Reflections on the Past, Transitions to the Future: The American Society of Nephrology

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It is funny how perceptions change over the years. I would like to spend some time reflecting on my impressions of my first ASN meeting, a little over thirty years ago, when I was but a child. I was impressed by the meeting because just as today, everyone was sitting in a single room, and all these people I’d read about, senior investigators and the like, were in the first few rows asking really probing and insightful questions. In fact it was a pretty contentious group. That impressed me. There was also a large cadre of young investigators that seemed eager to get their scientific points across. This meeting was characterized, I thought in my naïve state, by a certain degree of intimacy and yet was simultaneously a very contentious group. This was really cutting edge stuff, and I was really impressed. Of course you could say anyone who had only been in their fellowship for two months was not a particularly accurate observer of such events.

The first meeting, held during 1967 in Los Angeles, was a two-day meeting with a rather limited program, by today’s standards (Figure 1). In fact, there were just a few free communications that occurred after the plenary sessions. There were recognizable faces in attendance, including some young “wunderkinds,” like Ike Robinson and Belding Scribner, Floyd Rector, and Mo Berg, all of whom presented. Most in attendance were exceedingly impressed with the nature of this meeting, but when one steps back, it was rather small, only a thousand people, and only three symposia occurred simultaneously. But, it was balanced among clinical topics and basic science for the time, and of course, salt and water talks, which were basic sciences at the time.

Now, what does our past teach us? I suppose one could take away the concept that size alone is not an index of the quality of a meeting or the organization itself that it represents. Let’s look briefly at the rate of growth of our society, because I am going to try and reflect on where we have been and where we are going. I will spend very little time on the past. Attendance at the ASN meeting (Figure 2) reflects a classical growth curve pattern, and obviously second order kinetics of some sort. In the early seventies, there was a very slow rate of growth. Then all of a sudden, thanks to decisions of past presidents who are in attendance at Renal Week 2002, we had a change in the slope of growth. The international attendance started increasing in the mid-1980s, and the clinical short courses were added, so the popularity for clinical nephrologists increased. Over the last few years we have observed a kind of semi-plateau.

Can a society really be measured in terms of the quality of the organization simply by the rate of attendance growth at a meeting? There are some examples we can reflect upon; that of a well-studied society important in the United States for most of the 20th century: the AFCR, ASCI, and AAP (The Old Turks/Young Turks) meeting, usually held in Atlantic City. There have been several published reflections on what has happened to this society. Maybe we can learn something from the abstract submission curve; as we will see, there was a continuous increase until the mid 80’s when this society went into decline (Figure 3) (1). At the same time, there was an explosion in attendance and abstract submissions to subspecialty meetings: American Heart Association, American Thoracic Society, the GI Meeting, and the American Society of Hematology. Most of the subspecialties were in the positive growth category, while the Old Turks/Young Turks meeting went into decline somewhere during the 1980s.

Now the question is: What can we learn from their pattern of growth or decline? There have been several reflections, in print and in conversation, about the natural history of the tri-society meeting. First, this decline was attributed to increased specialization in medical science and that the growth in attendance of the subspecialty meetings was essentially sequestering investigators from this wonderful scientific meeting. The pie never gets bigger but if the subspecialty piece is getting larger then the general medical scientific meeting has to become smaller. Or, it might have reflected a general pattern of growth of fragmentation of medicine, which we know has happened over the last three or four decades.

In another view, again presented in the New England Journal of Medicine, Holly Smith, postulated that the decline came in 1977 (1) with the departure of the meeting from Atlantic City, because Atlantic City had a certain character. There was a tradition to the meeting, and there were very few alternative activities at that time and location, so it was an important meeting and the venue conferred both tradition and specificity. Dr. Donald Seldin also predicted that when the meeting left...
Atlantic City, it would probably go into decline. So, two of the major Chairs of Medicine in this country predicted that accurately. However, there are some other more recent articles by Ajit Varki and Rosenberg, who basically attributed the changes to a generalized decline in the physician-scientist and an inability to maintain this meeting as a cutting edge forum for basic science (2). In 1984, there was an article in the American Scholar by Gordon Gill, a basic scientist, physician, and member of our faculty at UCSD who wrote a poignant article in which he reflected on his initial impressions in the 60s of this basic science meeting, specifically, how impressed he was with the meeting. He returned twenty years later and was somewhat disappointed by how it had changed (3). The audiences were observers in the 1980s of presentations by cutting edge basic scientists imported into the meeting, and were no longer participants in the process.

