Ladies and gentlemen, members and guests of the Society. It gives me a great deal of pleasure to officially open this 31st Annual Meeting of the American Society of Nephrology and the continuation of Renal Week, and to welcome you to Philadelphia, the birthplace of our Republic. This meeting has exceeded past records, both in terms of abstracts submitted and in registrants from North America and abroad. This growth reflects the increasing realization by nephrologists and renal investigators internationally that this is the premier clinical and scientific nephrology meeting in the world. For its success, we are indebted to the Program Committee, the Postgraduate Education Committee, and the Basic Science Committee, and their respective Chairs, and to the Society’s corporate sponsors.

Now I would like to turn my attention to some of the salient points of my presidency, to some of our accomplishments, and to some of the challenges that lie ahead. A major focus of our Society has been advocacy for increased federal funding of medical research in general, and of kidney research in particular. Large inequities exist in the funding of research on kidney disease relative to other disorders.

Let me illustrate for you some of these inequities, and for this I shall use data published in the Institute of Medicine’s report on the National Institutes of Health Research Priority Setting, titled Scientific Opportunities and Public Needs, and also data derived from other sources such as the USRDS and the Centers for Disease Control (CDC). In 1995 there were 43,115 deaths in the United States due to AIDS. In the same year there were 50,226 deaths due to end-stage renal disease (ESRD). In 1992, the direct cost of HIV infection and AIDS is estimated to have been $10.3 billion. In the same year the total cost of caring for ESRD patients is estimated to have been $12.3 billion. In FY 1997 the budget authority at National Institutes of Health (NIH) for AIDS was $1.5 billion. In the same year the budget authority at NIH for kidney disease was a paltry $196 million. Clearly, an inequity does exist, and we have reason to believe that it could make a difference were a paltry $196 million. In the same year the total cost of caring for ESRD patients is estimated to have been $12.3 billion. In FY 1997 the budget authority at National Institutes of Health (NIH) for AIDS was $1.5 billion. In the same year the budget authority at NIH for kidney disease was a paltry $196 million. Clearly, an inequity does exist, and we have reason to believe that it could make a difference were a paltry $196 million. In the same year the budget authority at NIH for AIDS was $1.5 billion. In the same year the budget authority at NIH for kidney disease was a paltry $196 million.

We have just learned from the CDC that deaths attributable to AIDS have fallen by 28% in 1996, and by another 47% in 1997, reaching the astonishing number of only 16,685. This remarkable decline in AIDS mortality is doubtless the result of the many recent advances in therapy that have been fueled by the outpouring of resources to support AIDS research. If this were true for AIDS, it could have been true for kidney disease.

Even with the comparatively modest allocation of funds at NIH to support kidney research, we too can identify improvement in the outlook for kidney patients. I need only point to the retardation in the progression of renal parenchymal disease, especially diabetic nephropathy, by the use of angiotensin-converting enzyme inhibitors, and to the decline in the rate of increase in the annual incidence of ESRD from 9 to 7%. I am persuaded that the allocation of greater resources to kidney disease research can result in even better outcomes.

We have taken this message in the past year to the NIH Director, to the Director of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and to individual Representatives and Senators who sit on key Committees; and we testified before Committees that set the appropriation for the NIH and for the Veterans Administration. As a result of these efforts, we have been successful in getting many Congressmen to write to the Director of NIDDK urging him to allocate more money to kidney research. We have gotten language inserted in the NIDDK and the National Heart Lung and Blood Institute (NHLBI) appropriation bills specifically prompting these institutes to allocate funds to ESRD-related research. Also, thanks to the efforts of the entire renal community, we have just received a 14% increase in the NIDDK budget, which surpasses by far the 8.6% received last year, and starts us on the road toward the bipartisan goal of doubling the NIH budget in 5 years. Welcome as these increases in funding are, however, we have only begun to scratch the surface.

