Let's Continue the Revolution

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Richard J. Howard, M.D., Ph.D.

Last year in his presidential talk Avi Shaked talked about revolution and evolution. Let us continue with the revolution. Let's consider reorganizing clinical transplantation in academic medical centers. Clinical organ transplantation began just over 50 years ago. Medicine in general and surgery in particular have seen revolutionary improvements during these 50 years, and these improvements will continue. Some examples of major improvements that have contributed to the advancement of surgery include such diagnostic techniques as CT and MRI scanning. Advanced computer programming has made 3-D reconstruction possible for calculating liver volumes and determining the arterial supply of the kidneys so that standard angiograms are no longer necessary. Many technical advances such as those of transplantation, cardiac surgery, endovascular surgery, and

minimally invasive surgery have made possible previously unimaginable operative procedures. And advances in non-surgical therapies such as immunosuppressive agents, ventilator care, antibiotics, intravenous nutrition, and pharmacologic therapies for sepsis and cardiovascular instability have added greatly to our ability to care for patients. We stand on the threshold of robotic surgery, and the promises of gene therapy, stem cell therapy, genomics and proteomics, nanotechnology, tissue engineering, the widespread use of new biologic agents, and other advances we cannot yet imagine. Perhaps some day we will even have easily achievable tolerance and xenografting. A surgical Rip Van Winkle who went to sleep at the time of the first successful kidney transplant would barely recognize many surgical diagnostic and therapeutic techniques if he suddenly were reawakened today, just as we will be amazed at what surgery will be like 50 years from now. These advances we have seen have permitted the development of complex tertiary care, of which transplantation is a prime example. And yet we are trying to provide modern complex

medical care with an organizational structure that has barely changed in 500 years. We need a structure for the 21st century – especially for delivering complex tertiary care. There is a better way to deliver medical care, and transplantation may be the best field on which to model a new organizational structure.

For complex tertiary care we must move from a horizontal, department-based structure to one that is vertically integrated and will bring together all the individuals who interact in the care of the patient, in this case the transplant patient.

And yet that is not how we are currently organized. We are still organized for the most part around traditional basic science and clinical departments. This departmental structure keeps apart those who participate in a patient's care, like the separated pieces of a puzzle, separate and without form. We need a structure that will allow all the pieces to come together into a coherent whole. Administrators commonly call this new structure, based along diseases, organs, or areas of the body, a "product line," "service line" or "center of excellence". For lack of a better name, I will

call it a center. There are other areas of medicine where a different type of structure would be also beneficial for the patient, patient care, and quality – cancer, cardiovascular disease, gastrointestinal disease, and neurological diseases come to mind – but transplantation is perhaps the best example.

Academic medical centers and their departmental-based structure have a long history that has served patients, physicians, and other employees of the medical center well for a very long time. It is not lightly that we should consider disturbing the current organization. And this structure is appropriate for much of medical care. Still, the current departmental arrangement can lead to inefficient and disjointed care for patients, delays in treatment, poor patient satisfaction, dissatisfaction by referring physicians, and increased costs for those patients who have complex medical problems; in other words, to low quality. We need a vertical structure that will put the patients' needs and convenience at the forefront.

Transplantation is a revolutionary field. Cooperation among specialists from various fields occurred from its very origin; it was always multidisciplinary. It grew up outside the normal departmental structure. . Patients view us as members of a transplant center. They and their referring physicians usually don't come to us because we are outstanding surgeons or physicians. CMS, UNOS and payers view transplantation as a separate organizational structure. They contract with medical centers for transplantation that includes all elements – physician and hospital. It's time that we view and organize ourselves the same way. We have the best opportunity to do this because of the history we have. We have an opportunity to prove this model.

What do we want from complex tertiary health care? We want quality: good outcomes, high patient satisfaction, high physician satisfaction, efficiency, no delays, ease of access, and low cost. Making ourselves into a true transplant center will lead to: (1) better patient care; (2) better outcomes; (3) better coordination of care; (4) greater efficiency; (5) less inexpensive care; (5) increased

patient satisfaction; (6) increased satisfaction by referring physicians; (7) increased satisfaction of participating medical personnel; (8) increased academic productivity; (9) a better research environment; (10) a better educational environment, and (11) increased accountability. In other words, high quality. No matter what structure we have for a medical system, we must keep in mind that the main goal is to better people's lives – mainly that of our patients, but also that of our colleagues and fellow workers. We must never lose sight of the covenant we have made with the patients whom we have the privilege we have to treat. To accomplish this we should put the patient at the center of what we do. But to achieve this goal successfully we will have to make a revolutionary change about the way we are organized.