When I reflect back on past Presidents’ messages, it is obligatory for each President to have something semi-literate in philosophy, history, etc. to prove they are reasonably erudite, that they had experienced some kind of a liberal education in the past, and that they are not scientific or clinical “geeks.” This quote suffices to take care of that: “Those who cannot remember the past are condemned to repeat it.” (4) I would also like to point out that this quote is usually attributed to
Toynbee or the Durants, but was actually George Santayana (1863–1952). Santayana, a philosopher and poet, generated this statement and has since been misattributed many times.

Let us begin a discussion of what we are doing currently to learn from the past. Let us start by asking a question: Can any society, meeting, or organization continue to grow or maintain an interest solely on the basis of an excellent annual meeting and an excellent journal? Certainly the Tri-Society meeting qualified in both respects. It was an excellent meeting throughout the 20th century, and the Journal of Clinical Investigation is considered an excellent journal. The experience of the Tri-Society meeting would suggest that this answer is no. Applicable to the future directions for us; must the society encourage membership involvement to properly survive? I would suggest that activities must be in evidence throughout the year, in addition to providing an excellent meeting or series of meetings, and that there be a “big tent” approach with multiple opportunities for membership input for the society to function as a truly professional and scientific organization. Now let us ask an additional question, and we will move into the present and hopefully into the future: How has ASN been governed, and what is the future direction of our Society?

An anonymous donor sent me a picture several weeks ago. It purportedly depicts a typical ASN council quarterly meeting, but I do not recognize the venue of this Bacchanalian event. I think this picture merely makes a point of protest that must be clarified. There has been a general feeling that the American Society of Nephrology is a highly centralized organization where policy and governance are dictated by a small cadre of people on ASN Council. We must address that issue seriously as to whether it is true and whether that form of governance can continue to benefit the organization.

I would like to describe the new committee structures that began during Bob Alpern’s presidency and have further expanded during this year: There is now a very activist Basic Science Committee under the chair of Patricia Preisig and an equally activist Clinical Science Committee under the leadership of John Sedor and Paul Kimmel. I want you to know that the tenure of membership on these committees is generally two to three years, so there is turnover and future opportunities to serve. The purposes of creating these committees are, firstly, to decentralize the process of governance and, secondly, to involve a greater percentage of the membership with their expertise and talent in the process of decision-making (Figure 4). The Transplant Advisory Group has existed for a few years, but we have three new advisory committees that lend expertise in the process of decision-making, and on which a council member sits as a liaison member (Figure 5). Johnathan Himmelfarb chairs a Dialysis Advisory Committee, the Hypertension Advisory Group met for the first time at this meeting and is chaired by Stuart Linas, and Sudhir Shah chairs the new Acute Renal Failure Advisory Group. The existing Transplant Advisory Group, William Harmon chairs. We recently voted at a council meeting to add a fifth advisory group on Chronic Kidney Disease. This expanded structure allows a group of talented people that have an understanding of that issue specifically to deal with problems and make suggestions so that action can be made on behalf of this organization. Most importantly, it expands the involvement of the expertise and talent of the Society and allows for a turnover in these groups so that an increasing number of members can become involved in the issues, which are of ever-expanding importance to the Society.

In terms of these committees/advisory groups, we need
volunteers with interest and talent. We need to add other committees, and we are accepting suggestions for other interest groups that function within the umbrella of the American Society of Nephrology. The Government Relations committee, which has primarily focused on lobbying activities, has expanded the breadth of activities to committee interactions with NIH and with other executive offices within Health and Human services. We are also changing the charge of this committee, to include marketing and public relations.

