The American Society of Nephrology at 50: A Personal Perspective

William M. Bennett

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Dr. William (Bill) Bennett was the founding Editor-in-Chief of the *Clinical Journal of American Society of Nephrology* (*CJASN*), a Past President of the American Society of Nephrology (ASN), and the generous donor establishing the William and Sandra Bennett Clinical Scholars Program. His passion for nephrology, patient care, training, and education is widely known by patients and colleagues. In recognition of the 50th anniversary of the ASN, the Editors of the *CJASN* invited Dr. Bennett to provide personal reflections.

Gary Curhan, MD, ScD, Editor-in-Chief, *CJASN*

Introduction

The ASN will be 50 years old in 2016. As I reflect back on this half century, it occurs to me that my career in nephrology is approximately the same age. These are my reflections on how the ASN and I matured together.

The Beginning

In the late 1960s, clinical divisions of nephrology were largely focused on basic physiology, sodium, potassium, and acid-base balance. Dialysis was available but usually reserved for patients with acute renal failure. Intermittent peritoneal dialysis was most often used. Hemodialyses were usually carried out with a twin coil dialyzer, which used a single dialysis bath for dialyzing two patients simultaneously. Obviously, this was before knowledge of viral transmission of HIV, hepatitis C, and hepatitis B. Successful kidney transplants following the work of Nobel Prize winner Joseph Murray and his Boston nephrology colleague, John Merrill, were slowly becoming available at major centers (1). Immunology was rapidly expanding. The availability of azathioprine, also a Nobel-recognized discovery, allowed deceased donor transplantation to become a reality (2,3).

The annual ASN meeting was initially held in Washington, DC. It featured largely 10-minute oral presentations regarding the latest advances in basic science research. Major controversies of the day involved the nature of sodium and water retention in edematous states, the role of a putative "natriuretic hormone," and the etiology of essential hypertension. Many believed that the majority of cases of essential hypertension were in fact caused by primary aldosteronism. Others more correctly argued that mineralocorticoid excess was a rare cause of secondary hypertension.

I often think back to the awe and excitement that I experienced at my first annual meeting. The thought-provoking content of the presentations and seeing all of the academic celebrities was stunning. These were the men (and they were all men) whose publications and textbooks inspired my budding career. I remember vividly going across the street from the meeting hotel to have a late night beer with a fellow colleague only to observe a table at the back occupied by the nephrology icons Frank Epstein, George Schreiner, and Donald Seldin, who obviously were discussing nephrologic subjects, albeit through a haze of pipe and cigar smoke. We did our best to look invisible.

Chronic dialysis in this period was experimental, largely because of the lack of chronic vascular access and limited finances. Committees were formed to decide who would be treated by chronic dialysis and who would die—these were the true "death panels." I remember vividly sitting on such a committee in my first faculty job in Portland, Oregon, where divorce was considered a psychosocial barrier for successful outcome. Diabetes and lupus were systemic diseases that would "certainly" recur or worsen, thereby precluding dialysis or transplant treatment. At this time, the field of medical bioethics became a day to day clinical reality fostered by too many patients and too few resources.

Until 1972, nephrology was not recognized as an official subspecialty of internal medicine. There were no fellowship certificates to be awarded and thus, those of us who entered nephrology after military service expecting to get the Government Issue (GI) Bill of Rights to sustain our families were told that absence of an American Board of Internal Medicine (ABIM) "certificate" made us ineligible for the GI Bill. Thus, it was my pleasure to receive years later my full GI Bill compensation on the basis of a threatened law suit on behalf of all "unapproved" subspecialties filed by an aggressive Harvard law student.