The care of transplant patients requires complex decisions involving many specialists and others from different backgrounds. These physicians and other health care providers often interact more with each other than they do with members of their

traditional departments. These specialists share common interests in several areas: clinical care, research, and education.

Transplantation requires the input of a broad spectrum of health care providers including physicians, surgeons, pediatricians, clinical and laboratory pathologists, anesthesiologists, clinical psychologists, social workers, transplant coordinators, dietitians, pharmacists, financial planners, transplant administrators, and others from both the medical school and hospital. To get individuals from all these disciplines working together to benefits patients most, we must develop an organization around how we think about disease and treatment.

The main goal of this new structure is to put the patient at the very center of how we deliver medical care and to actually organize ourselves in such a way that achieves this goal. We must have an organizational structure that reflects how we think about disease and actually practice medicine. The basis of a center's organization should be clinical disease and not the traditional

departments. Besides putting the patient at the center, this vertical structure will allow the best from each individual. In the end, of course, it isn't even the system per se; it's the individuals who make it up. A center type structure will create a system that doesn't get in the way and allows the best in individuals to come out.

The center will also foster getting the hospital's and medical school's interests into better alignment. The current departmental structure and division between the hospital and the medical school does not currently provide for the greatest efficiency.

The center organizational structure should have a physician responsible for the administrative and organizational details. The success of the center structure will depend on getting the best individuals into leadership positions. This structure should ensure accountability. The goals must be clearly delineated.

Responsible physicians would be accountable for all aspects of the center. They would be responsible for outcomes, patient and physician satisfaction, education, research, coordination of care, and fiscal integrity of the center. But with responsibility must

come authority to make changes in such a way that will achieve the goals of the center. Responsibility without authority is a recipe for failure. It must be a true center in fact, not in name only. It should not merely be a marketing tool. Ultimately it means fiscal integration. Some institutions are already developing a center type structure.

The leader of the center would report the CEO of the hospital and the dean of the medical school. They would ultimately be responsible for the performance of the leader and the service line.

To create a true transplant center will require the support of the leadership of the academic medical center, which usually means the dean and CEO of the hospital. Without their support, it is unlikely it will come about. There will be a lot of built in opposition from departmental chairpersons if the new arrangement dilutes their authority or power. Many cogent arguments will be used to avoid change: it's too difficult; we have too many other issues to deal with; it's not the way we do things here; the residency review committee will object – as if we should base

patient care around how we educate rather than the reverse. Without forward thinking leadership who would be willing to give a new organizational structure a try and a chance at success, it is unlikely to happen. But those centers that do institute such changes will serve patients better and will have a competitive advantage in the market place over those that do not. Therefore, in the end, these changes may be forced on academic medical centers in any case. And I believe they will eventually come about. But most important, patients will do better and we will do a better job of caring for them and taking care of each other. It will be up to us, the current and future leaders of transplantation to accept this challenge of reorganizing transplantation. But it can be done.

First of all, I would like to thank all of you for allowing me to be president of the American Society of Transplant Surgeons. It

is truly a great honor, and I am grateful. There are many individuals who deserve my gratitude. If fact, it would take me the entire allotted time to express my thanks properly; so I will have to be brief. My wife and family deserve special appreciation for their understanding throughout the years of my missing too many dinners, baseball and soccer games, school performances and, occasionally, even birthdays. As we know, transplantation is a demanding profession.

I am also grateful to the ATS Council, committee chairs, and committee members, and members of special task forces, and all those who have worked so hard and with such devotion for the ASTS, often with inadequate recognition of their efforts. Anything that has been accomplished this past year is largely due to their effort. Because of time I cannot mention all of the committees. The membership committee under the leadership of David Mulligan has increased membership; so that the ASTS now has more than 1000 members. The Vanguard Committee, which is limited to members in their first five years of ASTS membership and is led

by Elizabeth Pomfret, is responsible for the ASTS Winter Symposium. This past January we had a successful symposium titled, "The Science and Art of Immunosuppression". 279 members and fellows in training attended the meeting. In conjunction with that meeting we had sessions on the ethics of organ payment. NATCO and UNOS also held meetings in conjunction with our winter symposium.

