CHAPTER 2

Growth and Maturity

The Board of Governors

> *Article IV: Bylaws*
> *Section 1. Composition*
> *The College shall authorize a Board of Governors composed of representatives from various geographical areas including districts, states, regions, or territories of the United States and Canada to serve as a liaison body between the Board of Trustees and the Membership of the College. Governors must be Fellows in good standing of the College.*
>
> BYLAWS OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY 1954

Evolution

Governors of the American College of Gastroenterology form one of the most important and distinctive features of this professional society. Elected locally, the governors represent member interests and concerns to the College and help to articulate College policies and programs. The modern Board of Governors is often characterized as the largest committee of the College; indeed, the governors perform a significant portion of the work of the College. The core purposes of the Board of Governors are to stimulate interest in membership in the College locally and to assist in the development of regional ACG educational meetings. Membership growth parallels in many ways the degree of success with which these purposes (as well as others) have been achieved.

How did the College come to have an elected body of governors? It may have begun life as a twelve-member organization whose name signaled its New York origins, but in time the society saw the value of becoming the parent of a larger organization, national in scope, one that aimed to meet the needs of both providers of care for patients with digestive disorders and the patients themselves. Plans for the method of expansion are detailed in an undated document, probably written in 1934.

> The time has now arrived that the Society for the Advancement of Gastroenterology, which was founded and incorporated under the laws of the State of New York, to standardize, regulate, and elevate the practice of gastroenterology as a specialty, as well as to encourage research, should be controlled by a National Council . . . composed of delegates or representatives or alternatives from the various chapters throughout the country in the National Council for the Advancement of Gastroenterology. The number of delegates and alternates to the Council shall be distributed geographically in such a manner as to provide for proper representation. The Society for the Advancement of Gastroenterology, through its Inter-relations Committee, intends to provide greater facilities for the creation of the council by the correlation and establishment of these various affiliate organizations or chapters throughout the country. At the present time a chapter may be established in any section of the country by the application of a number of qualified MDs practicing this specialty or interested in allied subjects, to the Inter-relations Committee. The National Council of the Society will, when sufficient chapters are formed, supplant this committee, and thereafter application must be made directly to and approved by this Council. The members of this National Council shall be composed of delegates or representatives and alternates from the affiliated organizations to meet once per year.

Thus, the seeds for the creation of the Board of Governors were planted as early as 1934 in the form of its antecedent, the National Council, whose authority was limited because it functioned only in an advisory capacity to the Executive Board. The council's assigned purpose and scope of authority were set forth in the same document:

> Arrange and conduct all matters pertaining to the request of places of instruction, radio talks, society meetings held outside of New York City. . . . All actions of the National Council must be approved by the Executive Board.

As part of the 1954 Bylaws change, the new Board of Governors was established to act as a liaison between the membership in the various states, the Board of Trustees, and officers of the College. This entity replaced the old National Council.

> *Section 1. Election*
> *At the annual meeting of the American College of Gastroenterology, Fellows, in open session, shall elect certain of their members to serve on the Board of Governors, each for a term of three years as follows: one from each state, territory or possession of the United States and each Province of the Dominion of Canada which has one or more Fellows of the College. One member each may be elected from each of the following: Armed Forces of the United States, U.S. Public Health Service, U.S. Veterans Administration, Association of Medical Colleges of the U.S., American Medical Association, American Hospital Association, American College of Physicians, American College of Surgeons, American College of Radiology, American College of Pathology, American Proctology Society, American Gastroenterological Association. In addition, one [Governor] from each country with one or more Fellows of the College.*

The country was divided into four regions, and a vice president was elected from each of them. Limitation was also placed on the number of trustees that could be elected from any one state. This served to stimulate the rise of new leadership on a national basis. Over a period of time, the concept of Regional Vice-Presidents was dropped and their functions were largely assumed by the Board of Governors. (Appendix II: Board of Governors)

The purpose of the Board of Governors was stated in the original 1954 bylaws:

> *The Board of Governors shall act as liaison between the Board of Trustees and the fellows and act as a clearing house for the Trustees on general assigned subjects and in local problems. They shall attend convocations and other formal meetings of the Fellows and Governors. They shall aid in the establishment of groups, and encourage regional meetings. It shall be the duty of the individual governors to coordinate and further the best interests of the College in their respective states, territories, possessions, provinces, medical society, or their countries as the case may be, and to perform such other duties as may be assigned them by the Board of Trustees.*

The Board of Trustees was empowered to add additional members to the Board of Governors from each state, territory, possession, country, or other geographical unit "in which on account of extent or population it is desirable to have additional members for the better conduct of the work of the Board of Governors." Each governor was expected to attend each meeting, but an alternate appointed by the governor

could serve as a voting proxy if an absence was necessary. The board was mandated to select a chairperson, who would also serve as an *ex officio* member of the Board of Trustees.

The available records give no evidence that the Board of Governors did, in fact, have governors appointed from the many eligible organizations. Except for attendance at meetings and establishment of regional meetings, the tasks of the early board were vague.

In 1954 the Board of Trustees named the executive secretary of the College to serve concurrently as the secretary of the Board of Governors. In that same year the Board of Governors was given the authority to appoint three members to serve on the Credentials Committee. Meetings of the board, irregular at the outset, were required to be held annually at the time of the annual meeting of the College "at the call of the Chairman with the approval of the President of the College."

PAST CHAIRS OF THE BOARD OF GOVERNORS

2005–2007	Francis A. Farraye, MD, FACG
2004–2005	Richard P. MacDermott, MD, FACG
2002–2004	Harry E. Sarles, Jr., MD, FACG
2000–2002	Roy K.H. Wong, MD, FACG
1998–2000	Edgar Achkar, MD, FACG
1996–1998	Douglas K. Rex, MD, FACG
1994–1996	P. Gregory Foutch, DO, FACG
1992–1994	Luis A. Balart, MD, FACG
1990–1992	David A. Peura, MD, FACG
1988–1990	William D. Carey, MD, FACG
1986–1988	Albert C. Svoboda, Jr., MD, FACG
1984–1986	E. Marvin Sokol, MD, FACG
1982–1984	Gerald Becker, MD, FACG
1981–1982	E. Marvin Sokol, MD, FACG
1980–1981	Alvin M. Cotlar, MD, FACG
1976–1980	Robert L. Berger, MD, FACG
1973–1976	Richard N. Meyers, MD, FACG
1970–1973	Albert M. Yunich, MD, FACG
1969–1970	Edward I. Melich, MD, FACG
1968–1969	Manuel Sklar, MD, FACG
1967–1968	Edward I. Melich, MD, FACG
1966–1967	Warren Breidenbach, MD, FACG
1965–1966	Edward I. Melich, MD, FACG
1964–1965	Edward J. Nightingale, MD, FACG
1962–1964	Stanley Sidenberg, MD, FACG
1959–1962	Libby Pulsifer, MD, FACG
1958–1959	Dale W. Creek, MD, FACG

Francis A. Farraye, MD, FACG, chair of the Board of Governors, 2005–2007

1955–1958	Henry G. Rudner, Sr., MD, FACG
1954–1955	Henry Baker, MD, FACG

This history is a salute to all governors of the American College of Gastroenterology. Several hundred governors have put their hard work into the success of the College, both as governor and on many committees of the College. It would defy the space allotted to this portion of the College history to chronicle the path of each governor from 1954 until the present. Past chairs were requested to review on behalf of the concurrently elected governors the most important issues they faced and the meaningful events that occurred during their tenure. In correspondence with us, all past chairs acknowledged that any board is only as good as the dedicated members who serve—and fortunately the College has been blessed with an abundance of loyal and hard-working governors.

The years that followed the Board of Governors' founding have been arbitrarily designated In the Beginning (1954–1974), The Years of Change (1974–1980), The 1980s: Transition Years, The Early 1990s: A Gathering Storm, and The Modern Era (1995–2004).

