medicare deferred setting the low fees for liver and heart transplants that had been recommended based on fragmentary, historical information, a decision consistent with the ASTS position.

With respect to reimbursement for physician services for postoperative immunosuppression, there were two problems: differences in practice patterns nationwide and the participation of many individuals at each center. Together with the American Society of Transplant Physicians, we sought to weight the intensity of postoperative care as a function of time, but eventually agreed with HCFA to use appropriate individual visit codes rather than "bundling" immunosuppressive care.

A second group of issues concerned the extension of the period of Medicare reimbursement for immunosuppressive drugs from 1 to 3 years.

Because of the rapidly developing events related to financial reimbursement and the realistic concern of our members about its impact on transplantation practice, there was a pressing need for better communication between the Council and the members. Our newsletter, *The Chimera,* introduced the symbol of ASTS and its transplant enterprise, which had evolved from xenophobic "monstrous" theory to life-preserving and life-enriching surgical practice. It was an honor to contribute three additional president's columns - The Crisis in Cadaver Donation, New Challenges for the Coming Decade, The F(EES) Word - during the first year of publication and to assist Caliann Lum, an eminently suitable choice as editor.

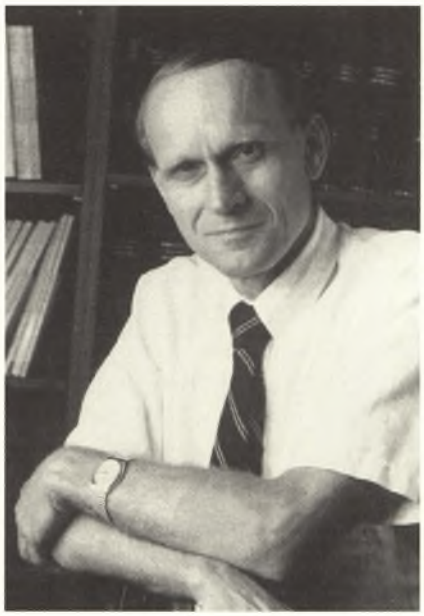
Another concern during my presidency was the need for an organized educational program. Since individual transplant programs tended to expose their fellows only to their own specialized areas of concentration, I felt ASTS should use the expertise of its members to offer a broad-based postgraduate course. Furthermore, many members, including Tony Monaco and Nick Tilney, felt that education in the fundamental immunologic aspects of transplantation was being smothered by the technical demands of transplant fellowship. The first 1990 course focused on immunosuppression, including mechanisms of rejection, generic complications, conventional approved agents, and new unapproved modalities. This effort laid the foundation for a successful series with burgeoning registration. The course added a new facet to our commitment to the education of apprentices and the updating of artisans.

It is my belief that ASTS represents the bright side of transplant practice. It offers a forum for presenting new information and acts as a major defender of excellent clinical patient care by virtue of its proactive position regarding both education and public policy. However, we have failed to assume spiritual leadership on the ethical, cultural, and societal issues critical to cadaver organ donation, a failure that endangers the lifeblood of our organization. Finally, I believe that ASTS must fulfill its mission as a "guild," extending beyond stringent training requirements and frequent inspections

to uphold the quality of the specialty, toward the brotherhood and sisterhood necessary to address the divisive challenges of future decades.

David E. R. Sutherland

President, 1990-91



The highlight of my year as president was the privilege to congratulate, on behalf of ASTS, our honorary member, 1990 Nobel laureate Joseph Murray, and to welcome him to the Presidential Dinner in May 1991. The dinner was attended by every one of the previous 16 presidents and by Murray's protégés—pioneers in their own rights—scattered throughout the world as leaders in transplantation. In a letter from ASTS to Murray after the Nobel Committee's announcement, we pointed out that it was his and his associates' vision, research, persistence, and clinical application of transplantation that made our society possible.

Vision was also an inherent trait of my presidential predecessors (all founding members). I called most of them for advice during the year I served.

