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Presidential address

The Academy: The past, present, and future

Richard F. Lockey, MD, Tampa, Fla.

My year as your President, although wonderfully exciting and stimulating, is one which I view sadly because Bill Pierson, my predecessor, was not able to share my presidency as I had fortunately shared his. I dedicate this presidential address to Bill, a great friend, but bedridden in Seattle, and to his wife, Louisa. I also dedicate this address to my late father and to my mother (Fig. 1).

BACKGROUND

Academy formed in 1942

Medicine and the specialty of allergy and immunology have undergone great changes since the Academy was formed in 1942. The Academy's membership, in this golden anniversary year, has increased from the original 272 members who created the Academy by merger of the American Association for the Study of Allergy and the Association for the Study of Asthma and Allied Conditions to 4717 (Fig. 2).¹ Members now include clinicians, academicians, research associates, and allied health associates from the United States, Canada, and 57 other countries.



FIG. 1. The late Stephen D. Lockey, MD, and his wife, Anne F. Lockey. Dr. Lockey was a practicing allergist in Lancaster, Pennsylvania until he was 81 years old. He died in April of 1985. Mrs. Lockey is 87 and currently resides in Lancaster, Pennsylvania.

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The Academy was formed 11 years after my father, the late Stephen D. Lockey, graduated from Temple Medical School. After graduation, he began private practice as a general practitioner. His first patient logbook, dated October 8, 1933, illustrates a typical day of practice in a small town in Lancaster County, Pennsylvania. Charges for office visits were between 35 cents and \$2.50 and total receipts for the day, between \$7.50 and \$15.00, and many were no charge (N/C) because he knew who could not afford to pay (Fig. 3). He also itemized how he distributed his income: itemized expenses included an allocation of several

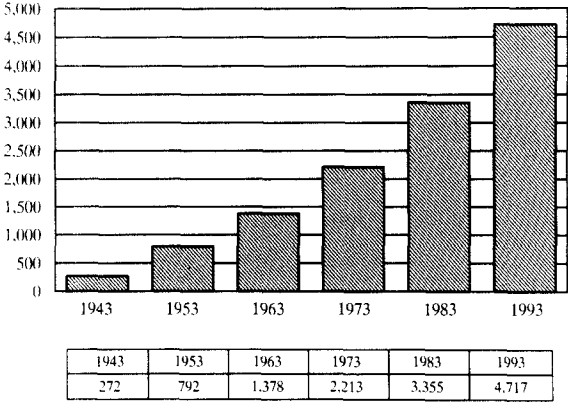


FIG. 2. The AAAI has grown from 272 members in 1943 to its current membership of 4717.

dollars to my mother, identified in my father's log by her name, *Anne* (Fig. 4).

The children of the family vividly remember going with my father on Sunday mornings as he made house calls to the homes of Pennsylvania Dutch farmers. He was often paid in kind with cherry or apple pies, eggs, poultry, milk, or a cured ham.

Father's brother dies of anaphylaxis

Dad was always interested in allergic diseases, having witnessed his 3-year-old brother's death from anaphylactic shock after an injection of horse-derived antitoxin for diphtheria. His continued interest in allergy motivated him to journey weekly to the University of Pennsylvania where he took an "apprenticeship" with Drs. Warren T. Vaughan, Harry B. Wilmer, and J. A. Clark. He later moved 5 miles to the city of Lancaster, Pennsylvania where he gradually assumed the role of the city's allergist. He staffed two free clinics, each a half-day per week, at the Lancaster General Hospital, as did his colleagues. Charitable activities were expected of physicians at that time in order to have hospital privileges.

Few physicians in this room can remember medicine in this not so distant past. My two brothers, Stephen D. Lockey and James E. Lockey, and I became physicians (two allergists/immunologists and one pulmonologist with skills in occupational medicine), and our only sister, Doris Lockey Monroe, became an executive for a company that makes automatic self-injectable devices. Dad believed that physicians had God-given special healing powers and that the medical profession transcended all other professions.

