

The following presidential Address is not the original one that I delivered at the 1995 Annual meeting, but instead is a reconstruction from my columns in the *Chimera*, "Letter from the President"; from the minutes of the Council; and from my notes that I found in a file in my attic (at the time I wrote them in longhand on a yellow pad, and not on a computer as I do today).

Ladies and Gentlemen, Members and Guests,

First of all I want to thank you all for electing me to the presidency of this distinguished Society, which from its beginning had its feet in the 20th century but its brain in the 21st century, and whose progress has been like a comet streaking across the sky. Last year has been one of the highlights of my academic career and I thank you for letting me serve you. This year was just a small but significant part of the journey of our Society. Many both big and small steps forward were taken with the help of very capable ASTS Officers, Council members, committee chairs, and their associates. I owe them all a great debt of gratitude for guiding me in what had to be done and inspiring me to innovations in servicing our transplantation community, including our patients, both donors and recipients.

I want to particularly thank Ron Ferguson, who as secretary was my advisor, critic, and strategist for our negotiations with the government and with our sister society, ASTP. I am very grateful to Nick Tilney, our president-elect, who as treasurer not only kept honest books, but more importantly kept reminding me of our Society's critical role as a vehicle for training and education. I also want to thank my first mentor in transplantation, Dr. Anthony Monaco, who guided me into this field in 1968 and who dubbed us all as "the eggheads of surgery" in his presidential address in 1986. Thank you also to Dr. Keith Reemtsma, my chairman at Columbia,

who encouraged me and gave me a carte blanche, but aided me whenever I needed him, in creating an interdepartmental transplantation program of which I am very proud.

It goes without saying that the constant loving support of my wife and children, who are here today, has always been the fuel and the engine that keeps me going.

In the first part of this talk I want to discuss the main accomplishments and concerns of the Society this year and how they were addressed. In the second part I will share with you some of my thoughts about the difficulties that we will face in the future and the need to be prepared to overcome them.

We have all been concerned for several years with the quality and quantity of training of a new generation of surgeons for transplantation of all organs, both below and above the diaphragm. It is not just a numbers game and how many transplants trainees must be able to perform before they can set up a transplant program. The issues here are not only the technical skills of the surgeon, which in fact may be sufficient even after short-term training, but training in recipient and donor selection, pre- and post- transplant management of the patient, and particularly training in immunobiology so that future surgeons can improve on what has been accomplished in the past. They must be able to partner with basic scientists in translational research to readily move the expected innovations from the bench to the bedside.

I am proud to say that in the past year, with the assistance of the Education Committee headed by Dixon Kaufman, we re-evaluated and re-established our training criteria and set up a registry for trainees that will permit us to monitor the manpower needs for many years to come. In the past year we have initiated the establishment of more precise and standardized criteria for certification of training centers as well as of individual transplant surgeons, ensuring not only

technical proficiency through performance of adequate number of cases, but also training in clinical management of patients and learning about the administrative functions of the unit.

When we enter the 21st century we must not only continue to lead in the development of the field of transplantation but must maintain our confidence and skills in the overall care of the patient, based on scientific knowledge and developments to which we must remain the main contributor. The future trainee must be able to transplant all organs below the diaphragm (we will leave those above the diaphragm to others), including cells, although they undoubtedly will concentrate on one or two organs such as the liver or the kidney, as surgeons have done in other specialties.

As we look back to our roots, we see that many of us started out in the laboratory learning immunology and applying it to the development of new methods of immunosuppression, identifying rejection, and developing new technical surgical approaches to transplantation of extra-renal organs. We worked side-by-side with colleagues in various disciplines, especially immunologists, and developed ideas that could benefit our patients. We must demand that training in immunology be part of education of our transplant surgeons even though many will focus primarily on patient care and not on basic research. The transplant surgeon must understand basic scientific concepts and be able to communicate with the basic scientists in order to continue to fulfill his/her clinical role effectively—although “cutting and sawing” well is critical, it is insufficient in our field.

As we are inundated with all the "new health care brouhaha" (from Nick Tilney's correspondence) and hampered by the lack of research funds, we must continue the Society's effort on its educational and training mission by raising more training and research funds and by close collaboration with industry. To that end I have established in the past year the Industrial

Advisory Council to systematically develop a research funding plan for the Society. The small number of training grants must be increased in both number and in amounts through a concerted effort of the membership and its supporters.