Apart from the unique opportunity that the awarding of the Nobel Prize to an ASTS member afforded for celebration, the year was also a stimulating exercise in politics—not internal, but external. We grappled with several issues thrust before us by our colleagues in Washington, D.C. I was preceded by a very proactive president, Barry Kahan, and as immediate past president he continued to give generously of his time. To work with him and the other members of an extremely responsive Council made the year easy and fun. The assistance of our Washington liaison, Henry Desmarais of Health Policy Alternatives, is also gratefully acknowledged.

Major issues we addressed during 1990-91 included:

1. The *Physicians Payment Reform Commission and the development of relative value scales for transplant services.* Barry had already initiated interactions with the commission. He and I made several trips to Washington, to meet with members of the commission or of Congress. We also traveled to Boston to meet with the developers of the Harvard Resource-Based Relative Value Scale (RBRVS). Transplant services had not been addressed by the commission, so it was important for us to be active in pointing out the uniqueness of our services. We organized surveys of ASTS members to rank the various procedures and services we provided relative to other surgical procedures and services. The process is still ongoing. Recently, our current president, Frank Stuart, and I, along with Jim Burdick and William Baumgartner, met with the

American Medical Association Relative Value Scales Update Committee (RUC). This meeting decided on the relative value scales for transplant services to recommend to the Health Care Financing Administration (HCFA). We appeared to be successful in having transplant services rank among the highest. The groundwork initiated by Barry and carried over into my year and beyond paid off.

2. *National Organ Transplant Program Extension Act of 1990 (H.R. 5146) and the Transplant Amendment Act of 1990 (S2946).* 1990 was the year that the National Transplant Act was reauthorized. Some of the changes proposed to Congress were dangerous, and the Council worked very hard to head them off. There had been dissatisfaction with organ distribution in several circles, with the perception that transplant surgeons still retained a buddy system. One proposal was to reconstitute the Organ and Procurement Transplant Network board, organized under contract with the United Network for Organ Sharing (UNOS), so that transplant surgeons and physicians comprised only 25% of the members. We issued a strong statement (white paper) to members of Congress on this proposal (see October 1991 *The Chimera*), and were successful in having it omitted. Indeed, the final act mandated that at least 50% of the board be transplant surgeons and physicians. We also continued the lobbying initiated by previous councils to extend immunosuppressive drug coverage by Medicare for a lifetime, rather than the existing one-year limit. The most recent reauthorization of the National Transplant Act includes this extension.

3. *Inspector General.* Curve balls were also thrown at us during 1990, the most significant being the release of a report by Inspector General Kusserow of a draft document entitled "The Distribution of Organs for Transplantation: Expectations and Practices." The document highlighted a twofold longer average waiting time for black vs. white renal transplant recipients, and stated it was due to a subconscious prejudice by transplant centers and transplant surgeons. Since ASTS and its ethics committee regard discriminatory practices by any member as a cause for expulsion, it was essential that we respond swiftly and precisely. The Inspector General's draft was extremely flawed, and we were able to make the case that the discrepancies in waiting times were due to other factors, including demographics and HLA matching requirements. Our response appeared to have been effective: the final report was considerably different from the draft, incorporating our comments and those of others. ASTS absolutely supports a color-blind policy in organ allocation. Our statements were as strong as possible in this regard, and no evidence to support the Inspector General's presumptions were forthcoming.

4. *Third-party reimbursement for extrarenal organ transplants.* This issue was also addressed vigorously in 1990-91. Lack of insurance, or limited reimbursement by insurance companies or Medicare, for heart, liver, lung, and particularly pancreas transplants was a major problem inhibiting their application. In a letter to the Office of Health Technology Assessment, we pointed out the success rate with pancreas transplants and strongly recommended that Medicare cover them (see August 1991 *The Chimera*). Coverage of pancreas transplants by Medicare is still pending, but the

Office of Health Technology Assessment has completed an analysis and will make recommendations to Medicare this year. Meanwhile, more and more insurance companies now cover extrarenal organs, including the pancreas. The efforts of the Council and individual ASTS members were undoubtedly responsible for the increase in pancreas coverage that occurred during the 1990s.