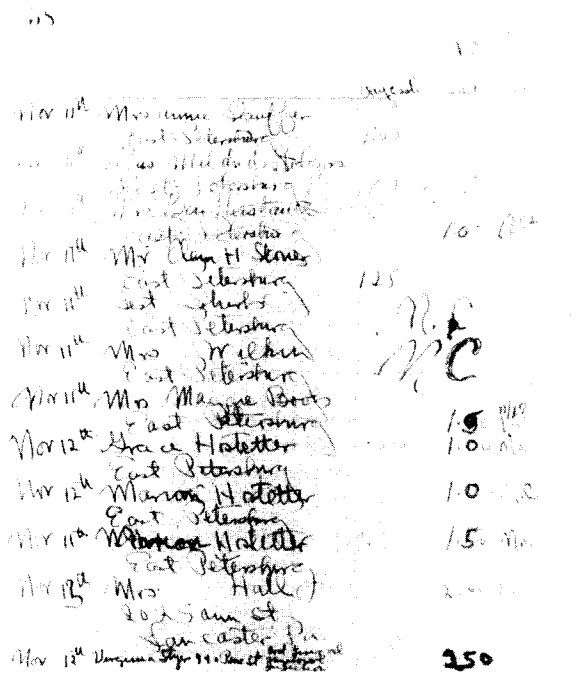


FIG. 3. From Stephen D. Lockey, MD's patient logbook, November 1933. He charged from 35 cents to \$2.50 per visit. N.C. indicates "no charge," a common courtesy at that time for those who were too poor to pay for services rendered. Ten dollars and twenty-five cents indicates the total receipts for the patient visit recorded on this page.

Clinical and Laboratory Immunology

Eligibility for board certification for my generation required certification in either internal medicine or pediatrics and completion of an approved 2-year fellowship in allergy. The Board of Allergy and Immunology became an independent board in 1971 after which, in 1982, the Academy changed its name to the American Academy of Allergy and Immunology to reflect the importance of clinical immunology in the specialty.¹ An optional third year has since been made available for training in Clinical and Laboratory Immunology.

Practicing medicine is life in the fast lane, with its science so complex as to make competence in its many disciplines virtually impossible. How things have changed from my father's simple life; a patient paid him in cash; he in turn gave cash to my mother and was expected, even required, to work in free clinics to take care of less fortunate individuals who were unable to pay for health care.

There is no returning to that simple life of going off in a Model T Ford to a home on a

Dec 8 th	Smother (MD)	6.00	
Dec 9 th	Food	2.55	Paid 11/8
Dec 9 th	Light Bulbs	.30	
Dec 10 th	My mother	1.00	
Dec 11 th	Anne	2.75	
Dec 12 th	Smithgalls	3.00	
Dec 14 th	Things of personal nature	2.00	
Dec 15 th	Electric	1.00	
Dec 15 th	Coal	15.00	
Dec 16 th	Drugs	3.00	Paid 11/15
Dec 16 th	Butcher Mr. Hodge	2.72	
Dec 16 th	Mr. Phipps & Bill	1.35	Paid 11/16
Dec 16 th	Mr. Smith in Smithgalls	.60	
Dec 16 th	Drugs Smithgalls	3.00	
Dec 16 th	Butcher	2.53	Paid 11/16
Dec 17 th	Anne	1.00	
Dec 18 th	Electric Light Bill for Month	9.40	Paid 12/18
Dec 19 th	Carfare	.50	
Dec 19 th	Phone association	1.00	
Dec 19 th	To Bancroft Hotel Co.	5.08	
Dec 19 th	Drugs	1.75	
Dec 19 th	Drugs association	3.00	Paid 12/19
Dec 19 th	Drugs	5.00	

FIG. 4. This page illustration from the patient logbook summarizes his office and personal expenses as a private practitioner. For example, on December 9, \$2.55 was expended for food and 30 cents for light bulbs. My mother Anne received \$1.00 on December 11 and \$2.75 on December 15. On December 15, \$15.00 was expended for coal. On December 16, \$3.00 was expended for drugs from "Smithgalls," a local drug store in Lancaster, Pennsylvania. My father, at that time, dispensed his own medications. The electric light bill on December 18 was \$9.40.

Sunday morning to make a house call. However, there is much to learn from the past, which we can use to adapt to the future.

First Academy meeting in 1944

The first annual meeting of the Academy was held on December 11 and 12, 1944, at the Waldorf Astoria in New York City. The meeting was attended by 121 physicians, and 21 papers were presented.¹ In the 50 succeeding years, the Academy's program has changed dramatically. This year's 5-day meeting (1993) presents 973 papers, 3 postgraduate sessions, 15 courses, 53 workshops, and 140 breakfast and luncheon seminars (Fig. 5).

