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President's address

On working together

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Not many years ago allergy was the neglected stepchild of the medical profession. To most physicians allergy merely indicated a few common but not vitally important diseases—hay fever, asthma, urticaria—and the allergist was regarded merely as a technician who did skin tests, the more extensive the better, which he assumed were a sort of diagnostic Rosetta stone. Unfortunately, this too frequently was warranted.

Gradually but steadily the situation for allergy has improved. It is emerging from its adolescence, a period quite common to most new fields of science, because careful study on the part of many has brought new knowledge which evidences the basic soundness of its concepts. Today allergy stands at the threshold of real development, for the broader vision of many minds has served to extend its horizons and increase its applicability to the possible solution of many medical problems.

Fellow members of the Academy and welcome guests, the words I just read are timely; but I cannot claim them as my own. They come from an editorial written by Robert A. Cooke almost a quarter of a century ago.[1] The situation has not changed much, has it? Dr. Cooke also discussed the impressive progress regarding the attention given to allergy by basic scientists as well as clinicians in other specialties, in contrast to the deficiencies in the teaching of allergy in schools and hospitals. He also emphasized the need for fulfilling basic requirements in medicine or pediatrics before embarking on allergy training. How pertinent these comments seem today.

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Robert Cooke's comments came soon after the merger, in 1944, of our 2 parent societies: the Society for the Study of Asthma and Allied Conditions, and the Association for the Study of Allergy. Only 4 years before that, the joint Committee on Standards representing the 2 societies had become the Advisory Board of American Allergists,[2] which succeeded in gaining approval of the reluctant American Board of Internal Medicine for subcertification in allergy. These developments might have been cause for celebration and rapid consolidation of the specialty after World War II. Alas, such was not to be. I cannot possibly, at this distance, understand completely the climate of the period. Too much is unwritten and much left unsaid. Many physicians became bitter or frustrated by the barriers to formal recognition; but no pattern emerges other than the situation with pediatric allergists, who lacked recognition until the American Board of Pediatrics agreed to establish subcertification in 1945.[3] Meanwhile, the American College of Allergists had been organized on November 23, 1942, and another society existed for a short time after the war which offered independent board certification.[4] The feeling of being left out in the cold was strong among many allergists at the time. This feeling comes to all of us at times, so we can sympathize. Anyway, the schism was on.

This problem clearly was aggravated in the 1950's by the erosion of the stature of our profession, perpetrated by the poor practice of some. In fact, the image of the specialty may actually have deteriorated rather than rising, as its leaders hoped, after World War II. Though Robert Chobot's words come from his presidential address on December 4, 1943, they differ little from the tone of later addresses and editorials which appeared in the JOURNAL OF ALLERGY in the 1940's and 1950's. Let me quote:

> Organized medicine, of which allergy certainly was a subdivision, regarded us as we were. A bewildering nomenclature, a lack of unanimity even on the simplest matters, bitter differences often based on inconsequentialities, resulted in a specialty virtually devoid of stature in the eyes of our medical colleagues. In addition, we permitted the entrance into the field of some men who took the attitude that allergy consisted of needles, syringes, and a patient's extremity; men who failed to appreciate the fact that to know allergy one must first know medicine. Let us face the facts squarely: The want of esteem from which allergy has suffered in the past comes entirely from our own shortcomings.[5]

I would add that too many physicians would go from hypothesis to clinical exploitation and dogmatic teaching without ever testing the hypothesis critically by carefully controlled investigation. Certain methods of treatment so developed and promoted persist to this day.

This bad image of the 1950's, I assume, led to a blacklash from the establishment. By 1960, when I looked toward board certification, the requirements of the American Board of Internal Medicine were such that at least 10 years after medical school graduation were needed to finish the requirements for examination in the specialty of allergy! No wonder so few became certified at the time. Why bother?

Of course the result was a counter backlash and more schism among the allergists. And thus developed the planning that culminated in the emergence of the American Association of Clinical Immunology and Allergy.

The schism between pediatric and adult allergy did not help. The rigid separation of the 2 perhaps was unavoidable because of board requirements of the time, but I think it did hold back progress of the specialty. Considering the splendid associations with pediatricians I have been privileged to have in my own community and in my activities in the Academy, I find it difficult to understand why these problems had to develop.