5. *Honorary Membership.* I had the privilege of nominating Fritz Bach to be an honorary ASTS member during my year as president. Bach is widely recognized as one of the most innovative scientists of our time, and it was an extreme pleasure to be his sponsor. His contributions are too numerous to list completely, but include the development of immunologic methodology (mixed lymphocyte culture and its derivative tests); key discoveries in immunogenetics (including the division of the major histocompatibility complex into class I and class II antigens, each serving different functions in the context of T cytotoxic and T helper cells); advances in cellular immunology (including the steps in functional maturation of T lymphocytes as described in his classic 1976 paper in *Nature)*; and leadership of the team that did one of the first (if not the first) matched bone marrow transplants in the 1960s. Bach has also been the adviser for many transplant surgeons receiving basic training in immunology. It was fun having him as a colleague and friend for more than 13 years at the University of Minnesota. It was a privilege to induct him as an honorary member as one of my final acts as president.

6. *Postgraduate Courses.* Finally, I enjoyed the opportunity to help develop the our postgraduate courses. The first was during my first week of president, immediately after the 1990 meeting. The concept was Barry Kahan's, and we worked together to organize the first two courses. The second, in 1991, was the first to have its proceedings published (in *Clinical Transplantation*). The 1991 course was also special because nearly a third of the speakers were protégés of Joseph Murray, in attendance that year as our guests to honor him. They included Sir Roy Calne, Cambridge, England; Jean Michael Dubernard, Lyon, France; Ross Sheil, Sydney, Australia; and Guy Alexandre, Brussels, Belgium. My immediate successor, Gil Diethelm, also a protégé of Murray's, spoke as well. The course was also attended by another distinguished guest, Gertrude Elion, who had received the Nobel Prize two years before . Her comments on various papers gave a special aura to our course.

Of course, the ASTS mission is to promote the science of transplantation. Politics is secondary. Thus, the Postgraduate Course complements our meetings in fulfilling this mission.

No organization has meant more to me professionally than ASTS. I have attended every meeting, served on several committees, and was secretary for two years in the 1980s. During my six years on the Council, I found our meetings always lively. We dealt with serious issues yet had fun at the same time. I cannot imagine another group of individuals with whom I would rather be associated than the members of our society. Serving as ASTS president was truly a highlight of my life.

Arnold G. Diethelm

President, 1991-92

It would be very difficult for me to identify specific events that occurred during my year as president that did not have their origin one, two, or many years earlier, all requiring a great deal of effort by members of the Council and former presidents. Similarly, some ideas that were embryonic during my presidency may be of importance in the years to come. Four areas merit mention:

The first important point of emphasis is the Education Committee, the backbone of the educational components of ASTS and our fellowship training programs. It is important to recognize, as John Najarian did many years earlier, that the Education Committee does not credential surgeons but programs. This basic concept has allowed us to prevent a collision course with the Residency Review Committee and the American Board of Surgery. At the same time, it has also allowed us to avoid the use of an examination, which in turn would then credential the transplant surgeon rather than the transplant fellowship program. At a time when specialization continues to expand at a rapid pace in American surgery and even more so in American medicine, the basic concept that the Education Committee examines and approves fellowship training programs has been a fresh and unique approach, thereby avoiding Certificates of Added Qualification through the American Board of Surgery. The Education Committee will become increasingly important in the years ahead. It will eventually have to determine the number of fellows to be trained, the type of training, and to encourage programs not to lose sight of the importance of research as an integral part of fellowship training. There is great risk that the transplant fellowship programs will become a clinical training camp as opposed to a true research and educational experience. The success of organ transplantation in the past has largely been the result of the emphasis of transplant surgeons upon research. It is hoped that this emphasis will not be lost in the future as the clinical needs increase to develop large-volume patient care programs. The Education Committee has frequently addressed the question of whether or not small-volume transplant fellowship programs can be excellent in quality. The answer is a clear yes and the number of cases performed by the fellow should never be considered as the most important measure of the quality of the program.