To foster these new developments, ASN needs to have better vehicles for communicating with the membership. A few weeks ago, a new ASN interactive web site was established. Over the first few months, we are going to bother you by asking you several simple questions through the site to define better the demographics of our society. What are your interests? What are your assets? What are you interested in for involvement? I know it is bothersome to receive such e-mails, but we hope you will bear with us while we define your interests. The ASN web site will be a two-way communication device through which you talk to us and we talk to you, and within groups, you can talk with each other. It is a vehicle for enlisting volunteer involvement and also a potential public relations vehicle through which we hope to replace our published ASN Highlights. After determining your interests, we will provide you with a more focused set of information that comes to you on a regular basis. It obviously supplies educational opportunities. We have had several good ideas that are being considered to provide clinical material for lectures, public policy position papers, reviews, and teaching documents. Most importantly, the newly interactive web site offers great potential as a government and public relations vehicle for involvement on national and regional areas for membership to influence polices that are thought to be beneficial for the society.

About a year and a half ago, we made a decision that it was necessary for the field of nephrology to have a larger expanded menu of clinical trials. Until this time, we have primarily conducted clinical trials through a federal funding mechanism, and we have not been able to incorporate networks and other pharmaceutical industry trials into a “big umbrella” system.

We had a focused meeting at ASN headquarters with our fellow colleagues at NIH and at least 60 investigators and representatives from government and industry that met under the leadership of Eric Nielson, who moderated that meeting. It

Figure 4. The new algorithm of ASN committees.
was a very successful meeting. The meeting attendees created a document basically suggesting that a clinical trials consortium become established, headquartered at NIH but not totally dependent upon federal funds. It was also determined that this consortium would exhibit a capacity to expand the menu of clinical trials and to do so more efficiently. The objectives are to conduct trials that encourage innovative approaches to diagnosis, treatment, and prevention of kidney disease; to evaluate and improve the process of implementing clinical trials; to make recruitment easier, which has always been a problem; to complete the studies more efficiently; to provide a centralized facility for coordinated data analysis, which might be appealing to networks and to industry; and to reduce the overall cost of clinical trials. The report and recommendations have gone to NIH and are currently in the Congressional record. NIH is committed to funding a centralized facility. We envision at least 30 or 40 clinical trials centers that will not be solely academic, but could involve large private practice groups, in which participants would demonstrate their expertise and be reviewed as clinical trials centers. Ideas for these clinical trials can derive from sources outside the clinical trial centers. The ideas would be evaluated and applied by a steering committee. These clinical trial centers would survive and persist on the basis of their frequency of participation in trials. The hope would be to correct some of the problems in having only federally funded trials that appear for five years and then disappear. Ultimately, a consistent network will be created that is distributed throughout the country. We propose that this will be a success. The Clinical Science committee and the Government Relations committee of ASN were very instrumental in pushing through this concept and getting it done in a remarkably speedy period of time.

We are also working on improving our interactions with other kidney societies. Our long-standing relationship with the Renal Physicians Association (RPA) is continuing, and we are updating the nephrology manpower study. The Council of American Kidney Societies (CAKS), represented by ASN, National Kidney Foundation (NKF), RPA, the American Society of Pediatric Nephrology, the Polycystic Kidney Disease Foundation, and the American Society of Transplantation, is being used effectively as a single voice to get across ideas that are important to all of us. Our collaborations with the NKF have expanded over the past year; we are actually very complementary organizations. I would congratulate Dr. Norm Siegel, Tom DuBose, and Brian Pereira for putting together a very successful combined grants program, whereby we will review grants for fellowship and for young investigators together under the chairmanship of Joe Bonventre. We hope this grants...
program will simplify the processes for all of you in training programs interested in fellowships. This program would allow you to go to either organization’s web site and find out what is the best application for you. This process would also eliminate some of the redundancies that currently exist in terms of fellowship opportunities and young investigator grant programs. I would like to congratulate all of the participants involved in this process from the Basic and Clinical Sciences Committees and the NKF. There are several committees that the RPA currently shares with the ASN, and I would encourage you to join this worthwhile organization that focuses on socioeconomic issues. You may use our web site to show your interest in all of these areas, if you choose to participate.