How enviable is our position today compared with my father's when he began to practice medicine. His brother would have probably lived without contracting diphtheria. Allergic diseases and asthma are now among the most treatable of chronic diseases. Elegant research of the immune system and its deficiencies has so improved our understanding of allergic and immunologic dis-

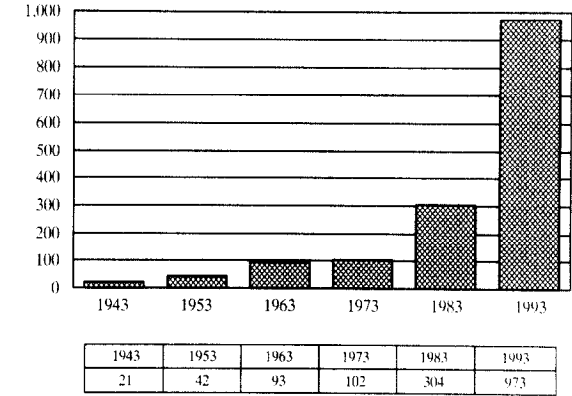


FIG. 5. The number of scientific papers has increased almost exponentially in the last 10 years from 304 to 973 during the 1993 meeting.

eases that we now successfully treat some diseases with bone marrow and organ transplantation and biologic modifiers. Further advances during the next years will undoubtedly provide monumental successes.²

Optimistic about future

What will the future bring to our Academy and to our specialty in this complex system of health care delivery when there is such a loud cry for more generalists and fewer specialists? I am optimistic about the future because the immune system, about which the specialty of allergy and clinical immunology developed, involves every organ system. Extending this field of knowledge is essential for all generalists and specialists. As many as one sixth of all Americans have allergic diseases and/or asthma; an even larger proportion will react adversely to foods, drugs, or insects during their lifetimes, and many others will suffer from immunodeficiency and occupational environmental allergic diseases.

Medicine will not become simpler in the future but only more complex. The problem we must help solve is how quality medicine can be applied and practiced in the most cost efficient manner. It is our responsibility to assure that medical resources are appropriately allocated for all and that patients with complex allergic and immunologic diseases have access to physicians in our specialty.

How can the Academy, which is us, position itself to adapt our specialty to the inevitable changes of the future?

WAYS TO ADAPT

Reorganization of the Academy

As a first step, we must reorganize our governance and bylaws to provide all constituencies with input and appropriate representation in the Academy structure. The Academy began to restructure several years ago by creating six Interest Sections; by organizing the Regional, State, and Local Allergy and Immunology Societies; by providing for their representation on the Executive Committee; and by organizing the Training Program Directors Committee.

During this meeting, we will vote on what I believe to be the most significant reorganization of its 5-year history. Currently, the Academy operates under the governing process that was instituted at its inception, which was designed to serve the needs of the 272 members and fellows, all of whom probably knew each other reasonably well. The Academy's present 4717 members have become more heterogeneous, necessitating greater representation and more visible pathways to its leadership positions.³⁻⁶

The second phase of the reorganization proposes to accomplish the following: (1) give better definition to Academy reorganization; (2) permit more individuals to participate in Academy functions; (3) give new Council chairs direct access, by many committees, to the Academy's governing body where none previously existed.

Two kinds of committees are recommended. "Working" committees, under the aegis of the six Interest Sections, on which any Academy member can choose to serve, regardless of whether he or she is a member of an Interest Section or of his or her Interest Section membership, and "Appointed" committees, which consist of members appointed by the President-Elect and approved by the new Board of Directors.

Three new councils and new research council

The Executive Committee of the Academy has proposed that three new councils be formed and that the Research Council be reorganized and be given the primary role to promote and identify sources for funding and research and to obtain and provide research funds for research by Interest Sections and Working Committees.

Three other councils, the Practice Standards Council, the Related Organizational Council, and the Standing and Ad Hoc Committees Council have also been proposed.