What a change now! The Conjoint American Board of Allergy and Immunology is now a functional body, approved and encouraged by all groups, including the Academy, the College, the American Association of Clinical Immunology and Allergy, the American Board of Pediatrics, the American Board of Internal Medicine, the American Board of Medical Specialties, and the Council on Education of the American Medical Association! This is a remarkable achievement in compromise among the various societies and is an encouraging sign that the roots of the schism of the 1940's have been weakened, if not destroyed! Here is proof that allergists can cooperate in compromise—a most valuable boon to the specialty! I plan to return to this later.

Certainly our image is far better today than it was in 1947; this is due in part to our greater involvement in clinical immunology, in which the mechanisms are often clearer and the problems require cooperative efforts from specialists from other disciplines dealing with seriously ill patients in the hospital. What about bread-and-butter allergy? Even now, we are faced with widespread skepticism. This skepticism is not helped by those who would substitute tests for good judgement and random data collection for equanimity when dealing with clinical uncertainties. I am reminded here of Derek Bok, the new president of Harvard. In his remarks to the Freshman Class last fall, he had this to say:

> . . . it is our hope that we can instill certain attitudes of mind—a decline in dogmatism and willingness to accept ambiguity, uncertainty, and the lack of definite truths; a sense of the complexity of human affairs . . . an independence of thought, a respect for facts and for the uncomfortable conclusions to which facts sometimes lead.[6]

Fellow allergists, we must not succumb to the natural human impulse to assign a cause to every event without substantial proof to support the assertion. Such equanimity requires special effort, but it is essential to professionals, in contrast to those who are satisfied with vocational and technical pursuits.

In this regard, I am now disturbed by 2 matters which face our specialty.

One has been with us a long time. In 1954, an editorial appeared in THE JOURNAL OF ALLERGY which decried the activities of clinical testing laboratories in New York.[7] These laboratories, of course, thrive elsewhere, and my own region is not exempt. They thrive, in part, because they reflect the image of allergy held by some, and reinforced by a few in our specialty, that the only tangible service of the specialty is to provide results of skin tests and stereotyped directions (and materials) for injection treatment. I need not cite the simplistic but profitable approach here and need not mention how little training in our specialty is needed to set up the service. That the results may be inappropriate in a clinical context is unimportant. There is little critical feedback between the hospital or office and the lab regarding allergy testing, because most phy-

sicians who use the service are quite inexperienced in our specialty. Recently the Ethics Committee of the Academy was informed of a new laboratory service now offered to physicians in southern California. This provides allergy diagnosis by rat–mast cell degranulation. Now we all know that the rat–mast cell technique is an interesting new research method for studying reaginic sensitivity. This exploitation of an experimental procedure, openly advertised to physicians as the answer to their problems, not only reflects the limited understanding of our specialty by gullible or overworked physicians but also indicates how its image can be damaged by the practice of a few allergists who have set the example for these laboratories to follow.

The other problem with which we are confronted has to do with a certain "school" of allergy diagnosis and treatment which has become fashionable now among some otolaryngologists and is very effectively promoted around the country. Please note that Dr. Herbert J. Rinkel was an honorable man and was a Fellow of this Academy. The exploitation of his theories needs the restraint of controlled clinical investigation, and the American College of Allergists is planning to do just that. We should cooperate with the College in achieving this worthwhile goal.

I do not wish to dwell more on these problems. We in the Academy can help to solve them by doing more to cooperate among ourselves, by working with others in establishing uniform standards, and by promoting carefully controlled clinical trials of all new or controversial methods of diagnosis and treatment.

Let us now go back almost a half-century to the time when the 2 parent societies were founded. One of them, the Society for the Study of Asthma and Allied Conditions, enumerated 6 goals at a meeting held in New York City on March 7, 1924.[8] I find these goals quite interesting:

1. The relations of infections of the respiratory tract to asthma. How little progress has been made!

2. The investigation of asthma clinics. This was the start of efforts to develop standards which led eventually to board certification.

3. The investigation of industrial asthma. This is still a timely topic.

4. The classification of asthma and allied conditions. Forty-eight years later, we are still struggling to classify asthma. In 1957 a committee of the Academy made very little progress because there was too much disagreement! The time is ripe to try again, and the Allergy Foundation is now starting such a project with the support of the NIAID.