1954–1974: Board of Governors—In the Beginning

On October 7, 1955, Henry Baker, MD, the first chair of the Board of Governors, wrote the following letter announcing the inaugural meeting of the board:

> Dear Doctor,
>
> Enclosed please find the notice for the annual meeting of the Board of Governors. This meeting will be the first since the Board was activated in 1954.
>
> In order for us to properly carry out the duties and functions as set forth in the constitution and bylaws, it is essential for each governor to be present in person. I, therefore, urge you to make every effort to attend the meeting in Chicago.
>
> Should you be unable to be present in person, you may, under the provisions of the bylaws, appoint a Fellow of your district who will be present in Chicago as your alternate. This Fellow will have all of the privileges which you as a governor would have.
>
> I trust that you will make every effort to personally be present in Chicago.
>
> Henry Baker, MD
> Chairman, Board of Governors

The agenda for that first meeting, held on October 26, 1954, was as follows:

1 Roll call
2 Approval of the meeting held on October 26, 1954
3 Election of the chair
4 Appointment of members to serve on Credentials Committee
5 Recommendation of members to serve on the Nominating Committee
6 Consideration of sites for regional meetings

There is no known surviving list of attendees at that first Board of Governors meeting, nor any record that makes it possible to gauge the enthusiasm of its new members. Of some interest, however, is that the form and agenda for this meeting was replicated almost exactly for the next twenty years.

In 1967, a bylaws change redefined membership representation by each governor. This change required that each region represented by a governor must have a minimum of twenty-five members, of which five had to be fellows of the College. For foreign countries to be represented by a governor, the requirement became five members of whom two had to be fellows. It would be nearly twenty years before the goal of at least one governor from each state would become a reality.

Edward Melich returned to the helm of the Board of Governors in 1967 and 1969, and Manuel Sklar served in 1968. The published agendas of the period document the continued involvement of the board in selecting members for the Credentials Committee and recommending members for the Nominating Committee. During this time the governors added a prominent African American to its membership. Leonidas H. Berry, MD, was a professor in gastroscopy and gastroenterology at Cook County Graduate School of Medicine. He was a clinical associate professor of medicine at the University of Illinois Medical School, and senior attending physician at Cook County Hospital, Michael Reese Hospital, and Provident Hospital. He was also a past president of the National Medical Association.

Leonidas Berry, MD, MACG

In 1970, Albert Yunich, MD, from Albany, New York, ascended to the chairmanship of the board and would serve as chair for the next three years. Dr. Yunich was associate clinical professor at Albany Medical College and attending physician at Albany Medical Center, and a consultant at both the Albany Veterans Administration Hospital and St. Peter's Hospital.

Surgical representation in the ACG took a big step forward in 1973 when Richard N. Myers from Philadelphia ascended to the chair. Dr. Meyers, a diplomate of the American College of Surgery, was associate

professor of surgery at Jefferson Medical College and an associate in surgery at the Lankenau Hospital.

1974–1980: The Years of Change

From 1974 through 1976, Dr. Myers chaired Board of Governors meetings in Bal Harbour, Florida; Las Vegas; Montreal; and Toronto. During his tenure the board increased the frequency of meetings from once to twice annually. Also, for the first time, records permit us to gain insight into some of the specific meeting agenda items. The 1977 Toronto meeting called for the governors to discuss a membership campaign, an improved mechanism for approving applications, and active participation by governors in the convocation ceremony of the ACG annual meeting. The board also directed attention to issues important to local chapters and discussed ways of increasing the number of regional educational meetings.

Robert L. Berger, MD, MACG, chair of the Board of Governors, 1976–1980

Robert L. Berger, MD, 1976–1980

The Marriott Hotel in New Orleans was the site of Chairman Robert Berger's first Board of Governors meeting on October 25, 1977. Dr. Berger was director of the gastroenterology resident training program at Memorial Hospital in Hollywood, Florida, and clinical associate professor of medicine at the University of Miami. He served as board chair until 1980, thus earning the distinction of being the longest-serving chair.

When Dr. Berger became ACG governor for Florida, he took seriously his mandate to encourage membership in the College. Although there were many gastroenterologists in Florida, not many were familiar with ACG, and the College had few Florida members. He took on the task of writing a personal letter to every gastroenterologist in Florida, pointing out the advantages of joining and praising the annual meetings, which were geared to the practicing gastroenterologist. He also noted that the annual meeting is free to members, and that the amenities, including food and libation, made for an even more collegial meeting. As a result of his efforts, College membership from Florida grew to be second only to that from New York, the birthplace of ACG.

During his term as chair, Dr. Berger made his approach to enhancing membership to the other governors and encouraged them to follow the same plan. He and his fellow governors noted the active involvement of the GI groups from the Cleveland Clinic and the Lahey Clinic as selling points. They met with continued success as membership grew across the country and the governors became active spokespersons for the College. Another issue during his tenure included the transition of

the executive directorship from Daniel Weiss, who had spent his entire adult life in the service of the College. Finally, there was the matter of *The American Journal of Gastroenterology*, which needed to be revamped to keep pace with the growing and diverse ACG.

The 1980s: Transition Years

Before 1982 the chair of the Board of Governors was selected not by the governors themselves, but by the president and president-elect of the College. Most chairs were appointed to serve a term on the Board of Trustees once their terms were over, and this was usually the end of the road for involvement with College governance. Before this time, only Henry Baker, the first Board of Governors chair, had ascended to the presidency of the College. The 1980s was a significant period of redefinition, however; during this period, the Board, with its its grass-roots democratic structure and its participation in College policies at all levels, became an incubator for future leaders of the College. By the end of the decade there was a governor on every committee, and the chair of the Board of Governors sat on the Executive Committee and frequently moved into additional leadership roles. By changing the board's structure so that the chair was elected by the governors rather than appointed by the president (not without a struggle), the board achieved credibility through significant decision making. The governors, for example, participated actively in the decision to have the ACG annual meeting remain separate from Digestive Disease Week.

Alvin M. Cotlar, MD, 1980–1981

Alvin Cotlar, who assumed the role in 1980, was the last chair to be selected by the ACG president and president-elect. He was responsible for initiating a series of internal discussions about the role of the Board of Governors—which until then had been minimal—both in self-governance and in the affairs of the College. The turmoil this initiative caused resulted in his resignation as chair, but not before he set in motion the energy and will of the governors to assert a more significant role for the board.

On the resignation of Dr. Cotlar as board chair, Marvin Sokol served out his unexpired term. In 1981, Drs. Berman, Sokol, and Becker, candidates for chair, debated the future role of the Board of Governors. Dr. Becker was elected and was succeeded by Dr. Sokol.

Gerald H. Becker, MD, 1982–1984

Gerald Becker is one of many ACG governors whose devotion to the College spans three decades. He served as governor representing Illinois from 1968 to 1972, whereupon he moved to Arizona. In Phoenix,

he, along with Bob Kravetz, formed an interdisciplinary group of surgeons, general practitioners, radiologists, and internists who were interested in gastroenterology. Starting with just seventeen members, the group grew into the Phoenix Society of Gastroenterology. Becker used this forum to enlist members for ACG, and in 1974 he petitioned the Board of Trustees to form a Western Region consisting of Arizona, Nevada, Utah, and Montana. He served as governor for nine years (1973–1974) and as chair from 1982 to 1984.

As previously noted, not since the first convening of the Board of Governors had any governor risen to the presidency of the College. Becker played an important role in the Board of Governors' evolution into the College's most democratic entity. He campaigned on a platform that the ACG would benefit from a paradigm shift in the way the governors were viewed by the members. His decision to challenge the existing order did not sit well with College leaders at the time. Nevertheless, direct election of the BOG chair became a part of the fabric of the BOG. In time, several chairs were nominated to the Board of Trustees; at the time of this writing, four have become president of the College.

Becker's term occurred when discussions were underway to determine if ACG should become part of Digestive Disease Week, and he and the Board of Governors took the position that the interests of the College were best served by retaining its own distinctive meeting. The Board of Trustees concurred with this position, and this first attempt at merging the College into a confederation of GI societies did not come to pass.