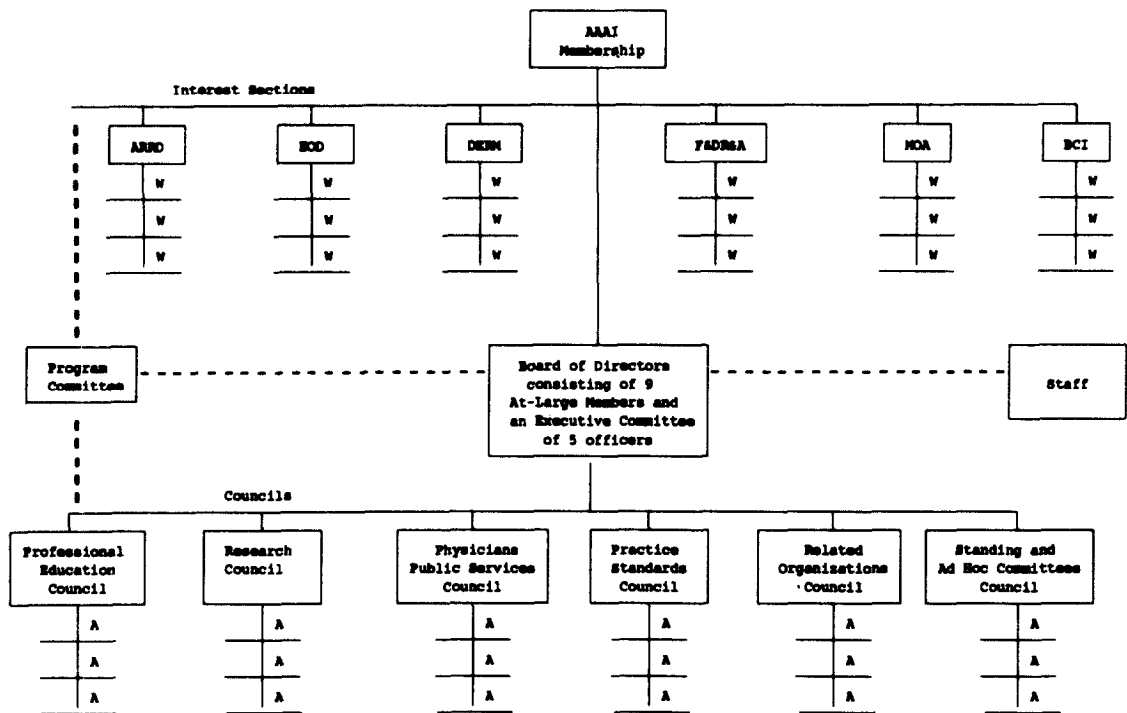
The Practice Standards Council will make rec-

ommendations about unproven practices and procedures, as well as about the inappropriate use of established procedures. We are sorry that we need a Practice Standards Council, but there is no evidence that scientifically based medicine will be mandated in the near future. The elevation of the Practice Standards Committee to a council by the Academy will indicate its highest emphasis on sanctioning practices based only on scientifically derived knowledge and not on theory or belief alone. A number of questionable practices today have little or no scientific merit. Syndromes, born almost one a day, such as "sick building syndrome," "chronic fatigue syndrome," "Desert Storm syndrome," and "multiple chemical syndrome," to name a few occupy our news media, increase the public's anxiety, lead to increased costs for alleged work-related illnesses, and result in excessive litigious activity, resulting in a tremendous loss of resources, which should be used more effectively. The country can no longer afford continuation of these practices, and mechanisms must be established to assure that, as Dr. William Osler defined it, "The practice of medicine is an art based on science."

The Related Organizational Council's primary purpose will be to interact with other medical organizations. We must counteract the tendency of medicine to remain too fragmented. Organizations must identify mutual goals and cooperate to implement them. Specialists' organizations must also cooperate to assure that those in need of specialized care will have proper access to such care.

The far-reaching third phase of the Academy's reorganization will lead to a more democratic reorganization to provide the mechanism to assure representation to the entire Academy's constituency on the leadership team.

Moving in that direction, the Academy will meet jointly with the American Association of Immunologists and the Clinical Immunology Society in 1997. Negotiations are also underway to involve the American Thoracic Society in our annual meeting in about the year 2000. A program to sponsor symposia, to collaborate, where possible, and to exchange faculty at meetings of other organizations is already in place. This Related Organization Council will also develop more formal relations with international organizations and interact, where possible, with our colleagues in the Food and Drug Administration, National Institutes of Health (NIH), and other governmental institutions on a more regular basis.



ARRD, Asthma, Rhinitis and Other Respiratory Diseases; BOD, Environmental and Occupational Disorders; DERM, Dermatologic Diseases; F&DR&A, Food and Drug Reactions & Anaphylaxis; MOA, Mechanisms of Allergy; BCI, Basic and Clinical Immunology.