As you probably know, there are millions of people in the United States who suffer from some form of kidney disease. Twenty million of these people have lost half of their function as measured by creatinine clearance or have significant proteinuria (5). The National Kidney Disease Education Project has been established to reach this group of people. It is chaired by one of our Past Presidents, Tom Hostetter, and its goals are to reach those patients who are at risk and involve the primary care physicians in the process of simple treatment algorithms for patients with early disease: (1) treatment when appropriate with ACE inhibitors and ARBs; (2) BP reduction; (3) glycemic control in the diabetic population, and dietary counsel. Most importantly, the internists and PCPs must realize that there are increased cardiovascular risks that have to be treated, which is a very difficult problem. In the final analysis, how much should nephrologists be involved, and how much should be delegated to primary care providers?

This is a huge problem for our society, and I am sure for every society in the world. The problem relates to the recognition that there are large populations that have kidney disease, and this is a formidable task. We are either going to be part of the solution, or someone else is going to provide a solution and take care of these people. We are talking about seventy-five million U.S. citizens (Figure 6) potentially involved with some degree of renal dysfunction (5). In the United States, there is some degree of geographic heterogeneity to these numbers, and this heterogeneity in CKD is partially explained by the wide variation in geographic ethnic differences. A large percentage of these are certainly the elderly, and that would condition some of our approaches.

CKD presents significant problems for nephrologists. Let’s do a little simple math. What if 25% of those 20 million people that have lost half their function, or five million people, are referred to a nephrologist? This would require forty additional outpatient visits per week, if the patients were seen twice a year. Currently, and I hope I am not being too rude in saying this, our current fee-for-service pay scales are not a tremendous incentive for adding forty new outpatient visits to a practice, especially when compared with nephrologist activities in inpatient ICUs and ESRD. A successful, practicing nephrologist in the United States could be working 96 h a week, or six sixteen-hour days. An approximate breakdown of hours is: (1) 24 h of dialysis care; (2) 25 h of inpatient ICU rounding; (3)

**Figure 6.** Estimates of adult US patient population with chronic kidney disease as indexed by altered GFR or significant proteinuria; the data are described in both percentage of adult population and the absolute population afflicted.
12 h of interventional nephrology; (4) 20 h of outpatient care, and then of course, the paperwork and telephone calls (approximately 15 h). Now where in the world do you find all this time? Obviously, we have a tremendous manpower problem.

There are several problems and potential solutions. (1) The nephrologists may just be too busy to see these additional patients. (2) Everyone may be better served by something other than our current payment structure. (3) We can incorporate other healthcare professionals into the practice of preventive medicine, which is essentially what we are talking about with early CKD patients. This consideration is currently being addressed by several organizations. (4) It is important for nephrologists to be a major participant in the process of how this system works. (5) Should we enlist the cooperation and further educate primary care physicians and internists in this effort? It is important for us to be involved in this decision-making. As far as reaching the patients, that probably will be made easier because of the advantage of familial clustering. If you examine ESRD patients, a significant number will have a close relative with kidney disease, and one could find the likely afflicted high-risk patients through dialysis units and networks. This familial clustering of kidney disease may be even more prominent in certain ethnic groups.

For this reason, the Council of American Kidney Societies (CAKS) has decided to have a large meeting on the topic of CKD. We want to study these issues and address solutions rather than just “educate” the audience. We are having a Stakeholder meeting, which will include not just nephrologists, but insurance payers, managed care directors, disease management organizations, other healthcare societies, and certainly members of federal regulatory agencies and payors, in February 2003. We will address: (1) Some of the problems about the demographics: Who should we serve first with limited manpower? (2) How much should we alter clinical care models to deliver that care? (3) How radically should we recommend that the payment system be changed to affect delivery of care to a large population? I would encourage all of you to participate in this process because the Stakeholder decisions will be presented at a large meeting in Washington, DC. We hope to have follow-up meetings held with several of our societies that will continue the process after the initial call to action (Figure 7) (6,7).

