Inaugural: American Society of Transplant Surgeons

THOMAS E. STARZL, 1974–75

From time to time, a news story appears about the birth of a husky, full-term baby, much to the amazement of the chagrined mother who had not realized that she was pregnant. Mother surgery seemed thus to have been caught by surprise when clinical transplantation burst upon the scene in the early 1960s. Then last October 21, 1974, at the American College of Surgeons meeting in Miami Beach, another infant was delivered, again with minimal warning or fanfare. I am referring to our American Society of Transplant Surgeons, a group which is meeting officially for the first time today. As your first president, I want to look at the prognosis for survival of our new organization, to describe some ways of nourishing it, and to identify how *not* to poison it during its defenseless early years.

Before exploring these matters, it behooves us to recall the immediacy of the total modern history of transplantation. For example, the clear beginnings of an understanding of the mechanisms and significance of homograft rejection are only 30 years old. Most of the investigators who probed these mysteries in animals still are alive and vigorous, including the incomparable Sir Peter Medawar and his first coworkers, Thomas Gibson, Rupert Billingham, and Leslie Brent.

Unequivocal successes after clinical renal homotransplantation under immunosuppression were not recorded until 1958 and 1959 when, first in Boston and then in Paris, homografts were taken from fraternal twin donors and started on their long survival in irradiated recipients. The presently employed multiple-agent techniques of immunosuppression were not evolved until 1962 and 1963, just about 12 years ago. Liver, heart, lung, and pancreas transplantation with extended recipient survival was not achieved in man until 1967 and 1968. Of the leading figures in the complete panorama of clinical organ transplantation, only David Hume is no longer with us and even his death in May 1973 was tragically precocious from a traumatic accident.

The brief duration of our clinical specialty does not connote a lack of substance. Instead, I believe that the scientific commitment of a decade ago to transplantation

represented the greatest interdisciplinary effort ever mounted in clinical medicine up to that time. Small wonder then, the amazing harvest of new facts and concepts that poured forth.

It has been common within universities to appoint department chairpersons or division leaders on the basis of an expertise in new and broadly significant areas of development. The consequence has been that general, neurologic, thoracic, vascular, and cardiac surgeons have come in waves across the academic beaches. Transplantation has been no exception. In the U.S., 11 chairmanships have been filled from our ranks (Table 1), as well as numerous division chiefships, exclusive of those divisions that were created solely for transplantation. A similar pattern has occurred in foreign schools too numerous to list.

Table 1.
Surgical chairmen from transplant ranks*

Name	School
F. Belzer	Wisconsin
R. Egdahl	Boston University
D. Hume	Virginia Commonwealth
S. Kountz	New York Downstate
J. Mannick	Boston University
J. Najarian	Minnesota
K. Reemtsma	Columbia
P. Russell	Harvard
N. Shumway	Stanford
T. Starzl	Colorado
J. Turcotte	Michigan

**The list is a gross understatement. Some of the chairmen who were originators of transplantation such as William P. Longmire (UCLA) and Francis D. Moore (Harvard) have been omitted because they are best known for work in other areas. An incomplete list of other part-time transplanters who have made major contributions includes James D. Hardy (Mississippi), Vallee Willman (St. Louis University), Michael E. DeBakey (Baylor), J. Bradley Aust (Texas) and Lloyd D. MacLean (Magill).*

The fact that transplanters would yield in droves to these administrative offerings does not necessarily speak well for their intelligence or character. (One of the notable resistors has been Joseph Murray at Harvard.) But it does suggest the extent to which transplantation has been accepted as a leading discipline in university surgical circles and the degree to which its practitioners have contributed to the mainstream of academic life. In addition, many from the modern crop of transplantation surgeons have served as presidents of the Society of University Surgeons (Richard Egdahl 1970; Samuel Kountz 1974) and the Association for Academic Surgery (John Najarian 1968; Thomas L. Marchioro 1974).

Why mention such details? It is to indicate that our new society already contains the most important determinant for its own success. The work we do has the fiber and the depth to justify the organization. Without this intrinsic worth our prognosis would be hopeless, no matter how cleverly we conducted our affairs. With it, our failure to thrive can be explicable only by errors in our perception of our objectives or by miscalculations in the pursuit of these goals.

Granting this, you cannot shrink from a clear enunciation of our first priorities. My own bias is simple. I think that we exist mainly for the development and exchange of accurate information and informed opinion. By definition, our principal objectives are, therefore, intellectual and professional, and this must be reflected in the programs that we develop annually. We have made a great start in this our first meeting, but I hope in the final analysis that this year's program will be judged to have been the weakest when compared to those coming in the years ahead.

The incentives are there, leaving aside any collective instinct for organization self-preservation. An outlet for rapid publication of our program papers has been arranged through one of the finest of today's journals. *Surgery.* This alone should ensure the submission of new and outstanding work only, since the articles will be reviewed and edited closely. The conditions of publication are analogous to those for the prestigious Society of University Surgeons or the Society for Vascular Surgery. If we fail to respond to the challenge, this opportunity could be lost.