E. Marvin Sokol, MD, 1984–1987

Marvin Sokol, MD, from Long Island, New York, served on the Board of Governors from 1976 to 1987. During his term as chair (1984–1987), he promoted better communication between the membership and both the Board of Governors and the Board of Trustees. He and his governors also made efforts to establish a line of communication with Congress. At the time, Medicare officials had begun discussing a new form of reimbursement that used the Resource-Based Relative Value Scale as the basis for payment for physician services. Sokol testified before the House Ways and Means Committee in 1987 to help ensure that gastroenterologists and their patients were dealt with fairly during the transition.

Albert C. Svoboda Jr., MD, 1986–1988

While attending a governor's reception at the annual meeting, then-Chairman of the Board of Governors Alvin Cotlar expressed the need

for an additional governor in California and appointed Albert Svoboda as representative until the Board of Trustees approved the position of a second California governor. When the board acted, it created separate northern and southern California governorships, and Svoboda was elected from the northern California constituency. At that time, nominations for chair were made from the floor immediately prior to the election rather than by a more selective process. Svoboda became a candidate along with Ed Schneir from Ohio. The ballot was nearly tied, but Svoboda prevailed, and his first action was to set a precedent by asking the governors to name Schneir as vice chair.

Albert C. Svoboda, MD, MACG, chair of the Board of Governors, 1986–1988

Svoboda recalled three primary accomplishments as chair of the Board of Governors. Most important was establishing a governorship for each of the fifty states: by the end of his term there were governors in all fifty states (and more than one in five states), six international governors, and governors representing the military; Puerto Rico; and Washington, DC. Previously there had been seventeen states with governors (two in New York), six governors of regions (i.e., the West), and seven international governors. Thus, the national shared governance of College affairs called for in the Ryan Report of 1947 was finally accomplished. Svoboda also began the division of the board constituency into regions, a process improved upon and finished by his successor, Bill Carey. Svoboda's final effort was to publish two newsletters, one for the governors to detail decisions made by the executive committee and one for his own constituency. His period as chair was a time of growth, with better definition of governors' roles to follow.

The Early 1990s: A Gathering Storm

The early 1990s saw the emergence of the Board of Governors as an increasing force within the College, a change that represented the fulfillment of the goals first articulated by Gerald Becker. The reorganization of the board and an increasingly activist agenda contributed to the growth of the College, which was seen as the most vibrant and successful of the GI societies in the United States. Building upon the gains achieved by previous boards and recognizing that governors are engines for the College's growth and momentum, the governors of the early 1990s continued to develop the board into an even more effective force.

William D. Carey, MD, 1988–1990

William Carey came to the Board of Governors in 1987, representing northern Ohio. A relative newcomer to the College, he had few preconceptions about the history of the board. He had been attracted to the ACG by his mentor, Richard Farmer, whose enormous energy,

William D. Carey, MD, MACG, chair of the Board of Governors, 1988–1990

enthusiasm, and vision showed the College at its best. Albert Svoboda recruited Carey to become involved with committee work and appointed him a member of the Public Relations Committee, which Svoboda chaired. The growth of the governors that took place under the leadership of Albert Svoboda created a group too large to function effectively as a committee. Carey's perception was that the board could better serve the interests of the members and the College if there were more formal pathways of organization.

During his term, Carey sought to improve the structure of the board. Before 1987 the board sat as a large assembly with a short agenda, and in many cases it seemed to act primarily as a repository of reports from committees and the Board of Trustees. Carey organized the Board of Governors into geographical regions, each with an elected regional councilor. Each region had a formal caucus to define items of particular interest to bring to the attention of the board. He also led the board to make the position of vice chair ascend automatically to the chairmanship. With the approval of the Board of Trustees, the Board of Governors assumed its present structure, with five U.S. regions, a Canadian region, and an international region.

In 1989 and 1990, during President Jamie Barkin's tenure, changes were enacted to make the Board of Governors more representative of the membership. At this point, there were seventy-three governors. A Regional Council was developed with the help of the board chair, William Carey. The Regional Council would allow the Board of Governors to conduct College affairs between meetings of the entire board. Also, continuity of leadership was established with the election of a vice chair who would automatically succeed the chair.

David Peura, MD, 1990–1992

David Peura came to the Board of Governors in 1986, representing the U.S. military services. At the time, he was stationed at the Walter Reed Army Medical Center in Washington, DC. His motivation for serving as governor came from the realization that the military needed a strong presence in organized gastroenterology. He served for a period of six years, and was chair from 1990 to 1992.

Luis A. Balart, MD 1992–1994

When asked to join the College by Chesley Hines, Luis Balart was—and continues to be—impressed with the concept of the Board of Governors, a forum where new ideas and solutions to the more vexing problems in our specialty can be discussed and acted upon. Balart spent six years on the Board of Governors and two years as chair dur-

ing challenging and exciting times. He continued the work started by William Carey and David Peura to give the board a more effective structure and to ensure a more meaningful voice in the Board of Trustees. The planning and execution of regional postgraduate courses was streamlined and made easier for governors, and the board worked out techniques for integrating with existing courses, such as those of the Texas, Virginia, and Florida GI associations. These methods have been extremely successful and continue today. The Board of Governors also developed guidelines for the recruitment and retention of members from outside the U.S. and contacted legislators about the needs of our patients and members. During Balart's two years as chair, ACG began the concerted effort to have colorectal cancer screening included as a Medicare benefit, and this drive paid off in 1997 when the benefit was passed as part of the Balanced Budget Act. This landmark achievement opened the door to the application of modern and effective screening techniques to those at risk and served as the major catalyst for a huge period of growth in our specialty.

Luis A. Balart, MD, MACG, chair of the Board of Governors, 1992–1994

The Modern Era: 1995–2004

P. Gregory Foutch, DO, 1994–1996

Greg Foutch served as governor from Arizona from 1990 to 1994; he reports that his friend and colleague, Bob Kravetz, who preceded him as ACG governor from Arizona, thrust him into the role. Foutch's youthful energy drove him to take on the challenge "because I wanted to make a difference," and his vision and leadership resulted in the current central importance of the Board of Governors within the College. He had noted early in his tenure as governor that having a clear agenda supported by both the Board of Governors and Board of Trustees seemed to be a requirement for effective board leadership. His ambitious agenda was prefaced with a statement outlining the philosophy behind it, which may be summarized in three main points: (1) the ACG mission of education and research requires a strong infrastructure; (2) the Board of Governors is the most important committee of the College; and (3) the governor's basic duties should be augmented by additional volunteer activities, which may include service on ACG committees, participation in ACG educational activities, visibility in research activities, and other services of value to the College.

P. Gregory Foutch, DO, MACG, chair of the Board of Governors, 1994–1996

Foutch proposed and led the development of a new midwinter GI education course, the Biennial International Governor's Conference assisted by Doug Rex, Florian Cortese, Del Chumley, and Bill Hall. The conference had a distinguished faculty, seventy percent of whom

were current or former ACG governors, and there were 297 registered attendees. Many committees, the Board of Governors, and the Board of Trustees chose to have their own meetings in conjunction with this course. Thus, a new and enduring ACG tradition was born.

Foutch lobbied within the College to ensure that all committees have one or more governors as members. Using the proceeds made available from the very successful course, the Board of Governors made an unprecedented contribution to the Research Committee of $50,000 and established the Governor's Awards for Excellence in Clinical Research. Foutch also organized three Governor's Awards: one for the best contribution by a first-term governor, another for a senior governor, and finally, the William D. Carey Award, given to a governor who has provided particularly meritorious and sustained service to the College.

Among Greg's other contributions was to provide valuable guidance to College leadership related to the role of international governors within ACG's structure. His communications with the International Relations Committee and the Board of Trustees were instrumental in forming the basis for a comprehensive review of this topic.

Douglas K. Rex, MD, FACG, chair of the Board of Governors, 1997–1999

Douglas K. Rex, MD, 1997–1999

Douglas Rex was asked to stand for governor by David Steury, who was completing his own stint as governor. During his first term, Rex ran a membership drive in Indiana that gained twenty-two members in a single meeting of the Credentials Committee. He and Glen Lehman served as the proposer and endorser for all twenty-two new members.