The ASTS through its Legislative Committee, under the leadership of John Roberts, has been an advocate for patients in Washington, D. C. Last month and in June, 2004 we visited the offices of members of the House and Senate appropriations committee seeking funding for the Organ Donor Bill. Those who were in Washington met with HHS Secretary Tommy Thompson and presented him with as ASTS award thanking him for his support for transplantation. We also met with Dr. Jim Burdick, a member of the ASTS, and director, Division of Transplantation in HRSA, to emphasize our continuing interest in seeking funding for this bill in the current Congress. We also met with Dr. Carolyn

Clancy, Director, Agency for Health Research and Quality, to enlist her interest, since part of the Organ Donor Bill is administered through the AHRQ. She was very receptive and suggested we propose a conference on the state of the art on the technical aspects of organ recovery and preservation. The Legislative Committee has also advocated for increased medical coverage for post-transplantation immunosuppression.

The ASTS provides funds for 15 awards for young faculty, fellows and residents to enable them to take time out of their clinical activities to enhance their research skills. The Awards Committee led by Kim Olthoff is responsible for making these awards from the many qualified applications. Our partners from industry sponsor many of these awards, and we at the ASTS believe providing these awards is one of the most important things we do.

The ASTS working together with the AST established a task force under the leadership of Mike Abecassis to respond to the newly proposed CMS Conditions of Participation: Requirements

for approval and re-approval of transplant centers to perform organ transplants. This joint effort produced a thoughtful document that is now being considered by CMS. Dr. Abecassis also leads a joint task force to respond to ever-increasing requirement for data submission by transplant centers. He has also worked with the RUC to get new transplant-related codes for back-bench work.

The Ethics Committee under the leadership of Doug Hanto has had to respond to the many difficult ethical issues raised by transplantation. This work of this committee has required the members to take time out of their normal activities to respond in a timely fashion to various issues.

All the ASTS Committees, their chairs and members have done yeoman work for the society. And I certainly appreciate their efforts.

Our Executive Director, Katrina Crist, has provided the glue for the society and facilitated the work of the members. We are thankful she has chosen to come back to the ASTS after being away for several years. Shelli Adams-Crosswell and Joyce

Williams have also provided great support for the membership at the ASTS office. Please go by the ASTS booth and thank them.

We should all thank Pam Ballinger and her colleagues at Association Headquarters Incorporated for again arranging for an outstanding meeting and facility. She has seen to the millions of details that require attention which we cannot even imagine. The American Transplant Congress is now the largest transplant meeting in the world. As of this morning more than 5000 individuals were registered at the meeting and there are 115 industrial exhibits. This meeting provides the greatest forum for sharing the newest information about transplantation there is. The program committee of the ATC has had the Herculean task of sorting through thousands of abstract submissions and selecting the best for presentation and then arranging the sessions, symposia, special lectures, poster sessions, and other presentation into a coherent whole. I am in awe of what they have done.

This meeting is a joint effort of the American Society of Transplantation and the ASTS. Dr. Jay Fishman, president of the

AST has been easy to work with and our two societies have cooperated in every way. I appreciate his being so congenial. I believe this is the first year that the ASTS and AST held a common presidential dinner, and it is symbolizes the ever-increasing cooperation of the two societies. As we say, he is a real "mensch". Together with the AST, the ASTS established this American Transplant Congress. Our organizations together own The American Journal of Transplantation which has been more successful earlier than we had anticipated. Under the leadership of Dr. Phillip Halloran and his board of editors, the AJT was indexed by the National Library of Medicine at the earliest possible time. It currently has the highest impact factor of any transplant journal and is only second among surgery journals. For those of you who want to know how the impact factor is calculated, talk to Dr. Halloran.

My colleagues at the University of Florida deserve my gratitude for their understanding of my frequent absences while

traveling on behalf of the ASTS this past year. I appreciate they were willing to cover for me during this time.

We should all be grateful to our teachers who helped develop our knowledge and skills. I am certainly thankful to all the instructors at the University of Minnesota where I was a resident and transplant fellow, but especially to Drs. John Najarian, Richard Simmons, two former presidents of this society, and to the late Robert Good for teaching me so well about the basic science and clinical aspects of transplantation.

Finally, and by no means least, we are also extremely grateful to our supporters in industry. Without their continuing generous support this meeting and much of the other educational activities we do, such as our winter meeting and the consensus conferences would not be possible. We thank Astellas, Roche, Wyeth, Novartis and our newest industrial partners, Genzyme and Bristol-Myers Squibb.