Of great concern to me is the number of investigator-initiated renal research grant applications (RO1) submitted by M.D. investigators to NIH, and assigned to NIDDK, and the total number of renal research grant applications submitted by all investigators (M.D., M.D./Ph.D., and Ph.D.) over the past 5 years. An almost steady decline in the number of submitted applications can be observed: from 171 to 139 RO1 applications submitted by M.D. investigators to NIH, and assigned to NIDDK, and from 370 to 309 total research grant applications submitted by all investigators (M.D., M.D./Ph.D., and Ph.D.) over the past 5 years. An almost steady decline in the number of submitted applications can be observed: from 171 to 139 RO1 applications submitted by M.D. investigators to NIH, and assigned to NIDDK, and from 370 to 309 total research grant applications submitted by all investigators (M.D., M.D./Ph.D., and Ph.D.) over the past 5 years. 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they are unable to submit research grant applications. What-
ever the reason, this is a dangerous trend that must be reversed
if the renal research effort is to be sustained, if not prosper.
More funds need to be made available to support a greater
percentage of applications, and to support faculty salaries, so
that young investigators can be freed from daunting clinical
responsibilities. Also, more funds are needed to support clin-
cal trials to test innovative new therapies. To achieve these
goals, we must maintain our vigilance and remain proactive in
Washington, both on Capitol Hill and on the NIH campus. For
its part, the ASN has created a research endowment, and has
allocated almost a million dollars of its own money annually to
fund our research grants program, thus putting our money
where our mouth is.

I have spoken earlier of the inequity in the funding of
research on kidney disease relative to other disorders. In its
recommendations for Improving Priority Setting and Public
Input at NIH, the Institute of Medicine (IOM) states that “In
setting priorities, NIH should strengthen its analysis and use of
health data, such as burdens and costs of diseases, and of data
on the impact of research on the health of the public.” The IOM
also recommends that “NIH should establish an office of
Public Liaison in the Office of the Director . . . .” One of the
key functions of this office should be to receive input from
disease-specific groups. We agree with and applaud these
recommendations. To develop a well thought out research
agenda and a set of priorities for our discipline that we can
present to the Director of NIH and to the Directors of NIDDK,
NHLBI, the National Institute of Allergy and Infectious Dis-
ases, and other relevant institutes and funding agencies, we
have decided to hold a research retreat in Washington, DC in
partnership with the Director of the Kidney/Urology/Hematol-
ogy Division of NIDDK, Thought-leaders, leading investiga-
tors, and patient representatives have been invited to this
retreat to serve on one of seven panels. The goals are to: (1)
identify and prioritize new research frontiers, tools, and meth-
odologies; (2) develop strategies to attract and train new in-
vestigators; (3) identify areas where clinical trials would be
appropriate; and (4) identify potential barriers, obstacles, and
challenges. At the conclusion of their deliberations, a summary
report will be drawn up by the panel team leaders and this
report will be published by the NIH.

Another major focus of our Society has been the issue of the
nephrology workforce and the concern about whether we shall
have in the next 15 years the manpower to staff our academic
nephrology divisions and to provide the specialized care that a
steadily increasing ESRD population will require. My two
predecessors have broached this subject before me: Dr. Wil-
liam Couser had suggested that we involve other health pro-
essionals, and Dr. Robert Luke suggested making our spe-
cialty more attractive to U.S. medical graduates (USMGs). I
agree with both of these approaches. With respect to the first
proposal, the Renal Physicians Association, with the support
and participation of our Society, has begun a dialogue with the
American Nephrology Nurses Association on a collaborative
model for the care of renal patients. With respect to the second
proposal, the ASN initiated a program 2 years ago intended to
attract into nephrology uncommitted USMGs during their early
years of residency training in internal medicine. This year we
have in our midst 105 medical residents attending our Annual
Meeting at the Society’s expense. It is our hope that these
young physicians will find the basic and clinical research
presented here fascinating enough to make nephrology their
career choice. My personal experience with this program tells
me that it has been enormously successful, even though we do
not yet have the data to back up this impression.