Rex became the vice chair of the Board of Governors and was the first vice chair to attend the Board of Trustees meetings, as a nonvoting member. As chair of the Board of Governors, he initiated the template letter, a newsletter crafted centrally and provided to each governor for distribution to his or her constituency.

The financial strength of the Governors' Postgraduate Course: Back to Basics provided the board with funding to support governors' research grants. Rex worked with his board to strengthen the series of regional postgraduate courses, and the board discussed a new initiative that might have provided firm funding of a junior faculty career development award. In the end, the governors decided instead to direct funding to a series of Clinical Investigator Awards, as in the past.

Governors continued to participate in legislative visits to Washington, DC. The main legislative agenda remained the improvement of the colorectal cancer benefit under Medicare, particularly the securing of the colonoscopy benefit for average-risk patients. HCFA's rules related to payment for ambulatory surgery center procedures as well as several coding issues that affect gastroenterologists were another priority.

Rex's board worked closely with President Sarkis Chobanian to highlight the special problems encountered by gastroenterologists in private practice. He also assisted President Christine Surawicz in identifying governors to serve on College committees.

Edgar Achkar, MD, 1998–2000

Edgar Achkar reports that his term as chair was a busy prelude to his selection as College vice president. The third Back to Basics Governors' Postgraduate Course—the first to be held in conjunction with the American Society for Gastrointestinal Endoscopy (ASGE)—attracted over 200 physicians and was a great financial and educational success. In recognition of the success of the collaboration with ASGE, Achkar obtained approval from the Board of Trustees to create a joint ACG/ASGE research grant that would be coordinated by the Board of Governors (representing the College) and ASGE. This program represented a significant step forward in the growing collaboration between the two organizations.

Edgar Achkar, MD, FACG, chair of the Board of Governors, 1998–2000

Achkar worked to refine the manner in which the governors select regional courses. Henceforth, regional councilors would serve as course codirectors. This step increased regional interest and attendance at these excellent educational programs. In addition, his board was very busy on the legislative front. Many of his governors took time from their practices to make trips to Washington, DC, for legislative visits, and the board under his leadership undertook an organized program of state-level initiatives that related to colorectal cancer screening.

During his tenure, the governors worked in collaboration with Delbert Chumley, chair of the Membership Committee, to create a more organized way for governors to identify and contact potential new members in their region to encourage ACG membership.

Roy K. H. Wong, MD, FACG, Col., U.S. Army, 2000–2002

Roy Wong has long been an ACG governor representing the military. He was attracted to the ACG because of the stellar group of former military medical officers who had been active in College affairs.

During his term as chair of the Board of Governors, he played a major role (along with Harry Sarles and, representing ASGE, Stuart Sherman) in the development of the Fourth Biennial 2002 Governors' Best Practices Postgraduate Course in Scottsdale, Arizona, which attracted 225 registrants. He and the board assisted in the development of three additional regional ACG courses in Florida, Texas, and Virginia in 2002. The Florida course, held in conjunction with the Florida GI Society, was geared to clinical gastroenterologists, surgeons, radiologists, and nurses. Additional governors' courses were held in other

Roy K. H. Wong, MD, FACG, chair of the Board of Governors, 2000–2002

regions. Discussions were initiated about the possibility of having an additional governors' course in Canada and in New York City, the birthplace of ACG.

Like many ACG governors, Wong was active in initiatives at the state level to create legislation requiring that all health care plans offered in the state include a colorectal cancer screening benefit. During his tenure, medical service issues such as the reimbursement for services at ambulatory surgery centers, the use of propofol as part of conscious sedation for endoscopy, and the relative role of virtual colonoscopy were matters of concern. His board discussed the role of physician extenders in gastroenterology as a way of helping in the management of busy GI practices. Wong contributed to the analysis that led to an expansion of support services for ACG which, until then, had fallen a little behind the needs imposed by a rapidly growing College.

Harry E. Sarles, Jr., MD, FACG, chair of the Board of Governors, 2002–2004

Harry E. Sarles, Jr., MD, FACG, 2002–2004

After Harry Sarles became governor for the North Texas Region in 1996, he participated actively in several state projects and initiatives that reinforced for him the importance of ACG governor participation in state issues affecting his constituents. He was reelected as governor in 1998.

During his tenure, the Texas legislature enacted into law a bill that mandates coverage for colorectal cancer screening for all Texas citizens. He supported and encouraged participation in the collaborative efforts between the Texas Society for Gastroenterology and Endoscopy and the ACG-sponsored Texas regional ACG postgraduate courses and meeting activities. This model served both TSGE and ACG well: the cooperative effort stimulated growth in both interest and attendance, which totaled more than 400 physicians and other health professionals.

Sarles's enthusiasm and achievements in Texas resulted in his election to vice chair of the Board of Governors in 2000 and chair in 2002. Acting quickly and effectively to a request from then-College President Edgar Achkar and the Board of Trustees to revitalize the governors, he asked governors to become more involved in the local, regional, and national affairs of the College. The first ever governor fly-in to Washington, DC, took place in conjunction with a dedicated meeting of the Board of Governors, which occurred in place of the usually scheduled board meeting during DDW in May. Time was set aside for governors to exchange ideas with one another and to become more active in legislative issues. Meetings scheduled with elected local and regional legislative representatives served as an excellent learning experience for all parties involved. Invigorated, the governors proposed amending the

ACG bylaws to increase an elected governor's term to three years and to limit tenure to two successive three-year terms. Caucus reports from the various governor regions were presented formally to the Board of Trustees of the College in an effort to improve communication between the boards. Recognizing the importance of rewarding work well done, the Board of Governors has added a rocker pin to the ACG lapel pin, designating service as governor; also, service awards were created to recognize those governors who have served the College in an exemplary fashion. Finally, the governor election process was streamlined by establishing a specific time limit for initial communication with member constituents, balloting, tabulation of ballots, and announcement of election results.

Regional courses were expanded, and support increased from both governors and local constituents. The outcome of this growth in participation was evident at the governors' winter course in Scottsdale, which raised a significant amount in support of ACG research-related activities. The Membership Committee of the College was formally incorporated into the Board of Governors, giving this body direct control over membership and streamlining the process of becoming an ACG member.

The Auxiliary

Established in 1953, the Auxiliary has served the changing needs and interests of its members and the ACG over the years. Membership in the Auxiliary is open to spouses, friends, and significant others of ACG members. The initial role of the group was to provide its members with social networking opportunities, including tours and luncheons, at the ACG annual meeting. This role expanded to include providing educational speakers at Auxiliary meetings; supporting the Women in Gastroenterology Committee by encouraging Auxiliary members to attend sponsored symposia and seminars; and funding annual research awards.

The awards are presented to the primary authors of two of the best papers presented at the ACG annual meeting. One award is given to a fellow or member of the ACG and the other to a physician in training. The award recipients, selected by the Educational Affairs Committee, each receive $1,000 in prize money.

In 2004, the Auxiliary adopted the following mission statement, making clear that its focus for the near future would be promoting fellowship among ACG families and supporting and advancing the mission of the ACG:

> The mission of the American College of Gastroenterology Auxiliary (the "Auxiliary") shall be to promote fellowship among the ACG families and to support and advance the mission of the American College of Gastroenterology (the "ACG") to serve the evolving needs of physicians in the delivery of high quality scientific, humanistic, ethical, and cost-effective health care to gastroenterology patients. The ACG Auxiliary shall accomplish its mission by promoting membership and membership activities at all ACG meetings; utilizing a portion of membership funds to establish monetary awards for individuals doing outstanding, cutting-edge research in digestive diseases; and providing communications and a directory of members to the membership.

Tours and activities are selected with both families and Auxiliary members in mind. A hospitality suite sponsored and maintained by the Auxiliary is an integral part of the ACG annual meeting, providing information on tours and activities, a continental breakfast buffet on certain days, and a relaxing place to recover from the day's activities or plan for the next day. The role of the Auxiliary continues to evolve to meet the changing needs and interests of its members.