Second, ASTS's relationship to government activities has increased in intensity since the mid-1980s, as we have all observed. The interaction is now far more complex and important than any of us would have expected in the early 1980s, thanks to the intricate interrelationship between transplantation and the federal government. The

development of an Ad Hoc Committee from the ASTS Council to deal with government policies in a timely fashion was an excellent step. This committee provides the Council with a summary of current issues in Washington and with recommendations to resolve matters relating to clinical transplantation. The Council can then react quickly, if necessary.

Third, the Postgraduate Course, developed one year before my presidency, is one of ASTS's major accomplishments. This course has been a superb contribution to our educational efforts, which are not only limited to surgeons. The speakers have been outstanding, the topics carefully chosen, and the information current. It is safe to predict that the Postgraduate Course will become an exciting component of the annual transplant meeting. I congratulate Dr. Kahan for initiating this idea.

Fourth, I hope that the Coalition on Organ Donation may be truly beneficial in terms of nationwide education. Organ sharing is one of the major obstacles to successful clinical transplantation today. Prevention and treatment of acute rejection has enormously progressed since the introduction of cyclosporine. Chronic rejection may be prevented in the future. Organ donation, however, has made little progress in the last 10 years. A large part of the problem is the lack of a coordinated, national educational effort. Such efforts have been beneficial in campaigns to quit smoking, to monitor hypercholesterolemia, and to buckle up in the automobile. A similar educational program, developed by professionals in advertising and communication, could make an enormous difference in the U.S. in terms of organ and tissue donation. Other solutions have been proposed and are being discussed, but expanded education, with emphasis on altruism, remains a simple, direct, and sound approach. It could be a mistake to prematurely assume that education and altruism cannot be further developed. To do so may lead us to search for solutions that, in the end, could create a negative public impression.

Clyde F. Barker
President, 1992-93

As in other years, most of the 1992-93 ASTS work was done by its committees. Four Council meetings were held: in August, during the Paris Congress of the Transplantation Society; in October, in New Orleans, during the meeting of the American College of Surgeons; in February, in Seattle during the meeting of the Society of University Surgeons; and in Houston, in May during the annual ASTS meeting.

The Membership Committee, chaired by Richard Howard, clarified criteria for membership; revised the membership application; and reviewed 58 applications (33 of which were approved for regular membership, and 7 for corresponding membership). Professor Peter Morris of Oxford was elected to honorary membership.

The Education Committee, chaired by Nancy Ascher, continued to certify fellowship programs rather than individual transplant surgeons. Levels of activity necessary to approve for training for different organ transplants were again discussed by this committee and the Council, but not finalized.

The Scientific Studies Committee, chaired by David Dunn, initiated a study of viral infections in transplant patients, especially Epstein-Barr virus infection and lymphoproliferative disorders.

The Bylaws Committee, chaired by E.A. Santiago-Delpin, recommended limiting the number of members on the Advisory Committee on Issues to the 9 most recent presidents plus 3 other members. This was approved.

The Ethics Committee, chaired by Jerry Turcotte, distributed a questionnaire to the membership regarding "rewarded giving" of organs, e.g. financial compensation to families of cadaver donors to cover funeral or other costs associated with the donor death. Of the 69% of ASTS members who responded, 72% favored some sort of compensation for donor families. There was no support for cash payments. Recognizing the difficulty of even a trial of rewarded giving, since federal law would need to be changed to allow it, the Council did not recommend implementation of such a program. But the Ethics Committee was asked to continue to explore the issue and asked to consider the recent interest and activity in xenografts.