In the past year we have also initiated the development of the electronic communication network under the leadership of William Marks and the newly named Informatics and Data Management Committee to facilitate the dissemination of information and prompt and rapid interchange of ideas among our members and those of other societies, both national and international. We think that this will also be the tool for submission of abstracts and their evaluation and more importantly for their distribution to the whole transplant community.

As part of activities in the past year we have continued to face questions on how to interact with ASTP and how to delay or prevent the fragmentation of our membership into individual organ-specific societies, an alphabet soup which now includes IHTS (International Heart Transplantation Society), IPITA (International Pancreas & Islet Transplantation Association), LTS (Liver Transplantation Society), CTS (Cell Transplantation Society), and others on the way. In the case of fragmentation, the die is cast and the one solution that the Society is pursuing, with only mixed success, is to bring the annual meetings of all these societies together in one large Transplant Week and encourage them to function as a Federation. In this way the members of the various societies, who frequently have their allegiances to more than one, will be able to share ideas, problems, and solutions with their colleagues. The early discussions with the officers of other societies have been met with only tepid interest, with objections arising mainly from the practicality of operating such a joint congress at one site and the effectiveness of a meeting where too many presentations lead to dilution of interest and therefore of attendance.

The idea of having a Federation of Transplant Societies is under discussion, and the final chapter on this subject still needs to be written.

The strength of ASTS remains its unity of purpose; once that is diluted, so too will go its effectiveness and impact. I am grateful to Oscar Salvatierra for heading an ad hoc committee that examined the various options on how we can best relate to ASTP. In a survey that Oscar conducted, 74 percent of our membership felt strongly that we should remain a separate surgical society, while half the membership would accept a joint society if the presidency, the council, and the officers were equally divided among the surgeons and the non-surgeons. A similar survey by ASTP found greater enthusiasm to merge the two societies, which is understandable since their membership is much larger than ours and it is likely that they could therefore exert administrative control over the merged societies. Everyone agreed that cooperative efforts must increase regardless of whether the societies merge or not. It was apparent from both ASTS and ASTP surveys that the societies should not be competitive, but rather supportive of each other.

I am very proud that this conversation between the two societies began on my watch and expect that it will be expanded in the future to the benefit of not only both memberships, but especially to the benefit of the patients which both societies serve. The idea that the societies should remain in close communication in developing position papers was strongly endorsed, while supporting separate presentations so as to have greater impact when speaking with two major voices rather than one when taking a similar position on critical issues. I feel that we have made a productive start in developing formal collaborative efforts with our non-surgical colleagues, and that this relationship will eventually constitute a new infrastructure for our

overall efforts in clinical transplantation and immunobiology. This interaction should be of greatest benefit and interest to members of both ASTS and ASTP.

Of greatest concern to everyone in the past year were donor shortage, organ allocation, extension of financial coverage to include immunosuppression, data on cost and outcomes, recognition and funding of new procedures, cell transplantation, and increasing support for UNOS to continue as OPTN contractor. It has become clear in the past year that ASTS must increase its interaction with Congress and the various regulatory agencies to emphasize the importance and value of transplantation to the community and to the country.

ASTS needed to address several main issues dealing with the donor organ shortage. These were: 1) rewarded giving and 2) enforcement of pro-organ donor regulations, which are variable from state to state such as required state laws, and 3) attitudes to presumed consent, which has not gained any foothold in the U.S. but has been newly adopted in a few European countries who converted from organ importers to organ exporters. The efforts regarding some of these issues have been led by individual states, such as Wisconsin and Kentucky, but now need to be promulgated at the national level through UNOS and through the National Transplantations Act.

As a Society and as most of us as members, we have kept our head in the sand in relation to our interaction with the various government agencies. My year as your president has revealed to me that this is not only no longer practical, but it is dangerous, and that we must become very proactive at the local, state, and national levels in supporting the interests of our patients. As part of cost-cutting, the government is examining everything we do in ever-increasing detail. Transplantation, although a relatively small specialty, has been targeted because of the availability of many of our data.

As the various suggestions and regulations regarding health care funding and service allocations come out of Washington, we must be active participants in their formulation and execution so as to avoid the shift in funding to favor non-surgeons and administrators. This is also particularly true in processing and licensing of new immunosuppressive drugs where we have been very active in interacting with the FDA through our very able representative, Barry Kahan. As your President I have made many trips to Washington together with some of the officers of the Society to discuss apportionment of adequate funds for basic and clinical research in transplantation and provision of adequate reimbursement to physicians and hospitals for care of transplant patients and for maintenance of the donor effort.