PAST AUXILIARY PRESIDENTS

2006–2007	Dorisann Rusche
2005–2006	Louise Chumley
2004–2005	Leslie Rex
2003–2004	Leilani Eveland Katz
2002–2003	Joyce Mattox
2001–2002	Mark Banchik, MD
2000–2001	Anne Osborne-Gifford
1999–2000	Marci Richter
1998–1999	Sylvia Hom
1997–1998	Ann DiPalma
1996–1997	Carol Popp
1995–1996	Lois S. Pardoll
1994–1995	Ann Gelfand
1993–1994	Deborah C. Glassell
1992–1993	Harriett Balart
1991–1992	Sandra Svoboda
1990–1991	Phyllis M. Hines
1989–1990	Mrs. Rafael D. Schwartz
1988–1989	Mrs. Eileen Schneir
1987–1988	Mrs. John P. Papp

1986–1987	Mrs. Robert E. Ringrose
1985–1986	Mrs. Robert E. Ringrose
1984–1985	Mrs. Joseph H. Hardison, Jr.
1983–1984	Mrs. Dorothy Jacobs
1982–1983	Mrs. Robert Bartunek
1981–1982	Mrs. James B. Chandler, Jr.
1980–1981	Mrs. Robert L. Berger
1979–1980	Mrs. Robert L. Berger
1978–1979	Mrs. David A. Dreiling
1977–1978	Mrs. Nelio Renzi
1976–1977	Mrs. Howard J. Eddy, Jr.
1975–1976	Mrs. William C. Wyte
1974–1975	Mrs. Robert P. Bissonnette
1973–1974	Mrs. Frederick Steigmann
1972–1973	Mrs. Angelo E. Dagradi
1971–1972	Mrs. Joseph Bandes
1970–1971	Mrs. Charles B. Crow, Jr.
1969–1970	Mrs. John M. McMahon
1968–1969	Mrs. Jerome Weiss
1967–1968	Mrs. John M. McMahon
1966–1967	Mrs. Murrell H. Kaplan
1965–1966	Mrs. Jacob Kaplan
1964–1965	Mrs. John Roberts Phillips
1963–1964	Mrs. Joseph E. Walther
1962–1963	Mrs. Maxwell Berry
1961–1962	Mrs. Harold F. Goulston
1960–1961	Mrs. William Abrams
1959–1960	Mrs. Theodore S. Heineken
1958–1959	Mrs. S. Bernard Kaplan
1957–1958	Mrs. Joseph Shaiken
1956–1957	Mrs. Arthur A. Kirchner
1955–1956	Mrs. James T. Nix, Jr.
1954–1955	Mrs. Lynn A. Ferguson
1953–1954	Mrs. Sigurd W. Johnsen

NEWS NOTES

ANNUAL CONVENTION

The Convention in Washington, D. C., to be held at The Shoreham, 25.26, 27 October 1954 will be the Nineteenth and Final Convention of the National Gastroenterological Association. This will also be the First Annual Convention of the recently activated American College of Gastroenterology.

Copies of the program for the Convention are being mailed separately to the membership. Additional copies are available from the Headquarters office, 33 West 60th St., New York 23, N. Y. They will also be available at the registration desk on the Convention floor.

In addition to various individual papers, the program will include panel discussions on "Twenty-five Years' Observation of the Gallbladder Controversy" and "Amebiasis", the latter to be given by the staff of the National Institutes of Health in Bethesda, Md. There will also be a symposium on "Esophageal Varices".

The Wednesday evening session, which has in previous years proved to be quite successful, will again be included.

LADIES AUXILIARY PROGRAM

An interesting and entertaining program has been planned for the ladies attending the Washington, D. C. Convention, by Mrs. Sigurd W. Johnsen of Upper Montclair, N. J., President of the Ladies Auxiliary, and her committee. Letters will be sent to the ladies with a business reply card asking them to make their reservations for each of the activities.

The program for the ladies follows:

Monday, 25 October 1954

Registration at the Registration desk in the hotel from 8:30 A.M.

Business meeting of the Auxiliary at 5:00 P.M.

Convocation Ceremony, 6:30 P.M.

President's Annual Reception, 8:00 P.M.

(*Tickets for the President's Reception will be given out only to those attending the Convocation Ceremony.*)

Tuesday, 26 October 1954

Sightseeing tour of Washington, Arlington National Cemetery and Mt. Vernon with a special stop to visit the White House, leaving the hotel 9:30 A.M.

Annual Banquet, 7:00 P.M. (to be followed by dancing).

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Announcement of the Ladies Auxiliary Program planned for the 1954 meeting

Educational Affairs

From its founding in 1932 as the Society for the Advancement of Gastroenterology, the ACG has placed a high value on practitioner education. An emphasis on education is explicit in the wording of the society's original certificate of incorporation: among the listed purposes of

the new organization are "to maintain and promote the highest standards in medical practice, medical education and in research in the field; to encourage greater interest among practicing physicians in diseases of the gastrointestinal tract, and to further their training in clinical gastroenterology; and to emphasize and advance the clinical practice and study of diseases and disorders of the gastrointestinal tract."

Educational Affairs Committee

Established in 1985, the Educational Affairs Committee organizes and administers all College postgraduate educational activities, most notably the annual postgraduate course and the scientific program for the annual meeting. As stated in the ACG bylaws (Article V), these activities include the solicitation of abstracts, the selection and invitation of special guest speakers, and the printing and distribution of the final scientific program. The committee reviews and approves all continuing education courses submitted to the College for approval or cosponsorship, and enforces all administrative and financial guidelines for the conduct of such courses.

In its capacity as planner of the College's postgraduate education activities, the committee works closely with postgraduate course directors, who are selected by the organization's incoming president. More than a year of effort goes into the selection of a course theme, topics, and session teachers. The committee selects topics and speakers for the breakfast symposia, afternoon symposia and workshops, and learning luncheons. The postgraduate course, which has been and continues to be accredited, meets Category 1 criteria towards the Physician's Recognition Award of the American Medical Association.

Additionally, the committee receives and reviews all abstracts submitted for consideration of presentation or posting. They rank order abstracts, selecting those for presentation during the daily plenary sessions as well as those displayed as posters throughout the three days of the formal meeting.

Over time, educational innovations presented to and approved by the Board of Trustees have included the following:

1. daily breakfast sessions, learning luncheons, afternoon symposia, and workshops with the annual postgraduate course;
2. the development of CME-generating self-assessment examinations (introduced in 1988) with separate, accompanying manuals providing answers and annotated bibliographies;
3. audience-response systems to accompany selected postgraduate courses;

4 the inclusion of a GI-specific mini-update course in internal medicine to occur in conjunction with the annual postgraduate course;
5 the addition of basic science and pharmacology courses;
6 the addition of a practice management course coordinated by the Practice Management Committee;
7 and the establishment of outreach at the local level through an ambitious program of regional postgraduate courses.

The ACG annual meeting has continued to prosper and grow. In 1954, the convention was three days in length. Today, with the inclusion of the postgraduate course, satellite education, and practice management courses, it spans six days packed with reviews, updates, and current information of interest to the clinical gastroenterologist. Over the past few years, the College has added new abstract sections on such topics as outcomes research and colorectal cancer screening with a total of 13 abstract categories.

Scientific Meetings

The early leaders of the ACG understood the importance of both education and continuing education. Initiated in 1933, scientific meetings of the newly chartered SAG were held monthly from October to May by the organizing members, all practitioners in New York City. The details of these meetings are not known, but it is likely that they were often informal and included discussions of the new organization and its relationship to established professional groups, presentations of articles published in the group's new journal, and case discussions. Respected physicians from outside the organization also presented scientific papers and participated in discussions "thus enabling members of the Society (SAG) to keep abreast of the latest developments and discoveries in gastroenterology" (p. 36—*The AGA Centennial Book* [1997], Dale C. Smith, Ph.D., author). Invited speakers included such notables as Max Einhorn, Edward Kellogg, Martill E. Rehfuss, Asher Winkelstein, B. B. Vincent Lyon, Walter Alvarez, and George Eusterman.