After Medicare

In 1972, the nephrology world changed. The Congress of the United States approved a law putting treatment of what they termed ESRD under the auspices of Medicare. Passage of this law, the country's first and only example (except for the Veterans

Legacy Transplant Services, Legacy Good Samaritan Hospital and Medical Center, Portland, Oregon

Correspondence:
Dr. William M. Bennett, Legacy Transplant Services–Legacy Good Samaritan Medical Center, 1040 NW 22nd Street, Suite 480 Portland, OR 97210. Email: bennettw@lhs.org

Administration [VA]) of a single–payer health care delivery system, was the result of hard work by an ASN President, George Schreiner. A patient of Belding Scribner was actually dialyzed on the floor of the Senate. Many patients were now eligible for treatment, and chronic dialysis therapies blossomed. This increase in availability of treatment was made possible with the emergence of the arteriovenous (AV) shunt pioneered in the early 1960s by Belding Scribner and the chronic peritoneal dialysis catheter by Henry Tenckhoff (4,5). Improvements in vascular and peritoneal access made chronic dialysis feasible and expanded the need for nephrologists to look after a rapidly growing number of patients. The ABIM approved nephrology as a valid subspecialty of internal medicine. The first board examination in nephrology took place in 1972, and I had the distinct pleasure to successfully participate in this written multiple choice examination. The written examinations were a marked improvement over what previously had been a qualifying written examination followed by an oral examination. In the latter, two preeminent examiners evaluated a candidate regarding history and physical findings on two test patients, for which the candidate was given 45 minutes each. The lack of uniformity in these examinations made the oral examination a terrifying experience for the candidate. There was a very high failure rate on both the oral and written examinations.

After 1972, with the emergence of CKD and ESRD as clinical realities, the ASN assumed a leadership role in educating the expanding numbers of fellows. The annual meeting soon outgrew the facilities in Washington, DC. It was always the highlight of the year for members in the ASN. As the membership expanded, trainees both domestic and international became lifelong members of the ASN. The meeting moved to first Baltimore and then, larger venues around the United States. With the society's growth, the dialysis industry also grew. Academic leaders who previously were worried that dialysis and transplantation would overwhelm training programs quickly ascertained that the revenues provided by these modalities could support entire Divisions of Nephrology and indeed, help support Departments of Medicine. In this era, the relationship between the ASN and industrial partners was one of close or as some thought, too close collaboration. There were parties, symposia, and other entertainment appended to the annual ASN meeting, usually in upscale venues outside of the main meeting. The industrialization of dialysis and the delivery of nephrology care rapidly changed the face of the profession. The nephrology meetings became an elaborate display of products and services that were available to nephrologists.

During my year as President of the ASN, 1998–1999, I tried to emphasize that these physician-industry relationships were not healthy for the profession. Ethical boundaries were becoming blurred, and both academic medical centers and private practitioners developed obvious conflicts of interest. Indeed, the first practice guidelines that were published in nephrology were rife with conflicted practitioners who likely had financial interests in the outcome of the guidelines (6). The erythropoietin story is one in which the use of the drug was prescribed well beyond the scientific evidence supporting it only to be found later to be unnecessary, expensive, and probably dangerous (7).

The ASN Council with the invaluable efforts of Bob Narins, Tom Hostetter, and Bill Henrich were strong advocates of making sure that ASN programming and educational activities were independent of direct commercial support. As is the case today, all of the program content and faculty were under the direct supervision of the ASN. In fact, the ASN was an early leader in academic industry-professional relationships and definitions of conflicts of interest.

For many years, the annual meeting of the ASN was preceded by the annual meeting of the National Kidney Foundation (NKF). The ASN meeting focused primarily on advances in basic and clinical science, whereas the NKF meeting was more clinically oriented. In 1991, the ASN President Dr. Craig Tisher expanded the clinical presentations at the annual ASN meeting. Ninety-minute sessions (The Short Courses) were devoted to clinical topics and incorporated into the annual meeting. The overlapping educational aims of both societies led to the NKF's decision to have its annual meeting at a different time and place. Under the leadership of Dr. Barry Brenner, the ASN initiated publication of a scientific journal that would contain the best original basic and clinical research. The *Journal of the American Society of Nephrology* (*JASN*) was born, with Dr. Jared Grantham as its first Editor-in-Chief in Kansas City. He brought the talented Managing Editor Bonnie O'Brien into the ASN fold. Bonnie has continued to this day to be the driving force behind the *JASN*. She also was the first Managing Editor for the *CJASN*. I had the pleasure of working with Bonnie as the first Editor-in-Chief of *CJASN*.