Why are we at ASN so interested in CKD? This sounds very much like a clinical talk. Why in the world am I talking about clinical issues only? Well I think it is important to the future endeavors of the American Society of Nephrology to demonstrate our involvement.

Some of you may find this Madison Avenue or a populist approach and potentially offensive; however, I believe the future efforts for the ASN involve three categories, and I am sure many of you can identify others. First, we have to market kidney disease better. The people who are interested in stroke, cardiovascular disease, and cancer have done a far more effective job than we have in delivering a message to the lay population and to practicing physicians than we have accomplished. Kidney disease is a huge issue in this country, but it is

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**CHRONIC KIDNEY DISEASE:**  
**A CALL TO ACTION**  
**STRATEGIES FOR SUCCESS**

Conference Chairman: Tom F. Parker, III, M.D.
Steering Committee:
Roland Blantz, M.D.  
J. Michael Larasus, M.D.  
Jonathan Himmelfarb, M.D.
Allen Nissenson, M.D.  
Thomas Hostetter, M.D.  
Tom F. Parker, III, M.D.
Alan Kliger, M.D.  
Brian Pereira, M.D. (Ex-officio)

- Physiology and Pathology of Chronic Kidney Disease
- Size and Characteristics of Population with Chronic Kidney Disease
- Opportunities to Alter Clinical and Economic Outcomes
- Health Care System Strategies to Meet the Challenge of Chronic Kidney Disease
- Next Steps

**WASHINGTON, D.C.**  
**SPRING 2004**

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*Figure 7. Chronic Kidney Disease Call to Action meeting, which will be held in Washington, DC. Preceding this, a stakeholder will put together a facilitated meeting among insurance payors, federal executives, managed care organizations, disease management organizations, healthcare professional societies, industry, and selected nephrologists in a facilitated setting to come to specific conclusions regarding the issue of delivering care to the large population of patients with chronic kidney disease.*
relatively asymptomatic. Second, we have to be concerned about the preservation of academic nephrologists as an endangered species. Third, we have to be concerned about maintaining NIH support for kidney research. We are now entering the fifth year of the doubling of the NIH budget. What happens after that doubling period is anybody’s guess. Let us consider these issues briefly.

Marketing Chronic Kidney Disease is an important part of our future. We have to deliver the message to the media, and I believe that this requires cooperation of all our societies. ASN is certainly becoming more involved in this issue. We have to make everyone aware that Chronic Kidney Disease increases cardiovascular risks, so that we expand our influence beyond the usual focus upon dialysis, transplantation, and progressive kidney disease. We also have to take advantage of familial clustering to contact those patients who are at risk. We have to cooperate with other medical organizations such as the American Heart Association, the American Diabetes Association, and other groups that represent ethnic populations to sell this message effectively.

The second issue is the preservation of the nephrologist in academic medicine. Many of us are involved in training programs, and all of us are products of these excellent training programs. I want to ensure that we recognize that each of the better training program faculties provide a spectrum of clinician teachers, clinician scholars, and physician scientists. Now, several things have happened over the last couple of years that give us some encouragement in this area. Number one is that the number of applications and the quality of the fellowship applications from good medical residents seems to be increasing in adult nephrology. Second, the NIH, and other societies as well, have expanded their funding mechanisms for junior faculty that are interested in clinical research as a discipline.

Therefore, there are greater opportunities through NIH to fund and train academic nephrologists in these areas. We are optimistic about the NIH Loan Repayment Program and have been actively involved in this program, alongside FASEB, to stimulate loan repayment. We are encouraged by the fact that the number of loan repayments awarded is increasing, perhaps to more than 700 this year. The funding rate has been quite good, and number of loan repayments awarded are increasing, perhaps to more than 700 this year. The funding rate has been quite good, anywhere from 60 to 100 percent in some NIH institutes. Please encourage your faculty to apply where appropriate. The average debt for an American trainee is approximately $100,000 and funding for loan repayment will influence whether or not they choose a career in academia.