Twelve scientific papers were presented at the first SAG convention, held in Atlantic City, New Jersey, in June 1936. As a measure of its success, conventions were held regularly thereafter, although those that took place during the early 1940s—coinciding with World War II—were on a smaller scale. The first postwar convention, held in New York City in 1946, was so successful it established the precedent for the annual occurrence of scientific meetings, which have continued uninterrupted for the past sixty-one years.

During the annual scientific meeting of present day, members attend daily plenary session presentations, special topic symposia, and breakout sessions and view poster displays selected from more than one thousand abstracts submitted annually. Breakfast and afternoon seminars, workshops, and learning luncheons fill in each day's hours and provide many opportunities to obtain *AMA PRA Category 1 CME credits*™. (See Appendix III: Annual Meetings)

Postgraduate Courses

Early in ACG's history, it was clear to the leadership that the presentation of scientific research was insufficient to ensuring up-to-date skills for the practicing gastroenterologist. While serving as president in 1949, William Reid Morrison, MD, of Boston established the first postgraduate course, conducted in cooperation with Tufts Medical College and the Boston City Hospital. That same year, Owen H. Wangensteen, MD, department chair and professor of surgery at the University of Minnesota School of Medicine, assumed the directorship of the postgraduate courses. The course proved so successful its first year that it has preceded the annual scientific meeting ever since. (See Appendix IV.)

In 1950, the organization recruited Isidore Snapper, MD, then director of medical education at The Mount Sinai Hospital, to serve as cochairman and medical coordinator of the course. He and Dr. Wangensteen proved to be an effective team. From 1963 to 1965, John I. Madden, MD, director of surgery at St. Clare's Hospital in New York City, capably replaced Dr. Wangensteen. After 1966, when the program format was changed, the course continued without coordinators.

According to Dr. John Galambos, ACG president in 1974–75, one of the highlights of his term was improvement in the postgraduate courses, with faculty participation by leading figures in gastroenterology and hepatology. Dr. Walter Harvey Jacobs, who served as president in 1984–85, recommended changing the postgraduate course to a board review course, and Dr. Richard McCallum ran the well-received and equally well-attended first one, which led to a period of rapid growth in ACG membership. This new format would for the next several years alternate annually with the conventional postgraduate course. In 1999, the American Board of Internal Medicine began offering GI boards annually rather than biennially, and this move prompted a consolidation of two purposes for the ACG postgraduate course, with the course serving as both a board review and a forum for clinical updates and difficult clinical cases.

Regional Postgraduate Courses

For many years ACG leaders had searched for a way to offer the latest medical information in locations close to practitioners so that travel and time away from practice were not issues, all at a reasonable cost, with CME credits included. The first regional postgraduate course, held in Tarrytown, New York, in April 1990, featured three speakers and attracted fifty-seven participants despite a spring snowstorm.

Since then, support of the regional courses has grown enormously. To date, sixty-two programs have been held throughout the continental United States, and one in Hawaii. (See Appendix IV, Appendix or Table listing locations, themes, dates of courses since 1990.) The first past president's course was held in St. Petersburg, Florida, in January 1999, and a West Coast meeting was held in February in Napa Valley, California, both underscoring practice management skills. Additional courses have been held in Louisville, Kentucky; Baltimore, Maryland; Houston, Texas; and Williamsburg, Virginia.

The reasons for the success of the regional postgraduate programs are many: the enthusiasm and organization of the Board of Governors and its regional council, which plans and implements the courses; the Educational Affairs Committee, which reviews their content and approves the awarding of CME credit; the outstanding speakers who share their weekends to educate their colleagues; the corporate sponsors without whose generous financial support the meeting would not be possible; and, of course, the attendees, who recognize the importance of their own continuing medical education as a means of integrating the latest information into day-to-day practice. The initiative represents a vision successfully translated to reality, and strong example of how the American College of Gastroenterology addresses the needs of its constituents.

Governors' Postgraduate Courses:
A Dream, Some Risk, Lots of Perseverance

From 1994 to 1996, Dr. P. Gregory Foutch served as chair of the Board of Governors with energy and vision. His objectives stressed the fundamental mission of the ACG, which includes commitment to patient care, education, and research. The governors' postgraduate course, designed to be a three-day intensive review of clinical gastroenterology for the practicing physician, formed the centerpiece of his agenda. Dr. Foutch directed the course and recruited as faculty a high percentage of current and past governors recognized as experts in various areas of gastroenterology. The goals for the meeting, titled "Back to Basics,"

were threefold: (1) to present a high-level educational event for the membership, (2) to raise funds to support clinical research, and (3) to improve patient care. Finally, there was the prospect that the success of the event would clearly demonstrate the unique effectiveness of the Board of Governors, the committee that distinguishes ACG's governance from that of other professional GI societies.

Presentation of the course at a strategic point in the calendar year was critical to its success. The leadership decided that the course should not compete with the annual meeting in October and should not replace or conflict with an ACG-sponsored regional course. February was chosen as the optimal meeting time and Phoenix as an ideal winter location; since the city was close to Dr. Foutch's residence, he would be able to maintain close links and participate in the local site selection process.

As an experiment, Back to Basics was not without risk. Competition was strong for a limited audience among numerous well-established, perennial postgraduate courses. The project required the full support and approval of the Board of Trustees, and Drs. Arvey Rogers, Christina Surawicz, and William Carey were influential in promoting the course, as was Mr. Tom Fise, who served as a deft facilitator behind the scenes.

Ultimately, the success of the course would be measured by attendance count, the level of industry support, and the income generated to underwrite ACG-sponsored research activities. The governors themselves were called upon to enhance the chances for a favorable outcome. They wrote letters to constituents in what proved to be a successful advertising campaign. A Board of Governors meeting was convened to be held concurrently with the course (in lieu of a board meeting at Digestive Disease Week in May), which was attractive and convenient for individual governors and directly encouraged their attendance and support.

Industry participation presented a more formidable problem because the course was new and untested. The governors were an important resource in confronting this challenge. Drs. Chris Gostout and Douglas Rex and Mr. Tom Fise were instrumental in securing key financial commitments. Glaxo Wellcome, Astra Merck, Janssen, Eli Lilly and Company, Microvasive, and McNeil were major donors, and their support was crucial. The first Back to Basics course was presented in February 1996.

A comprehensive assessment of physician response to the meeting was planned. Leadership knew that this data could prove to be compelling when making a request to the Board of Trustees to repeat the course. From the outset, the plan was to schedule Back to Basics as a

biennial event. Survey response forms from course attendees were carefully reviewed. Drs. Florian Cortese, Delbert Chumley, and Ernesto Puletti served as independent course monitors and provided a detailed analysis of the meeting. In the end, total attendance was strong (297), and 95 of those who attended the meeting rated the event as very good or excellent.

To fulfill its commitment to the mission of the College, the Board of Governors donated $50,000 from course revenues to the ACG Institute for Clinical Research & Education. They also established the Governor's Grant for Research and the Governor's Award for Excellence in Clinical Research. On behalf of the governors, five awards of $1,000 each were given at the 1996 annual meeting to individual clinical investigators presenting abstracts of merit.

On the strength of the initial meeting, Back to Basics has become a biennial educational activity for the College. Courses have been repeated in Phoenix in 1998 (course director, Doug Rex), Tucson in 2000 (course director, Roy Wong) and Phoenix in 2002 (course director, Edgar Achkar), and Scottsdale in 2004 (course director, Harry Sarles) and 2006 (course directors, Richard MacDermott and Francis Farraye). Beginning in 2000, Back to Basics was presented in conjunction with the American Society for Gastrointestinal Endoscopy. Partnership with ACG's sister society has strengthened the meeting by expanding its appeal among clinical gastroenterologists and should ensure its success for years to come (see Appendix IV).