The Issues Committee, chaired by Arnold Diethelm, continued to advocate reimbursement for pancreas transplantation, an issue under consideration by Thomas Holleran, director of Health Technology Assessment. ASTS views were presented to Holleran in a letter from the president and by personal contact with Sutherland. Holleran appeared favorably disposed, but delayed any decision pending his personal site visit to pancreas transplant centers.

The Committee on Standards for Organ Procurement, chaired by Sylvester Sterioff, proposed and submitted to the Council guidelines for organ procurement and allocation (published in the August issue of *The Chimera*). Controversial issues taken up by this committee included the use of donors of marginal suitability, such as those with hepatitis C. Efforts were also begun to coordinate interactions between the United Network for Organ Sharing (UNOS) Standards Committee, the International Organ Procurement Agency (IOPA), and the ASTS Committee.

The recommendations of the Nominations Committee, chaired by Arnold Diethelm, were accepted by the Council and confirmed by the membership: president-elect, Mark Hardy; secretary, Ronald Ferguson; councillors-at-large, David Dunn and James Burdick. The following committee nominations were also made: chairman, Liaison, Frank Stuart; Local Arrangements, Michael Abecassis; chairman, Postgraduate Course, Ali Naji; chairman, Thoracic Organ Transplantation, Vaughn Starnes; Bylaws, Frank Delmonico; Standards and Organ Procurement, Mark Deierhoi; chairman, Scientific Studies, John Fung; Education, Ira Fox; Program and Publications, Jonathan Bromberg; Membership, Dixon Kauffman and Stephen Bartlett.

During 1992-93, ASTS had a number of interchanges with officials and committees of the federal government over reenactment of the National Organ Transplant Act, President Clinton's impending proposal for health care reform, and the implementation of the resource-based relative value scale (RBRVS). Henry Desmarais of Health Policy Alternatives served as our agent in Washington for this work. Barry Kahan chaired the ASTS Committee on Government Relations. As president, I gave both written and verbal testimony at meetings of the Division of Organ Transplantation, at subcommittee meetings of Hillary Rodham Clinton's Task Force on Health Care Reform, and at a meeting of Congressman Waxman's Subcommittee on Health and the Environment.

In February 1993, at the annual meeting of the Division of Organ Transplantation, I was among representatives of several organizations who presented their views (including ASTS, ASTP, the National Kidney Foundation, and various others representing patients, transplant coordinators, and organ procurement agencies). I identified organ donation as the major problem facing the field and suggested several strategies to increase donation, such as educational appeals to the public, rewarded giving, and help to living related donors. I also spoke to the need to develop a more effective organ procurement organization (OPO) system and to implement reasonable but challenging OPO standards to diminish the present disparity in performance. I stressed the urgent need to extend coverage of immunosuppressive drugs (contained in a bill vetoed by President Bush in November 1992). Regarding the controversial issue of tissue transplantation, I reiterated the ASTS position, namely, that Congress should be cautious about imposing new regulations before full discussion of the issues. As an example, the FDA's decision to intensify regulation of one type of tissue, human heart valve tissue, was unfortunate. Finally, I called attention to the discouraging fact that the planned appropriation for the Division of Organ Transplantation ($2.7 million) actually represented a decrease from the previous year.

On April 22, 1993, during a hearing of Congressman Henry Waxman's Subcom-

mittee on Health in the Environment, a number of witnesses were asked to speak on the reauthorization of the National Organ Transplant Act. I emphasized ASTS's support for the current OPTN contractor, UNOS, in view of the considerable progress made over the last few years. Again, the need for addressing inadequate organ donation was emphasized. I asked for additional federal resources such as support of section 371 project grants designed to increase the number of donors. I reiterated the need for educational packets in elementary and secondary schools, as proposed by Arnold Diethelm in his 1992 ASTS Presidential Address. OPO performance criteria were again mentioned. I expressed the concern of many ASTS members over the delay in general availability of important new immunosuppressive agents, such as FK506; pharmaceutical companies and the FDA need to move expeditiously. Tissue transplantation was also mentioned. The subcommittee was cautioned that concern over tissue banks should not translate into burdensome regulation or be extended into regulation of solid organ procurement and distribution. I also expressed these views in a letter to Congressman Waxman. The Waxman subcommittee was particularly concerned with differences in OPO performance and fairness in organ allocation. I expressed ASTS's support for patient-oriented allocation schedules, but noted the reasons we did not endorse a single national list.