The Physician-Scientist is a special case, and we are all concerned about this issue. One thing we have to ensure, and you may disagree on this point, is that we must have departmental and divisional commitments to maintain the existence of the Physician-Scientist. I believe there is a temptation to oversimplify the programs. There is often a scientific pole and a clinical pole to divisions, and there remains a middle area, that of the physician-scientist, a member who conducts research but also understands clinical medicine, which may be forgotten or deleted. They supply the role models for future academicians, and they make the programs excellent.

How does this tie together with NIH support? It is pretty clear that you cannot go to a member of Congress and talk about something that has no impact on his/her district. You can talk about marketing of kidney disease as a problem, and you can even make a reasonable case that the budget for kidney disease ought to persist beyond the doubling period. I believe we have to effectively sell the concept that this is an important healthcare problem. Importantly, the clinical trials consortium can help with this concept, because we can market our research successes. If we provide a broader menu of clinical trials, which hopefully will be occurring over the next several years, then we can have something to discuss. We also hope that in the future there will be programs in the country to develop scholar experts in translational medicine. These programs would train faculty who understand basic science and clinical issues and who can move basic science observations into the clinical realm, enabling clinical trials to apply these concepts and see if they work.

Our society and others are interested in the process of reeducating academic or private nephrologists in state-of-the-art basic science or clinical science techniques. Sometimes, a career change is necessary, and we have been talking about both translational and sabbatical funding through NIH and societies to make available changes in career directions for academicians.

I hope you are not offended by the populist nature of this message, but I have tried to describe all of the programs that have been developed over the past couple of years to state that we want your involvement. We, as a society, speak better with a voice that includes a larger percentage of the membership who are also aware of the important issues. We hope that through our web site and some of these other vehicles you will be allowed to communicate with us better. We also hope our committee structure will provide opportunities for your involvement.

I would like to now thank some of the rogue’s gallery of people who are here and have been particularly effective this year. Norm Siegel and John Stokes took care of our transition to an independent status as a society this year and did so quite effectively. As I mentioned before, Norm shepherded our combined grants program with the NKF. John has been monitoring our funds and contributing in many other ways. I want to personally thank Bob Alpern, our Past-President, for all of his insights; whenever I ran into a problem I’d contact him and I’d always get an answer that I respected. In addition, I would like to thank the “gang of four:” the ASN Councilors who will each become president over the next several years. Dr. Mitch and Dr. Berl were liaisons with the basic science, clinical science, and government relations committees, and they were instrumental in bringing about the success of the clinical trials consortium. Dr. Henrich is liaison to two of our advisory groups and has been chairing an ad hoc committee on clinical education in conjunction with Bob Narins. Dr. DuBose has been interacting with our training program directors and our grants program, and he organizes the medical resident program for the 150 residents who are attending this meeting.

I would also like to thank our ASN staff, which includes our relatively new Executive Director, Dr. Karen Campbell, and Dr. Narins. Karen has been an absolute breath of fresh air of
organization and, otherwise, putting together all the programs of ASN; she has a background as Vice Chairman of a Department of Medicine, so she understands the adolescent behavior of nephrologists. Dr. Robert Narins continues to create excellent postgraduate education products. He has at least one idea per minute, and I can guarantee you that at least 30% of them are fairly workable. He has made major contributions to this and other meetings, as well.

Finally, my co-chair today, Dr. Paul Klotman, Chairman of Medicine at Mt. Sinai; he has developed a wonderful program due to a breadth of knowledge in nephrology and basic science. He has exerted leadership skills with this program committee and he has done so with good humor, which is a very difficult thing to accomplish. I would like to thank all of these people.

I’d also like to thank the members of my division at UCSD for not getting their usual “pound of flesh” of clinical attending out of me for the last year. And, I would like to thank my family for their patience; and the airlines for carrying me back and forth to Washington, DC, from California at least 12 times.

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