Additional Educational Endeavors

Fellows' Conferences

The first North American Conference of GI Fellows (NACGF) took place February 23–25, 1990, in Newport Beach, California. The chairs of what was to become an annual event endorsed by the Canadian Association of Gastroenterology were Drs. Gerald Friedman of New York City and Richard Hunt of Hamilton, Ontario. Philip O. Katz, MD, FACG, chair of the Gastroenterology Division at the Albert Einstein Medical Center in Philadelphia, has coordinated the event since its inception and, along with others, has served as chair. Dr. Sunanda Kane is the current chair. This first-of-its-kind GI-fellows-focused education activity evolved from a partnership with Procter & Gamble, which has provided support through an annual unrestricted educational grant. Fellows from the United States and Canada are invited to submit up to three abstracts of their clinical or basic science research work, either in progress or published within the preceding year. Case reports with extensive literature reviews may also be entered in the

Philip O. Katz, MD, FACG

competition. The program chairs score and select abstracts for poster or podium presentations, and honored fellows attend the conference on an invitation-only basis with travel expenses underwritten by the ACG. Faculty invited to participate in the conference present state-of-the-art lectures, participate in breakout sessions, and coach fellows on presentation skills. For the 2006 meeting, which took place in San Diego, California, there were over 220 submissions for 40 presentation (oral/poster) slots.

Initiated in 1996, the first AstraZeneca-sponsored National Fellows' Forum took place in Boston, Massachusetts. Dr. Philip Katz has coordinated and chaired this annual event. Fellows in training are invited to submit clinical cases that illustrate key diagnostic or therapeutic points. From the more than one hundred submissions, ten are selected for podium presentations as "unknowns" to invited faculty who discuss them in a grand rounds format. Twenty to twenty-five are presented in poster format with an opportunity provided for open discussion between the fellow and observers. Invited faculty participants fulfill an educational role during the two-day meeting (see Appendix V: National Fellows Conferences).

Other Educational Efforts in Both the Private Practice and Academic Arenas

Practice guidelines developed and reviewed under the auspices of the ACG Practice Parameters Committee have been both included in and published independently of *The American Journal of Gastroenterology*. A chart listing each practice guideline and its publication date follows:

PRACTICE GUIDELINE	MONTH AND YEAR OF PUBLICATION
Esophageal Disease in AIDS	November 1996
Acute Pancreatitis	March 1997
C. difficile Diarrhea	May 1997
GI Bleeding/Portal Hypertension	July 1997
Infectious Diarrhea	November 1997
Lower GI Bleeding in Adults	August 1998
Alcoholic Liver Disease	November 1998
Treatment and Prevention and NSAID Ulcers	November 1998
Management of *H. pylori*	December 1998
Liver Disease in the Pregnant Patient	July 1999
Diverticular Disease of the Colon	November 1999

Diagnosis and Management of Achalasia	December 1999
Esophageal Cancer	December 1999
Nonfamilial Colorectal Polyps	November 2000
Crohn's Disease in Adults	March 2001
Hepatic Encephalopathy	July 2001
Barrett's Esophagus	August 2002
Ulcerative Colitis in Adults	July 2004
Diagnosis and Management of Fecal Incontinence	August 2004
GERD Treatment	January 2005
Guidelines for the Management of Dyspepsia	October 2005
Acute Pancreatitis	October 2006

Additional education initiatives of the past two decades:

- In 1993 the first edition of a GI subspecialty medical knowledge self-assessment program (MKSAP) was published in cooperation with the American College of Physicians (APA), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), and the American Association for the Study of Liver Diseases (AASLD). Dr. Leslie Bernstein provided strong leadership.
- The ASGE has partnered with the ACG in the presentation of selective regional and governors' postgraduate courses (see the preceding section on these courses).
- An annual practice management course held in conjunction with the annual meeting was initiated in 1988.
- A GI Private Practice Task Force established in 1997 resulted in two publications: *The ACG Task Force Report on the Future of Private Practice* and *GI Clinical Practice Efficiencies: With a Special Focus on Clinical Academic Practices*.
- *ACG SmartBrief*, a twice-weekly online newsletter introduced in 2005, highlights important advances in the diagnosis and treatment of digestive disorders and keeps members aware of what patients may be reading from popular news sources.
- Education Universe, the newest educational offering from ACG, is an online, self-directed CME program that provides a way for all gastroenterologists to access useful tools when preparing for the GI boards or recertification, or when seeking necessary CME credits outside of ACG meetings.

Practice Guidelines in Acute Pancreatitis

Peter A. Banks, M.D., M.A.C.G.,[1] Martin L. Freeman, M.D., F.A.C.G.,[2] and the Practice Parameters Committee of the American College of Gastroenterology[*]
[1]*Division of Gastroenterology, Center for Pancreatic Disease, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts;* [2]*Division of Gastroenterology, Hennepin County Medical Center, University of Minnesota, Minneapolis, Minnesota*

(Am J Gastroenterol 2006;101:2379–2400)

INTRODUCTION

Guidelines for the diagnosis and treatment of acute pancreatitis were published by the American College of Gastroenterology in 1997 (1). These and subsequent guidelines (2–7) have undergone periodic review (6, 8–13) in accordance with advances that have been made in the diagnosis and treatment of acute pancreatitis. Guidelines for clinical practice are intended to apply to all health-care providers who take care of patients with acute pancreatitis and are intended to be flexible, and to suggest preferable (but not the only) approaches. Because there is a wide range of choices in any health-care situation, the physician should select the course best suited to the individual patient and the clinical situation.

These guidelines have been developed under the auspices of the American College of Gastroenterology and its Practice Parameters Committee, and approved by the Board of Trustees. The world literature in English was reviewed using a MEDLINE search and also using the Cochrane Library. The ratings of levels of evidence for these guidelines are indicated in Table 1. The final recommendations are based on the data available at the time of the publication of this document and may be updated with appropriate scientific development at a later time. The following guidelines are intended for adult and not pediatric patients. The main diagnostic guidelines include an assessment of risk factors of severity at admission and determination of severity. The major treatment guidelines include supportive care, fluid resuscitation, transfer to intensive care unit, enteral feeding, use of antibiotics, treatment of infected pancreatic necrosis, treatment of sterile pancreatic necrosis, treatment of associated pancreatic duct disruptions, and role of magnetic resonance cholangiopancreatography (MRCP), endoscopic ultrasound (EUS), and endoscopic retrograde cholangiopancreatography (ERCP) with biliary sphincterotomy for detection and treatment of choledocholithiasis in biliary pancreatitis.

PATHOPHYSIOLOGY

The pathophysiology of acute pancreatitis is generally considered in three phases. In the first phase, there is premature activation of trypsin within pancreatic acinar cells. A variety of mechanisms have been proposed including disruption of calcium signaling in acinar cells (14–18), cleavage of trypsinogen to trypsin by the lysosomal hydrolase cathepsin-B, and decreased activity of the intracellular pancreatic trypsin inhibitor (17, 18). Once trypsin is activated, it activates a variety of injurious pancreatic digestive enzymes.

In the second phase, there is intrapancreatic inflammation through a variety of mechanisms and pathways (16, 18–28). In the third phase, there is extrapancreatic inflammation including acute respiratory syndrome (ARDS) (16, 19–21, 29). In both phases, there are four important steps mediated by cytokines and other inflammatory mediators: 1) activation of inflammatory cells, 2) chemoattraction of activated inflammatory cells to the microcirculation, 3) activation of adhesion molecules allowing the binding of inflammatory cells to the endothelium, and 4) migration of activated inflammatory cells into areas of inflammation.

In the majority of patients, acute pancreatitis is mild. In 10–20%, the various pathways that contribute to increased intrapancreatic and extrapancreatic inflammation result in what is generally termed systemic inflammatory response syndrome (SIRS) (Table 2). In some instances, SIRS predisposes to multiple organ dysfunction and/or pancreatic necrosis. The factors that determine severity are not clearly understood, but appear to involve a balance between proinflammatory and anti-inflammatory factors. Recent evidence suggests that the balance may be tipped in favor of proinflammatory factors by genetic polymorphisms of inflammatory mediators that increase severity of acute pancreatitis (27, 30, 31).