To make our specialty more attractive to clinical practitio-
ners, we may need to look to cardiology as an example. Some
30 years ago to make diagnoses of cardiac disease, cardio-
lologists listened to heart sounds with a stethoscope and pondered
recordings of body movement induced by cardiac contrac-
tion—so called balistocardiography. Today they use the ultra-
sound in echocardiography to visualize the heart and valve
movements; they use color Doppler to look for regurgitant
streams and to estimate flow and pressure; they use balloon-
tipped catheters to dilate the coronary vessels, and to place
stents to maintain their patency, and they use radioisotopes to
image myocardial perfusion. Cardiology has become the most
invasive of medical subspecialties, and the most popular, at-
tracting hordes of medical house staff. Meanwhile, neph-
rologists have relegated renal ultrasonography to the radiolo-
gist, cystoscopy and ureteroscopy to the urologist, renal
angiography and angioplasty to the radiologist, and the recan-
alization of occluded dialysis grafts to the radiologist or car-
diovascular surgeon. Even the renal biopsy, a technique devel-
oped by a nephrologist, is being slowly surrendered to the
radiologist.

I have for several years been a strong advocate of reclaiming
these procedures for nephrology, and I am pleased to say that
interventional nephrology programs are beginning to develop
in several parts of the country. To assist our colleagues in
making the transition from the pristine intellectual and con-
templative nephrophologist to the interventional nephrophologist, we
have organized a postgraduate course on Interventional Ne-
phrology and have incorporated into the main program clinical
symposia on the management of dialysis vascular access. I am
persuaded that a move toward a modicum of procedure orient-
tion in our training programs, and in nephrology practice,
will help our discipline appeal to more USMGs. This is good
not only for our discipline; it is also good for our patients to
have more aspects of their care provided for by the nephro-
lgist instead of a chorus of other physicians and surgeons.

We also have gone to Congress and argued that a medical
specialty or subspecialty that can present scientifically valid
data demonstrating an existing or anticipated workforce short-
age should be able to petition the Secretary of Health for
greater funding for GME positions in this specialty. Presently,
Medicare reimburses training institutions the full salary of
residents up to their first Certification Board eligibility. Be-
ond that, i.e., for subspecialty residents, Medicare reimburses
only 50% of the salary. This represents a disincentive for
training institutions to create GME positions for residents
beyond their first Board. Our proposal would allow the Secre-
tary of Health to authorize full reimbursement for the salaries
of residents training in these disciplines where a workforce shortage exists. Rep. Pete Stark (D-CA) has been kind enough to introduce this legislation in the 105th Congress. This bill, H.R. 3940, entitled “Medicare Critical Need GME Act of 1998,” has received the endorsement and cosponsorship of a number of members of Congress.

All of these measures notwithstanding, I am very skeptical that any of these approaches will soon yield the needed results. First, a steady stream of data is now pointing to the importance for pre-ESRD patients of early referral for specialized care, as evidenced by the lowering of morbidity and mortality, and by reduction in the need for and duration of hospitalization, and in the overall cost of care. We are also told that the pre-ESRD population may number in the millions; 12.5 million one study suggests. Finally, our European colleagues tell us that an important reason for the lower mortality rate in their ESRD patients compared to ours is the fact that a European nephrologist spends one-half hour per week on each dialysis patient. They admonish U.S. nephrologists to spend more time with their dialysis patients. Putting all of these considerations together, I see no alternative to the need for a great many more nephrologists than we currently produce.

Let us then examine our nephrology manpower pipeline to determine whether the indications are favorable for us to meet those needs. The AMA’s annual Graduate Medical Education report, published in the Journal of the American Medical Association every September, which reports the total number of nephrology residents for the past 5 years and the breakdown into international medical graduates (IMGs) versus U.S. and Canadian medical graduates (designated as other), reveals that there has been a steady decline in the total number of trainees in nephrology until this past year. The decline coincides with the recent indiscriminate pronouncements, from many sources, that a surplus of specialists exists. The increase in the number of trainees this past year, I hope, can be attributed to our efforts to disseminate information to senior medical students and junior residents about the opportunities for careers in nephrology. It would be encouraging if these efforts are beginning to pay off. I want to point out, however, that we have only 250 USMGs at all levels of training. The remainder, who account for 60% of all trainees, are all IMGs.