5. The terminology of hypersensitiveness.

6. Methods of preparation of materials for testing and therpeutic use. Periodically we have heard or read pleas for standardization. Carl Arbesman,[9] in his 1957 Presidential Address, gave special attention to the need for standardization in several categories. Progress has been slow and by 1959 the policy of the Academy, in conjunction with the National Institute of Allergy and Infectious Diseases, was to concentrate only on the chemical make up of ragweed. The rest was too complicated.[10] The result of this focus was, of course,

antigen E. This was a breakthrough in standardization, but we still have a long way to go!

I would like to refer once again to the new Conjoint Board. This is a remarkable achievement! Three years ago, I was rather pessimistic about its chances. It does not give every allergist what he wants, but it provides more than most of us thought was possible. We must make it work!

We must work together to broaden the base of our specialty. It is true that most clinical problems are likely to come from those patients with common complaints, that is, the 31 million persons estimated to have atopic or allied disorders. Naturally, this is impressive, but is it enough? I do not think so. Many of us are thoroughly dedicated to the care of patients with atopic problems. Many fine allergists are full-time practicing atopists by choice or by force of circumstances. What, though, of the future? Admittedly, the majority of patients we work with are atopic and must have high-quality care. Yet other hypersensitivity diseases are just as important to the patients who have them and these diseases are too often more serious and dramatic. As consultants, allergists should also be knowledgeable in the nonatopic immunologic disorders in order to be most effective. After all, this is what is expected of consultants in other specialties. Furthermore, the skills that an allergist, who is also a clinical immunologist, can bring to bear on problems provide several more options for service than the ability only to perform skin tests!

I have emphasized the development of the Conjoint Board primarily as a splendid example of what can be done when the allergy organizations work together. Hopefully, many problems which plagued allergy in the 1940's and the 1950's have been resolved. I see other encouraging developments toward an ecumenical movement. I will mention these briefly.

The Allergy Section of the AMA has become an effective medium for communication and cooperation among our societies.

The Allergy Foundation is another focus for the common cause. The AAA and the ACA recently established liaison committees to the Foundation which should work together in stimulating and implementing worthy goals of the Foundation, goals of a problem-solving nature such as:

1. A new effort to achieve the 48-year-old goal to standardize allergenic materials.

2. Development of a self-assessment examination in our specialty along the lines of the pioneering effort of the American College of Physicians.

3. The program, which I mentioned earlier, to develop a standard classification for diseases.

We are working with the other societies in other ways. For example, our Medical Services Committee, chaired so ably by Stanley Hampton, has worked closely with representatives of the American College of Allergists and the American Association of Clinical Immunology and Allergy in the Conjoint Socioeconomic Committee, which was organized in 1970. In the process, they have developed an important line of communication with the American Society of Internal Medicine.

Throughout the 1950's, the AAA and the ACA exchanged presidents; THE JOURNAL OF ALLERGY published not only the AAA presidents' addresses but those of the ACA presidents as well. For some reason, this custom lapsed about 1960. I am happy to report that Dr. Ralph Hale met with our Executive Committee last week and discussed matters of common interest. As President of the College he has asked that our next President, Elliott Middleton, represent the Academy at the meeting of the College in March.

Periodically over the years, the Academy and College have considered amalgamation. The advantages are obvious, but many roadblocks to its successful achievement exist. My personal feeling is that in a perfect world such a step would strengthen the specialty substantially. I would like to see a joint committee of the 2 societies investigate once again the possibility of achieving this in the not-too-distant future. The more we can work together on common problems and goals, the more likely this will materialize.

We should do more than we have to strengthen the base of the specialty through efforts at standardization. This can be accomplished by working together. This is a difficult specialty to standardize. The atopist in particular is vulnerable, because he deals with patients who have widely variable symptoms a majority of which are mild enough to make objective assessment difficult. In contrast to the surgeon the feedback of information necessary to establish quality control is often very weak. We must put more effort into standardization and this must be a joint effort of the societies.

The reputation of our specialty is as much at stake as it was a quarter of a century ago. We must work together not only to maintain but also to raise our standards, to take a hard look at what we do in controversial areas, to be as critical of our own practices as we may be of the practices of others, and with the best of our abilities to promote research and not to perpetuate dogma. To end on a positive note, our specialty is strong and getting stronger. We can all work together to illuminate the many strong areas in our specialty in which fundamental truths have eliminated controversy and have established a common cause for teaching, research, and patient care.

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