W = Working Committee; any Academy member can serve on any Interest Section Working Committee regardless of their membership or Interest Section. A = Appointed Committee; members appointed by the President-Elect and approved by the Board of Directors. New = New Council. Reorganized = Reorganized Council.

FIG. 6. This illustrates the new organizational scheme adopted by the American Academy of Allergy and Immunology, Sunday, March 14, 1993. The 14-member Board of Directors includes a five-member Executive Committee, the latter of which is empowered to carry out Academy business as long as the action taken is unanimous and ultimately approved by the entire Board of Directors.

The preamble to the proposed constitution and bylaws states⁷:

So that the expanding size and diverse interests of the Academy's membership can be effectively represented, a reorganized structure is proposed. It calls for the creation of a 14 member Board of Directors, a five member Executive Committee, and a new participatory process for nominations and election to the Board of Directors and to officers' posts of the Academy. The results will assure that clinical and scientific interests are more democratically represented in decisions of the Academy.

The proposal for reorganization has been widely circulated and will be voted on at our annual meeting this evening. (It was approved at 5:15 PM, Sunday, March 14, 1993.)

With the reorganized structure operative, the new five-member Executive Committee will con-

sist of the Immediate Past-President, President, President-Elect, Secretary-Treasurer, and Vice President. The Executive Committee also will be part of a 14-member Board of Directors and will be empowered to carry out Academy business, as long as the action taken is unanimous (Fig. 6). Decisions that are not unanimous will be subject to a majority vote by the entire 14-member Board of Directors. On request of at least three of the 14 members of the Board of Directors, a special meeting of the Board can be called to consider actions taken by the Executive Committee.

The President will be authorized to have weekly conference calls to discuss business and to delegate tasks to members of the Board of Directors and Executive Committee. These changes will enable the President to cope with the tremendous number of tasks for which that officer is held

	1994	1995	1996	1997	1998
Grand Nominating Committee	X		X	X	X
Regional, State, Local Allergy Societies	X	X		X	X
Training Program Directors	X	X	X		X
Interest Sections		X	X	X	

FIG. 7. At-large members will be nominated by the Academy Grand Nominating Committee; Regional, State and Local Allergy and Immunology Societies; Training Program Directors; and Interest Sections. The entire membership will vote for one of two individuals nominated by three of four of these groups each year. Each at-large member will participate as a member of the Board of Directors for 3 years and can be re-elected for an additional 3 years.

responsible. Action taken by the Academy will also no longer necessitate a 3- to 4-month interval between Executive Committee meetings, as has sometimes been required in the past.

Change in nominating process

The nominating process for the current Executive Committee and officers was first agreed upon at the birth of the Academy 50 years ago. It was designed to serve the needs of a few hundred members and fellows, all of whom knew one another reasonably well. As the Academy has grown and become more heterogeneous, the need for greater representation and more visible pathways to leadership positions became necessary. Restructuring of the bylaws will achieve this goal.

The At-Large Director and the Secretary-Treasurer of the Board of Directors will be selected by the entire fellowship by vote. Two nominees for At-Large Director will be submitted by the Academy Nominating Committee; two by the Regional, State and Local Allergy and Immunology Societies; two by the Program Directors; and two by the Interest Sections (Fig. 7). The nominees will run against each other. Each year, three pairs of names will be nominated from three of these four groups. The following year, three pairs will be nominated by only two of the three groups that made nominations the previous year, and one pair will be nominated by the group that did not make nominations the previous year. A similar rotation schedule will take place each subsequent year. Members will be elected to the new Board of Directors for 3 years and can be reelected for an additional 3 years. Nominees for the Secretary-Treasurer must have served for at least 3 years on the Board of Directors.

	1994	1995	1996	1997	1998	1999
Office of:						
Past Past President	+	-	+	-	-	-
Past President	-	+	+	-	+	-
President	+	+	+	-	+	-
President-elect	+	+	+	-	+	-
Secretary-Treasurer	+	+	+	-	-	ELECT
Historian	+	+	+	-	-	-
Vice President	+	+	+	NEW	NEW	NEW
Sign	Represents					
+	"old" Executive Committee Members					
-	eliminated from new Board of Directors					
ELECT	first elected Secretary-Treasurer from two nominees					
NEW	selected by new Grand Nominating Committee					

FIG. 8. The new governing process of the Academy will be phased in between 1994 and 1999. The first Secretary-Treasurer under the new constitution will be elected in 1999.