In May 1993, I had a chance to represent ASTS in hearings of a subcommittee of Hillary Rodham Clinton's Task Force on Health Care Reform. I also outlined our views in a letter to Ira Magaziner. I urged including transplant procedures and post-transplant immunosuppressive drugs in any standard benefit package that might be proposed or adopted under health care system reform. I also stressed the need to provide funding for all transplants, including pancreas and lung, and to cover immunosuppressive drugs for the functional life of the transplanted organ. I also spoke of the importance of government support of academic health centers and, specifically, for research in transplantation.

With respect to Medicare Fee Schedule developments, RBRVs were revised in November 1992 to be implemented January 1, 1993. Possibly in part because of a recommendation by ASTS to HCFA's acting administrator, William Toby, Jr., HCFA agreed to retain individual carrier pricing of heart and liver transplantation, at least for 1993. This gave ASTS another opportunity to recommend appropriate relative work values for heart and liver. Goran Klintmalm, Sara Shumway, Bill Baumgartner, and Jim Burdick, along with Barry Kahan, worked to define these appropriate values. At the end of the year, there was still uncertainty as to what HCFA would do with the ASTS recommendations.

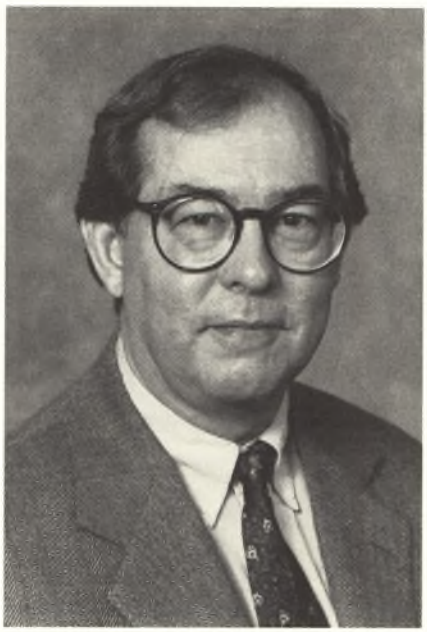
As usual, the most important event of our year was the ASTS annual meeting. The Program and Publications Committee received 358 abstracts, 88 of which were selected for presentation. These covered a broad spectrum of transplant subjects. The level of interest and attendance at the parallel sessions was excellent. Despite anxiety over the change of venue, attendance was large (over 725). Treasurer Nick Tilney was able to maintain a fund balance sufficient to keep the society solvent without increasing the dues. Almost 300 attended the excellent postgraduate course organized by Ronald

Ferguson. The course generated a profit, which helped allow its proceedings to be published in a special issue of the journal *Clinical Transplantation.*

I had the pleasure of selecting as the annual Hume Lecturer, my old colleague Jonathan Sprent, who spoke on the thymus. For me it was a special privilege to deliver the Presidential Address. In researching the topic, the history of transplantation tolerance, I had the pleasure of visiting my old teacher, Rupert Billingham.