Emphasis on Education

Many major educational milestones were achieved during the 11-year term of Dr. Robert Narins as the ASN's first Director of Education. Dr. Narins had a unique vision for how the ASN could fulfill its responsibility for providing high–quality scientifically based clinical programs for the swelling number of clinical nephrologists. He developed programs at the annual meeting and throughout the year that made up-to-date unbiased information accessible and palatable. The revenues generated from these programs energized the future educational and scientific endeavors of the ASN. Narins extended the annual meeting to include 2 days at the beginning that were dedicated to in-depth reviews and updates of clinically relevant topics (The Two-Day Courses); the annual meeting became Renal Week, and subsequently, it has morphed into Kidney Week. The popular Nephrology Quiz and Questionnaire sessions on controversies in nephrology and luncheon meetings were integrated into the weeklong program. In additional to promoting the need for a clinical journal and then lobbying for it, he and Dick Glassock developed the concept of the Nephrology Self-Assessment Program, which continues to successfully keep nephrologists current with recent advances throughout the domain of nephrology. In 1996, at the direction of the ASN Council, Dr. Narins developed the annual weeklong Nephrology Board Review Course and Update in San Francisco. The ASN Board Review Course and Update became and still is the most dynamic and well attended function to prepare for

the nephrology boards. Dr. Narins also promoted collaborations with other societies in the United States, Europe, and Asia. The ASN now has many foreign members and scientific contributors. The American College of Physicians worked with the ASN in promoting the reviews and updates in internal medicine that were key to the practice of nephrology. With Dr. Narins' leadership, Renal Weekends (now called ASN Highlights) were developed to review the findings and presentations from the annual meeting for those who were unable to attend. These functions were subsequently expanded to Central and South America, where ASN faculty literate in Spanish present to large audiences. At Dr. Narins' urging, the ASN Council initiated the guidelines for its members to become Fellows of the ASN. The program has increased participation in the society's activities from members worldwide.

Today

The ASN has always had interest in public policy and advocated successfully for increased funding for basic and translational research *via* federal agencies, particularly the National Institutes of Health. Increasingly, the ASN has itself supported fellowships and research to compensate for loss of outside funding sources. Under the auspices of the society's most recent leadership, Drs. Ronald Falk, Bruce Molitoris, Sharon Moe, and Jonathan Himmelfarb, research awards and grants have mushroomed. An endowment to support research of $20 million to support research fellowships has reached reality and should be a source of money for the next generation of promising leaders. Organizing program directors to enhance nephrology training experiences has been a major achievement.

Also, under the leadership of Dr. Ronald Falk, the ASN was brought kicking and screaming into the electronic age. Because of Dr. Falk's prescient analysis of the future, the ASN was an early player in converting many of its publications, examinations, and educational offerings to an electronic format. One only has to examine the ASN's outstanding website to see the fruits of Dr. Falk's vision.

The leadership of the ASN 50 years ago was decided in a small room among the founders and academic leaders of the society. The democratization of the process began in 1992, when a nominating committee held the first election of councilors. I was fortunate to be the first councilor who was elected rather than appointed. Subsequent councilors and leaders of the society have been elected by the membership.

The Future

Finally, as I look back over a career in nephrology and the history of the ASN, I see a future with many challenges, including a declining interest in nephrology as a discipline and the perception of many that clinical nephrology is fraught with hard work and low pay. I prefer to take the opposite view. I feel that nephrology is still the most fascinating of disciplines with a dynamic leadership succession looking to the future with optimism. Nephrology remains the ultimate discipline that requires its practitioners to be good doctors. We have been the pioneers of teamwork in delivering patient care. The need for competent practitioners will only grow. Research in basic science, genetics, molecular biology, and immunology is spectacular and will surely lead to new clinical treatments. The ASN and its educational programs should prioritize stimulation of interest in nephrologic research and clinical care. New blood will be needed to translate basic insights to clinical care. The ASN meeting participation by medical students and residents hopefully is a prelude to continued interest in nephrology careers.

Approaching the end of my career, as I reflect back, it is obvious that the ASN has been a major part of my professional growth. I have evolved from a young nephrologist trying to remain invisible among nephrology's founders to the ASN President concerned about the society's relationship with industry to an editor and mentor who is focused on helping the next generation. Most importantly, through the ASN's activities, patients with kidney disease will receive the latest and best in treatment and prevention of kidney disease.

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Disclosures

None.

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