Two fellows will be nominated for Secretary-Treasurer. The elected Secretary-Treasurer will then be in line to become President-Elect and ultimately President. The term of office of an Executive Committee member under the old constitution could last as long as 11 years. Under the new constitution, an Academy Fellow could be advanced to the position of President within 6 years of becoming a Board member. The new governing process of the Academy will be phased in between 1994 and 1999. The Interim Board will be made up of members from the "old" Executive Committee and from the new Board of Directors. The first Secretary-Treasurer under the new constitution will be elected in 1999 (Fig. 8).

Underrepresented minority program

Our second goal is the Academy's promotion of the training of underrepresented minorities in our specialty. This year we cooperated with the National Institutes of Allergic and Infectious Diseases and the National Heart, Lung, and Blood Institute to establish the Underrepresented Minorities Program. This will attract six minority representatives per year, for a total of 18 in 3 years, into the field of allergy and immunology and will stimulate high school and undergraduate students to pursue careers in the specialty.

The Academy has also formed an Underrepresented Minorities Committee and a Women's Committee to advise the Executive Committee on matters important to them.

I do not believe in quotas but am convinced that it is the responsibility of members of the Academy to make opportunities available to everyone. During my teen years, America was thought of as a "melting pot," and the Academy must be a "melting pot," welcoming all qualified physicians. Also, there should be no distinction

made between "a clinician" and "an academician;" those who contribute to the collective good of the patient and the specialty should find a home in the Academy and have access to its leadership.

Training programs need support

Third, the Academy's future is intimately related to the future of allergy and immunology training programs. Last year, I sent a questionnaire to the Program Training Directors asking for demographic and financial information for the 1991-92 academic year.⁸ Eighty-four of 91 responded to this questionnaire, giving the percent of their estimated total yearly division budget, which is "hard money" (i.e., the division does not earn) versus "soft money" (the division must earn).

Divisions proved to be directly responsible for 53% of their budget. Funds were derived from a variety of sources. Practice income for the division accounted for 20%, and sponsored federal research, 22%. "Soft" money paid for 35% and "hard" money, 65% of both the first- and second-year fellows' stipends. The soft money expenditure for the third-year fellow rose to 68% and to 87% for postgraduate fellows. Fifty-six percent of faculty salaries were derived from "hard" money and 44% from "soft" money. Full-time faculty spent 40% of their time in patient care and 39% of their time in research, whereas directors spent 37% of their time caring for patients. The average budget for a division was approximately \$918,000 and ranged from 0 in the U.S. Armed Forces to \$7 million. Sixty-four percent of divisions obtained government-sponsored research funds. Most concluded that "hard" money was not likely to increase in future years.

Most training directors optimistic about future

Training directors were also asked, "How optimistic are you that you can maintain your program as it currently exists over the next five years?" Fifty-nine of 82 who answered felt optimistic or somewhat optimistic, and 23 indicated that they felt not optimistic or very pessimistic in response to this question.

Another question asked was, "How optimistic are you that you can expand your program over the next five years?" Forty-eight answered positively and 24 negatively. Sixty-six of the 71 who answered needed additional faculty of approximately 1.6 per program. Most believed that their

programs were important to the teaching program and were important to their internal medicine and pediatric chairpersons. Each division had an average of 1.2 part-time salaried and 3.6 clinical volunteer faculty members. Eighty-seven faculty members had left academic positions over the past 5 years; 62 went in to private practice, 16 accepted other academic positions, and the remainder retired or went elsewhere. Inadequate salary was the primary reason given for leaving academic medicine.

Training programs largely depend on income generated within their programs to support both faculty and fellows; even so, most directors remain optimistic about the future.

What changes can we expect in the future? Health care costs now comprise 14% of the Gross National Product and cannot continue to increase unabated. This year, the National Institute of Allergic and Infectious Diseases funded only to the 14th percentile, the lowest in its history. The Mayo Clinic predicts that its physician revenues will, by 1996, drop by 25% under the Resource Based Relative Value Scale (RBRVS), and if all payers turned to those same payment levels, revenues would fall by 45%.⁹ Another issue of Physician's Payment Update states that "We're seeing a number of plans (Blue Cross/Blue Shield) talking about making a transition to RBRVS sometime next year."¹⁰ The new Council on Graduate Medical Education (COGME), a federally sponsored council, calls for a plan to change the specialty representation from the current 70% to 50% and discontinue direct or indirect expense reimbursement for specialist training, including allergy and immunology fellowships.¹¹

Such changes will profoundly affect training programs. Not only will funds drop from group practice sources, but they also may continue to decrease from federal and state resources; and as you have seen, revenues from these sources are vital to the training programs.