In all these interactions, the Society has been fortunate in having the assistance of Mr. Henry Desmarais, who through his knowledge of the playing field in Washington, through his advice to me and to the Council of the Society, and through his almost daily activities, has been an invaluable supporter of our interests in Washington. With his guidance and sage advice, our membership is being well served in the ongoing negotiations for reimbursements and in formulation of organ allocation based on existing data and on medical and ethical considerations.

In preparing this address I tried to decide on what subjects not to discuss and details regarding financial issues was one of them. Yet I feel compelled to mention some of the problems that we are all facing and which the Society must meet face on. Allow me to give you only a few examples of what we have been doing last year and thus provide you only with a taste of what is to come. HCFA is developing new rules to change Medicare Physician Fees schedule, which will include adoption of RVUs for heart and lung transplantation and perhaps some form of reimbursement for pancreas transplants at Centers of Excellence rather than relying on

payment decisions of individual Medicare carriers. Reductions in payments of fees and of assistant fees are being considered. The Society is working hard in negotiating with HCFA on setting the RVUs for various procedures, preserving payments for bench surgery and for immunosuppression and maintenance and increasing appropriately practice expense RVUs for many services under Medicare.

Health center reform remains very much a center stage issue in Washington. Establishment of HMOs raises the question of including all or some transplants. How that decision will be made is uncertain, but being eligible through Medicare may force the HMOs to provide transplant coverage. With the new President focused again on restricting health care costs, controls on provider charges or payments as well as on health insurance premiums are being suggested, which may disable the increasing transplantation efforts, prevent development of extra-renal organ transplants, and discourage new trainees from entering the field.

Another concern for the future is the effort by the government to organize a new system for financing graduate medical education under which Congress would set a limit on the total number of residencies and some agency would determine the distribution of such funds. Training in transplantation has not been considered as a major necessity for the future of American medicine and surgery. Although the last word has not been said about specialty distribution of future physicians, these determinations will undoubtedly have major implications for the future of transplantation in the U.S.

As part of the financial concerns and our relation with the various governmental agencies, the focus on long-term support for immunosuppressive drugs continues to be uppermost on our agenda despite the bill which was passed in Congress being vetoed. We are also very concerned about the FDA being slow-footed regarding approval of new immunosuppressive agents, and it

is our intent to establish much closer professional links with the FDA, at its invitation, to advise and consult in that regard.

The government's attention to outcomes for lung, heart, and pancreas transplants illustrates a new emphasis on approval and support of new procedures. The Society should not only be deeply involved in these determinations and evaluations, but support the effort as much as it can, since this promises to be of major benefit to the transplant community and particularly to the patients.

I want to leave you with the message, perhaps delivered already too late, that we should try to reassemble the various pieces of transplantation services found among several new organ-specific societies, piece by piece, and create a transplant federation that will speak to the country and to Congress with one voice on the most critical issues in transplantation. Such a voice or united voices will be clearly heard in the halls of NIH, Congress, and the Executive Branch. Without such unity, we might become just another pawn on the large health care delivery system chessboard, a game that will go on for many, many years to come. We, as our patients' advocates, must keep on winning this game despite the heavy odds against us.

Since I don't want to leave you on this worrisome note, let me remind you that the Society remains strong and that we have made significant progress in the field of training and education of a new generation of transplant surgeons, that we are establishing an informatics network that will facilitate our future activities, that we are making progress in uniting some of the scientific efforts of the two societies ASTS and ASTP. Most importantly, we are beginning to speak with one voice to our regulatory agencies and to Congress; we are being recognized as important cogs in the health care machinery, despite our relatively small representation, because of our high visibility which we are learning to utilize wisely. We must make the

policymakers in Washington understand that support for transplantation's academic and clinical efforts is essential in maintaining this nation's leadership in scientific innovation and high-quality medical care.

Again, I want to thank you all for placing your trust in me over the past year, and as I pass the reins of leadership of the Society into the capable hands of Dr. Tilney, our president-elect, I am confident that we are stronger than ever and that he will steer us wisely into the future. To quote Churchill, "This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning"—and a brighter and even more productive future is awaiting us.