Recently, I conducted a survey of all 135 nephrology training programs in America in which I asked two simple questions: (1) How many full-time faculty do you have and how many of them are IMGs? (2) How many research fellows (defined as spending at least 75% of their time on research) do you have and how many of those are IMGs? I received responses from 113 programs, an 83.7% response rate. The data was interesting in many respects. We learned for example that there are 44 programs that do not have research fellows, and that 57% of all research fellows receive their training in just 11 programs. However, the findings from this survey that I wish to point out are: (1) 25% of all nephrology faculty in the United States are IMGs; (2) 65% of all research fellows in this country’s renal research laboratories are IMGs; and (3) only 140 USMGs are in renal research training nationwide.

It is clear from this data that in the United States we are critically dependent on IMGs for both the clinical practice of nephrology and for academic and research nephrology. For their many contributions to American nephrology, I would like at this point to salute all IMGs for their contributions to clinical and investigative nephrology in this country.

What I find very frightening are all those naysayers in Washington who are telling the Congressional Medicare Reform Commission that no Medicare funds should be spent on the training of IMGs. For those of us in nephrology, the training of IMGs is a matter of survival. If we were to stop training IMGs, or even to limit their training opportunities, our specialty will be in peril. For my part, I would like to make a proposal diametrically opposed to that of individuals seeking to limit the training of IMGs.

Some months ago, the computer and software gurus were in Washington arguing for special immigration privileges for computer programmers and software engineers. These special immigration privileges for which they appealed have now been passed by both the House and the Senate. In the same vein, we know that the Immigration and Naturalization Service (INS) has permanent resident visa quotas for individuals with needed abilities and qualifications. We also know that the INS waives, for J-1 visa bearers, the requirement to return to their native countries, and awards them permanent resident status after 2 or 3 years of service in underserved areas. Consistent with these established practices, I propose that nephrology be designated an underserved area, and that IMGs trained in nephrology in the United States be considered as possessing a needed qualification that would entitle them to receive a permanent resident visa.

Only with such a bold step can we hope to meet the needs that now exist, and that we predict will become more acute in the years to come. Needless to say, such a move does not need to be open-ended. This special status for nephrology can be terminated when the ranks of nephrologists have been enriched enough to meet the need, and/or when enough USMGs have begun to gravitate toward nephrology that IMGs are no longer needed. It should be noted that I am not calling for thousands of physicians from abroad to be admitted to our graduate medical education system, but merely a few hundred. The Workforce Study that we had carried out 3 years ago indicated that we need to be training approximately 500 new residents annually in order to meet the workforce needs by the year 2010. Such a small number, and for a limited period of time, should not contribute to any real or perceived physician glut, but surely should immensely help meet nephrology’s workforce needs.

Time does not permit me to delve in great detail into all of the Society’s other activities in the past year. I assure you they have been numerous, and very significant. I do want to take a few moments to highlight some of these.

In recognition of the growing importance to nephrology of epidemiology, clinical trials, and outcomes research, we have formed a Clinical Science Committee. We have also formed a Renal Informatics Committee that has concluded a joint sponsorship and marketing agreement with HDCN, a hypertension, dialysis and clinical nephrology web site on the Internet. Speaking of informatics, submission of abstracts for next
year’s meeting will be possible via the Internet, and all of the submitted abstracts will be posted on the Internet. The Society’s Journal will soon publish, in full text, certain clinical articles on the Internet. There were numerous other activities just as deserving of mention, such as the Board Review Course and other educational activities completed or contemplated, but time and space will not allow further elaboration.

I want to conclude by saying that for me this has been a most rewarding and fulfilling year, and I want to thank you for the confidence placed in me by electing me your President. The work I have done would not have been possible without the support and understanding of my family and my associates. Nor would it have been possible without the support of the Society’s Council, the Society’s Committees, and the Society’s outstanding management team, government relations group, and conventions team. The valuable assistance of my administrative assistant and executive secretary is also acknowledged.