ASTS: A Precocious 2-Year-Old

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Members of the American Society of Transplant Surgeons and Guests:

First, it has been a great honor indeed to serve the past year as the president of ASTS. Tradition now calls for a Presidential Address. I must admit I have had great difficulty in finding something appropriate to say. Perhaps it would be a good idea if the presidents did more and talked less. Last year, Tom Starzl compared the birth of ASTS with that of a child. His task was easier than mine. When a child is born, one can talk about one's hopes and wishes for the future, and can always say something nice about the parents. Indeed, Tom showed us some nice and interesting pictures of some of the parents of ASTS. But what can one say about a child who is 2 years old? The parents have changed little, and it is difficult to expect that in this short period the child would have made significant contributions.

I will talk today, therefore, about my own personal feelings about this society, what I believe we have to do, not only to keep it viable, but to make it grow so that it may achieve the same stature as some of our other surgical organizations. Because these are my personal views, I would rather talk as a member of the society than as your president, and for this reason I will not submit this address for publication. Thus, I can always deny what I have said.

First, let's reevaluate why ASTS or any society should exist. Basically, the goals are:

1. to stimulate progress in a particular field
2. to make known this progress through publications and to teach new information to fellow specialists
3. to stimulate young physicians to enter the specialized field and to make contributions to it
4. to provide leadership in securing financially sound and optimal patient care

When we mention dissemination of information and publications, it might seem that ASTS is not really needed. A sufficient number of surgical societies accept outstanding contributions in transplantation. If ASTS is to be the outlet for papers not accepted by the Society of University Surgeons, the American Surgical Association, or other estab-

lished societies, then we are doomed from the beginning. And yet, I do believe there is a place for a transplantation publication. Material that may not be revolutionary, or general enough to be of interest to surgeons outside our field, still could be of great interest to transplanters. Also, daily matters in the care of transplant patients may not by themselves, perhaps, be striking enough to warrant publication in an established surgical journal, but would be appropriate for our own publication. For example, how does one prevent lymphoceles after renal transplantation; or, are brush biopsies sufficient to establish the diagnosis of pneumocystitis, or does one need to do an open-lung biopsy? We as members should decide if there should be panel discussions at future meetings regarding these perhaps not-very-scientific-but-very-important matters in patient care. Perhaps we could find a balance between the highest quality of paper for publication and interesting general information about patient care.

To what extent should ASTS become involved in training transplant surgeons? Should we define what adequate training is? Should we establish guidelines for what is to be considered adequate training? And, how and where should this training take place? Should every transplant service that has a hospital administrator generous enough to provide $16,000 have a transplant fellowship? How many transplants should a transplant service be doing to provide a good fellowship? Should every transplant surgeon be primarily involved in research, or is there a place for the clinical transplant surgeon? How can we make transplantation more attractive so we can attract the best and brightest young surgeons to enter this fascinating field for their careers?

We have already taken the first steps by listing in our program booklet some of the fellowships presently available. I confess I have no direct answers to these questions, but perhaps a task force made up of ASTS members could come up with some solutions.

The role of ASTS in the delivery of health care in the field of transplantation needs to be addressed. As you know, some have suggested that this society was born to be a strong opposition voice against a well-organized nephrology group. In traveling around and talking to transplant surgeons, I hear the complaint that nephrologists keep patients away from us because doing so is more financially rewarding for them. But one must not throw stones if one lives in a glass house. Before any one of us casts aspersions on our nephrology colleagues, let us at least make an honest appraisal.

What have our nephrology friends done in the last decade? Ten years ago, dialysis was only available in a few institutions. Patients died because of the unavailability of what is now considered appropriate health care. In the past 10 years, nephrologists have trained enough other nephrologists to provide dialysis to probably everyone that now needs it in the U.S. They have introduced innovative ideas such as limited-care facilities and home dialysis. The mortality—which was high initially—has decreased to an extremely reasonable level, even though patient selection has become more and more liberal, with many high-risk and older patients. In addition to providing health care, nephrologists are constantly involved in research efforts to further improve the art of chronic dialysis. At meetings that most surgeons do not go to, such as American Society for Artificial Internal Organs (ASAIO) and Kidney Foundation meetings, a

great amount of work is done to improve dialysis membranes, the size of molecules to filter, and related concerns. There have been financial rewards to these physicians, and in some cases the financial rewards have perhaps exceeded the individual's input.

But what have we, the transplanters, done? We have not greatly increased the number of transplants each year. As a matter of fact, this year, the number of renal transplants has actually decreased. We still have long lists of patients, including many young people, waiting months and even years for an appropriate cadaver kidney.

We still have unacceptable mortality figures of 20% to 40% in the first year post-transplant. Complications of iatrogenic Cushing's disease continue to plague us. There has been limited leadership in the field of organ procurement; probably the most innovative and productive approach was actually started by two nephrologists in Kansas City. If tomorrow one of the members of ASTS should publish a method to allow cadaver renal transplants with a 90% success rate, it would probably take us another decade before we had enough kidneys to meet the demand.

I certainly believe in some federal legislation approaches. Mel Williams and I suggested in the national guidelines, which to my knowledge still are not published, that every patient on dialysis with end-stage renal disease should be seen within six months by a transplant surgeon. But before we criticize our nephrology colleagues, it is much more important that we first improve our own results and provide better, more readily available, and less expensive health care. I sincerely believe that most nephrologists are honorable, dedicated physicians who would send their patients to us if optimal health care would be provided. Rather than deepening the cleft between transplant surgeons and nephrologists, maybe we should improve our relationship. I would like to see one or two transplant surgeons on the Executive Board of the Kidney Foundation. I hope we would not always be too busy to go to either government or local meetings. Gastroenterologists seem to work quite well with general surgeons as do cardiologists with cardiac surgeons.

Those of us who are in renal transplantation must work with our nephrology associates on the basis of mutual respect and optimal patient care. The Program Committee this year selected several excellent papers *not* in the field of renal transplantation. Our society is called the American Society of Transplant Surgeons, and I hope that we can continue to discuss scientific progress in all the fields of transplantation. If not, we might as well call ourselves the American Society of *Renal* Transplant Surgeons, comparable to our medical confreres who call themselves the Renal Physicians Association.

Finally, a word about another important aspect of professional societies: the ability to talk with one another and meet one another. I believe again that we owe our gratitude to Fred Merkel and his committee for organizing this meeting plus the evening that is to follow. The Program Committee wisely allowed enough time between presentations for open and free discussion which, as all of us know, can be more important than the actual paper. I would urge the more junior members of ASTS to get to know the more senior members. If there are any specific problems, ask them for advice. I hope we will never grow so big that we will not know each other on a personal basis.

Some may think I have been too critical of our shortcomings and perhaps have not emphasized the positive things we have done. Yet, just as with a 2-year-old child, our future is still uncertain and at times shaky. Only with firm guidance and a clear perspective of our goals will ASTS continue to prosper and improve, and I hope that we will all work for this particular goal.