Frank P. Stuart

President, 1993-94



Issues of most concern to transplant surgeons during the 20th year of ASTS focused on legislation of the U.S. government and the continuing severe shortage of cadaver organs for transplantation. The main feature of federal legislation was reauthorization of the Transplant Act. As these comments were written, the legislation had passed through the House of Representatives, but Senate action was not complete. The reauthorization act will probably not have been completed until sometime in early 1994. Meanwhile, the United Network for Organ Sharing (UNOS) was re-awarded the contract to serve as the National Organ Procurement and Transplant Network. Even though the reauthorization legislation is not complete, elements of it are under intense debate and will probably emerge in the new public law, resulting in:

1. Larger single waiting lists for cadaver organs—which will include not only entire organ procurement organization areas (OPOs), but perhaps several OPOs or multistate regions
2. Less flexibility for hospitals to work with OPOs, outside their own, for purposes of organ salvage
3. Stringent guidelines for OPOs, which will help them increase their efficiency and make more organs available for transplantation
4. More authority for UNOS to ensure increased and fair access to cadaver organs for transplantation throughout the U.S. Congress will probably mandate that UNOS study the fairness issue and propose a plan to ensure equal access to organs, no matter where the potential recipient lives. This will be difficult to achieve, but is a clear goal of Congress.

In addition to legislation concerning whole organs, Congress has become increasingly concerned with safety of tissues (e.g., bone, corneas, valves, skin) for transplantation. The U.S. is being flooded with tissues from other countries, where procedures to

ensure safety from transmissible disease may be insufficient. Consequently, it is very likely that a comprehensive tissue transplant act will become law in 1994. Meanwhile the Food and Drug Administration assumed responsibility for regulating tissue banks.

Transplant surgeons support responsible regulation of tissue banking and tissue transplantation. However, a way must be found in the new tissue legislation to ensure that tissue banks and OPOs will not work at cross-purposes. It would be unfortunate if some hospitals end up being tissue donors and other hospitals organ donors. Rather, all hospitals must be efficient participants for the national good to identify both organ and tissue donors in each hospital. Alabama may have led the way in resolving this potential conflict by giving OPOs in that state the responsibility to ensure that not only organ donors, but also tissue donors, meet an acceptable safety standard with respect to viability, transmissible disease, and other concerns.

Finally, the continued growth in the need for transplantable cadaver organs in face of a donor plateau for the third consecutive year has placed tremendous pressures on our specialty. Clearly, the American people need more organs for transplantation. The ASTS Ethics Committee and many of our members are exploring what once would have been marginal donors; that is, organs from older donors and donors whose heart has stopped before organ retrieval, even though brain death occurred earlier. The average wait for cadaver kidneys now approaches 3 years. The wait for critical lifesaving organs such as lung, heart, and liver may approach a year or more. Thus, there is increased interest in live, related donors. This has been standard for many years with the kidney, but has been applied now to liver and lung. It is likely that transplanting portions of the liver and lung will become more frequent.

In addition to living related donors, unrelated donors who are connected by friendship or other strong bonds are increasingly offering to donate organs. Some propose financial compensation for the family of the cadaver organ donor. However, current U.S. law does not permit such compensation. There is considerable debate about whether compensation would accomplish anything useful and whether the law should be changed to permit a trial of compensation.

The Transplantation Society and ASTS are strongly opposed to transplanting organs taken from executed prisoners, even if they expressed a desire to have their organs removed for that purpose. Nevertheless, a few voices in the U.S. are proposing this approach. Transplant surgeons believe that a healthy distance should be maintained between the execution process and organ transplantation. It is simply not worth blurring things in the public mind to obtain a handful of additional organs each year. Although organs are taken from executed prisoners and transplanted in several other countries, that should not be used as a rationale to extend it to Western societies and the U.S. in particular.

Another result of the static supply of cadaver organs is renewed interest in xenografting. During this past year, several attempts were made at transplanting livers from baboons into human recipients. However, the pig is increasingly viewed as a more likely source of organs for human beings. Such xenotransplants may become routine in the next 10 to 15 years.

Meanwhile, ASTS grapples with the question of whether or not the U.S. is training too many transplant surgeons during this transitional plateau in transplant activity. Most expect organ transplantation to increase rapidly with the coming of safe xenografting, but we may be training more transplant surgeons than needed during the next 10 years.

All in all, it has been a challenging, exciting privilege to serve as president of the ASTS during its 20th year.