We must counteract anticipated losses of revenue in at least six ways.

Legislative activity important

First, we must inform our legislators that our subspecialty is involved with the care of more than 40 million Americans. Funds must be increased from governmental sources to support the much needed research in allergy and immunology. Science and technology make sense both medically and economically.

Clinical research

Second, we must encourage the Pharmaceutical Manufacturers Association and pharmaceutical corporations to support basic and clinical research studies in colleges of medicine and in training programs. Their future depends on the training of skilled doctors of medicine who competently use special diagnostic and therapeutic modalities for complex illnesses. Training programs and their respective institutions have a responsibility to make it economically feasible for them to do so. The Training Program Directors must assure that such clinical research projects are properly done and completed so that industry funds future projects.

Alternative methods to pay fellows

Third, we must find alternative methods to pay fellows in specialty training programs. When funds are insufficient to pay full stipends, some trainees may not be fully compensated and some may accept a fellowship without compensation. Others may have to take 2 years of half-time training without pay from the institution to receive credit for 1 year while funding themselves by working half-time outside. Less acceptable would be noninterest-bearing loans to be repaid after they are established in practice; the Academy's Educational and Research Trust could be made available for these purposes.

History may be repeating itself. My father did general practice while completing his "preceptorship" when formal training was not yet universally available in our specialty. Perhaps today's economic reality will mandate a return to such a practice for some of our trainees.

Volunteer clinical faculty

Fourth, private sector physicians must volunteer to teach and assist in training programs. Training programs must in turn recognize the importance of clinical faculty and incorporate them as an integral component. The Academy has begun a program to organize volunteer faculty and recognize their contributions to education and clinical research. Again, as my father did, more of us must volunteer time to care for the less fortunate and to help train future allergists/immunologists.

Residency review committee

Fifth, the Accreditation Council for Graduate Medical Education Residency Review Committee for allergy and immunology must be flexible in

reviewing programs and do everything conceivable when reviewing programs to persuade the dean's office and department chairpersons of the importance of supporting training programs in allergy and immunology. Programs should be judged on merit and not on numbers of faculty or their sources of income.

Collaborative research

Sixth, collaborative research projects with basic science and clinical colleagues should be encouraged and supported. Some programs may be primarily clinically oriented, whereas others may be primarily research oriented.

Overregulation

Impinging on the above are problems created by overregulation. Teaching, research, and the practice of medicine, particularly at universities, has been increasingly regulated by government, private accrediting agencies, and the institutions themselves. The process of accreditation, certification, recertification, research grant application, academic advance procedures, performance of animal research, institution review, board approval, continuing medical education, and billing of services rendered must be simplified and be made more cost-effective.² I believe that all medical school administrative offices should be filled by physicians who spend most of their time seeing patients, who participate in teaching and research, and who give only part of their time to administration. They would not be sequestered in an office and in committee meetings but made available for clinical and research activities by having an assistant to help with their administrative responsibilities. They must be made aware of the time and expense imposed by each new and complex regulation.

Our training programs are today stronger than they have ever been. New and innovative ideas and programs will be necessary to keep them strong and enable them to grow.

OTHER ISSUES

Other issues that demand the attention of the Academy and our specialty include the following.

New "Vice President for Medical Affairs"

First, the Office of the Presidency of the Academy could be a full-time job. Even so, I think the President should *not* be paid because of the many qualified individuals who are available for service. However, the Academy might consider whether to

pay, initially part-time, a physician colleague, perhaps a Past-President, to assist the elected President as "Medical Director" or "Vice President of Medical Affairs." He or she could attend meetings of other organizations with which the Academy interacts and become known to the leadership of those organizations such as the American Medical Association, the Council of Medical Subspecialty Societies, the American College of Physicians, the American Academy of Pediatrics, and the American College of Chest Physicians; and he or she could be an Academy spokesperson to the Food and Drug Administration, the NIH, and other governmental institutions. That the Academy's President serves only 1 year disturbs continuity in interrelations with other organizations, and furthermore, the President is simply too busy to partipate in meetings of all other organizations while he oversees the growth and evolution of the Academy and keeps the home fires burning. The Executive Committee is currently exploring the possibility of creating a position similar to those that exist at the American Board of Allergy and Immunology and the American Medical Association.