The outlet in the journal *Surgery* has some interesting implications that are worth dwelling upon for a moment. So far, the field of clinical transplantation has grown up in what might be termed a giant interdisciplinary matrix. The explanation and need for, as well as the advantages of, this hybrid state have been obvious. So has been at least one possible disadvantage, which is the potential disconnection of our specialty from a traditional base. The arrangement to publish our proceedings in a surgical journal will remind us of our origins in surgery and well may affect our choice of presentations. It also should systematically place a concentration of our work before our less specialized surgical peers, something that has not been done before, except by the mechanisms of the *Surgical Forum.*

These new conditions will strengthen our surgical heritage, but they cannot be used as an excuse to limit our interests. The name "Society of Transplant Surgeons" is all-inclusive. It would be both tragic and inexcusable if we functioned as a society for kidney transplantation. I look forward to hearing here of research and progress about the liver, heart, lung, pancreas, bone marrow, and other organs.

Until now, essentially all of the immunosuppressive techniques have been worked out on the kidney model. It would not surprise me in the future if generally applicable improvements in care came from work with the extrarenal organs and were reflected back to the kidney. By being inclusive, no possible avenues will be blocked. The society will be assured of breadth as well as depth. The society deliberations should be a mixture of basic articles and clinical ones in the best tradition of modern surgical science.

At the same time, another great organization, the international Transplantation Society, to which most of us belong, must be kept strong. Every two years the international Transplantation Society formally brings together a heterogeneous collection of basic investigators and clinicians. The exposure of each group to the unfamiliar ideas and points of view of the other can create the kind of climate from which progress stems. The American Society of Transplant Surgeons and the Transplantation Society are not competitive but are complementary. One is sectarian, the other catholic.

If we can accept that the major objectives of the American Society of Transplant Surgeons are those I have just described, you will now take very seriously certain other justifications for our new organization which I have heard cited. The most degrading misconception reported to me has been that we are a lobbying group designed to influence the language and the intent of federal legislation and to affect the implementation of laws already enacted. Were this to be the purpose of our new society, my advice would be to go home now. A sandcastle doomed by the first tide would have been built by your Council.

Nor should our organization become an instrument for the negotiation and

establishment of financial matters, including professional fees. We conduct our affairs these days in a cynical social climate, leavened by occasional ennobling acts of which organ donation is a prototype. If it became perceived or imagined by the public that hypocrisy and greed were central to our transplantation programs, cadaver donors would become unavailable and all the other punitive side effects that you can easily imagine would follow. Ours is the medical specialty most founded on public trust and personal altruism. The corollary is that it is the most fragile.

I do not imply that we should not talk to those who solicit our assistance for health planning and other purposes. Subcommittees of our society will have to begin work promptly in several vital areas that have needed attention for some time. The most pressing requirement is to define the relationship of established or proposed kidney transplantation programs to the government, particularly because of the major effect that Public Law 92-603 already has had upon our medical and administrative practices. Data should be developed to help in deciding how many renal transplantation centers should be set up, where they would best be located, and how they can be run most efficiently for the citizens of those specific regions.

I now am confident that there also will be a real justification for cardiac and hepatic transplantation centers within five years from now. These are not necessarily going to be in the same places as kidney programs. As all of you undoubtedly know, another bill, the Beall-Health Manpower Act, currently before Congress, would be a giant step toward the concept of regionalization of health care. Since it is tied up so heavily in government financing, transplantation of all kinds is certain to become involved in government experimentation with such planning.

In the same connection, you should be looking within our own ranks to see how the demands being made upon us fit the numbers of our membership. Are we training enough transplant surgeons to catch up with the need, and if so, when will a superfluity of trainees be a problem, as it has become in a number of other specialties? What constitutes adequate training? If we work at these questions, maybe we can avoid some of the mistakes that other groups with interests in special fields of surgery have made.

Finally, we also will have to involve ourselves in setting up and maintaining professional standards. It would be a great pity if the lessons of the last decade were not applied wisely and had to be relearned by new groups (or established ones for that matter) at the price of human suffering. At the same time, the trap must be avoided of freezing immunosuppressive treatment in its present mold, which, we all agree, still has too great a morbidity and mortality rate to be completely acceptable .

And so in closing, let me return again to the beginning and to the emphasis that I placed on the role in scientific development which our new organization must play if it is to fulfill its destiny. T. S. Kuhn[1] the distinguished scientist and historian, has shown how progress consists of a series of great and small revolutions against authority. A great advance necessitates the overthrow of an established dogma, and when that occurs the advance itself becomes the new dogma to which advocates flock. It is natural for those disciplines to become protectors instead of improvers of the status quo, guardians of the past instead of seekers of the future. To make matters formal,

they might even consider creating a society that, if unaware of the dangers, could be the means by which the next stage of improvement were blocked.

We know this hazard, ladies and gentlemen of the American Society of Transplant Surgeons, and if you avoid it, we should take our place beside the other great professional societies of this country.

Reference

1. Kuhn, TS: The structure of scientific revolutions, Chicago, 1962, University of Chicago Press.