Highest moral standards

Second, the Academy must demand that its members adhere to the highest morals and avoid conflicts of interest. At the same time, we must not establish so rigid a set of guidelines for ethical conduct for officers and members that we are immobilized. I believe most people to be honest.

Standardized in vivo testing and immunotherapy

Third, the Academy must also standardize procedures used in its specialty. Members have been very critical of in vitro tests, but there remains too much variability of in vivo testing and immunotherapy. The Allergen Standardization Committee and the Training Program Directors Committee are drafting standards and standard forms for skin testing and for immunotherapy. Use of standard procedures and forms by our specialty will enhance physician communication, patient care, and training program uniformity.

International relations

Fourth, the Academy is primarily a North American organization, but it is reviewing its role in the international community. The Academy has already established and will maintain strong ties with European colleagues and will also expand

relationships in our own hemisphere and on the Pacific Rim. I predict that the Academy will soon have a Council of International Societies, similar to the Council of Regional, State and Local Allergy and Immunology Societies, perhaps with representation on our Board of Directors.

Joint NIH-Academy research projects

Fifth, the Academy's members and training programs should develop joint research projects with the NIH, other governmental institutions, and private industry. The current trend is for government to approve grants for focused research, which will benefit the patient and decrease medical costs. The Academy, through its newly formed Research Council, should take advantage of these resources and aim their research activities accordingly.

Recertification and continued medical education

Sixth, the Academy should continue to expand its role in recertification and assure that information necessary for continued medical education is available to its members. The *JAMA Primer on Allergic and Immunologic Diseases*, published every 5 years in cooperation with George Lundberg, MD, *JAMA* editor, and the *Allergy-Immunology Medical Knowledge Self-Assessment Program*, co-sponsored by the Academy and the American College of Physicians, will play a central role in recertification. The Academy is now exploring the feasibility of establishing 1- or 2-week sabbatical training courses in which allergists/immunologists actively participate. Recertification may become critical to everyone, regardless of the grandfather clause, since reimbursement is likely to be influenced by recertification.

Academy budgetary needs

Seventh, the Academy, during the last several years, has increased its reserve funds, not including Educational Research Trust funds, to \$1.9 million. We should have reserve funds for basic and service programs equal to at least 1 year's budgetary needs, which now amounts to \$3.7 million. In order to achieve this goal, the Executive Committee has voted to set aside at least \$275,000 each year until this goal is reached in 6 or more years.

Educational Research Trust support

Eighth, the Educational and Research Trust is vital to our specialty. Currently \$1.3 million has

been received, with pledges exceeding \$2.6 million. Also, the participation of Academy members has increased from 12% the first year to 18% in 1993. I encourage all of you to make annual contributions; if 1000 physicians gave \$1000, we could add \$1 million per year to our Fund.

One allergy and immunology society

My last but very important point is to remind you that allergy and immunology is the smallest of all specialties. The Academy must continue to foster the idea of a single national organization. Financial constraints will ultimately mandate all organizations to form a unified society, which could have 2 yearly meetings and several journals with differing emphases. The Academy and its members are on record as favoring unification.

Thank you

I close with thanks to members of the Academy who took the time to send suggestions, corrections, or admonitions. Many ideas from members have resulted in implementing important changes. That is what makes the Academy so viable and exciting.

I am particularly grateful to my wife, Carol; my sons, Brian and Keith; my mother; and other members of my family. Thanks also to Drs. Lichtenstein, Zweiman, and Anderson who generously gave of their time on a weekly basis, other members of the Executive Committee, and to Don McNeil, Sandy Koehler, Rick Iber, and their wonderful staff. I also thank Sam Bukantz, my dear friend and colleague, and all my colleagues at the University of South Florida College of Medicine who assisted me this year.

I would like to close by quoting Nicolai Fechin,

a painter with whom I became familiar while visiting with the Oklahoma Allergy and Immunology Society this past year. "We cannot live by the past. The present is so transient that it almost does not exist. We live by the future, or more accurately, we are unceasingly preparing ourselves toward it, trying to anticipate it. From this, flow all new ideas, both good and bad. It is impossible to be alive without the effort to create and bring something new into being."

Thank you for allowing me to be your President.

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