CLINICAL CONSIDERATIONS

Clinical Diagnosis
It has been estimated that in the United States there are 210,000 admissions for acute pancreatitis each year (13). Most patients with acute pancreatitis experience abdominal

[*]The members of the Practice Parameters Committee of the American College of Gastroenterology are listed in the Appendix.

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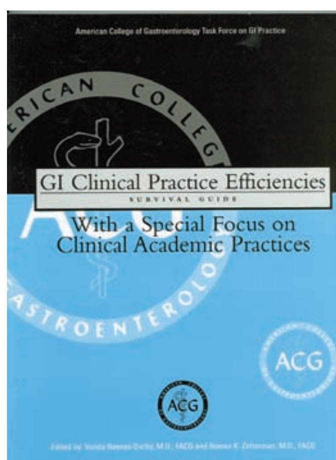
ACG's Practice Guidelines published in *The American Journal of Gastroenterology* and online at www.acg.gi.org



GI Clinical Practice Efficiencies: With a Special Focus on Clinical Academic Practices **published in 1997**

- An online self-assessment examination introduced in 2006 provides questions and answers based on the postgraduate course booklet distributed at the recent annual meeting.

Community- and institution-based physician members of the College with outstanding leadership skills and a sense of commitment have made possible ACG's achievements in postgraduate education. True to the aim set forth in its constitution "to maintain and promote the highest standards in medical practice, medical education and in research in the field," ACG has established itself as the preeminent organization in the field of postgraduate education in clinical gastroenterology.

CHAIRS OF THE EDUCATIONAL AFFAIRS COMMITTEE

2006–2007	Carol A. Burke, MD, FACG
2005–2006	Carol A. Burke, MD, FACG
2004–2005	Carol A. Burke, MD, FACG
2003–2004	Karen L. Woods, MD, FACG
2002–2003	Karen L. Woods, MD, FACG
2001–2002	Karen L. Woods, MD, FACG
2000–2001	Atilla Ertan, MD, MACG
1999–2000	Atilla Ertan, MD, MACG
1998–1999	Philip O. Katz, MD, FACG
1997–1998	Philip O. Katz, MD, FACG
1996–1997	Philip O. Katz, MD, FACG
1995–1996	Edgar Achkar, MD, FACG
1994–1995	Edgar Achkar, MD, FACG
1993–1994	Edgar Achkar, MD, FACG
1992–1993	Joel E. Richter, MD, MACG
1991–1992	Joel E. Richter, MD, MACG
1990–1991	Marvin M. Schuster, MD, MACG
1989–1990	Leslie H. Bernstein, MD, MACG
1988–1989	W. Scott Brooks, Jr., MD, MACG
1987–1988	Lawrence J. Brandt, MD, MACG
1986–1987	Seymour Katz, MD, MACG
1985–1986	Myron Lewis, MD, MACG
1984–1985	Arvey I. Rogers, MD, MACG
1983–1984	David Y. Graham, MD, MACG

(Prior to 1986, the group was called the Program Committee.)

Endoscopy and the ACG: Advancing the Cause

While it is generally conceded that no national organization can legitimately claim sole credit for advancing the cause of endoscopy, each of

three national gastroenterologic societies made distinct contributions: the American Society for Gastrointestinal Endoscopy (ASGE), the American Gastroenterological Association (AGA), and the American College of Gastroenterology (ACG). The constitutions and bylaws of these organizations define important differences in mission among them. A review of selected phrases from these documents can assist in understanding the positions each took during a period of technological advancement in and the broader application of endoscopy in the United States.

> ACG, founded in 1932 as the Society for the Advancement of Gastroenterology: *(Constitution, revised May 2003, page 1) "To advance and foster the development and application of the science and practice of gastroenterology and closely related fields of study . . . by providing leadership and aid in all aspects of this field, including patient care, research, teaching . . . scientific communication and matters of national health policy pertaining to Gastroenterology."*

> AGA, founded in 1897: *(Constitution, 2003; Article III, page 1): "The purposes for which AGA is formed are as follows . . . Serving as the leading authority and major voice in Gastroenterology . . . Encouraging and supporting research in Gastroenterology by serving as the major forum for presenting research and exchanging information to advance scientific knowledge related to Gastroenterology."*

> ASGE, founded in 1941 as the American Gastroscopic Society and renamed ASGE in 1961: *(Membership and Bylaws 2000–2001, page 1): "The core purpose of the American Society for Gastrointestinal Endoscopy is to be the leader in promoting excellence in gastrointestinal endoscopy."*

Many issues that today define the relationships among the three organizations existed in the 1970s when endoscopy rose to prominence. There were concerns about uncontrolled use of endoscopy in clinical care settings; the absence of standards defining the indications for endoscopy; and the qualifications of individuals performing endoscopic procedures. The importance of appealing broadly to growing memberships of physicians with diverse interests and commitments motivated the leaders of these organizations to find avenues in which to cooperate. Leaders then and now take strong stands in an effort to promulgate what they believe is in the best interests of clinical gastroenterology and patient care.

Our history as an organization is inextricably linked with the evolution of endoscopy in the United States. A brief review of that process

provides some basis for understanding the circumstances responsible for the slow acceptance of advances in endoscopic technology as well as the reactions of and the interactions among the national GI organizations.

A Brief History of Endoscopy

Rudolph Schindler, MD

Documented interest in diseases of the GI tract dates to the time of Hippocrates (460–370 B.C.E.), who first described dyspepsia. Some think of him as the first gastroenterologist, but if alive today, he would point to much later developments as defining the discrete practice of gastroenterology. Adolph Kussmaul in 1868 is credited as the first physician to pass a rigid, open-ended instrument (gastroscope); he had successfully convinced a sword swallower to participate in this momentous historical event. The difficulty of introducing the instrument, patient discomfort, and complications severely limited its clinical application. Two thirds of a century passed before Rudolph Schindler and Georg Wolf introduced their semiflexible gastroscope (1932), the forerunner of a fully flexible instrument with enhanced lighting and undistorted imaging capabilities through fiber-optic bundles.

Nearly all gastroenterologists practicing today were trained after the watershed year of 1960, which marks the first commercial appearance of the fully flexible fiber-optic gastroscope, the ACMI 4990. This was followed by the fiber-optic esophagoscope, and then the upper GI panendoscope and within a decade by the fiber-optic colonoscope. Just as cystoscopy early in the century fully established the specialty of urology, flexible GI endoscopes re-created gastroenterology. With the parallel development of other powerful technology tools—conventional and nuclear radiology, ultrasonography, computerized axial tomography (CT) and magnetic resonance imaging (MRI), among others—and new therapeutics, flexible endoscopy fundamentally and irreversibly changed gastroenterology beyond the horizon of even its most optimistic practitioners at midcentury.

Schindler and Weiss: Supporters of Gastroscopy and the Gastroscope

It is significant that the Wolf-Schindler semiflexible gastroscope was introduced in 1932, the same year the Society for the Advancement of Gastroenterology was chartered by the state of New York. One of the society's founders, Samuel Weiss, a practicing internist with a strong interest in digestive disorders and one of the first physicians in New York City to install an x-ray unit in his office, visited Schindler in Germany in 1925 and 1927 to acquire information about the semiflexible gastroscope in its development stage. It was common in the late 1890s

and early twentieth century for American physicians to study in Berlin and Vienna with renowned European physicians, and Weiss was committed to improving the diagnostic skills of those caring for patients with digestive maladies. Spending time with Schindler convinced him more than ever that gastroscopy had the potential to revolutionize the diagnosis of gastric disorders. Returning to the United States, Weiss campaigned vigorously to persuade American physicians to accept gastroscopy. Not only did he publish a paper entitled "A New Gastroscope," he also invested considerable time and effort on the design problems of the system then in development by Schindler and Wolf. When the semiflexible gastroscope with a built-in system of lenses was introduced in 1932, Weiss recognized the potential clinical utility of the new instrument and proceeded both to use it in his own practice and promote widely its clinical application.

Schindler Rigid Gastroscope

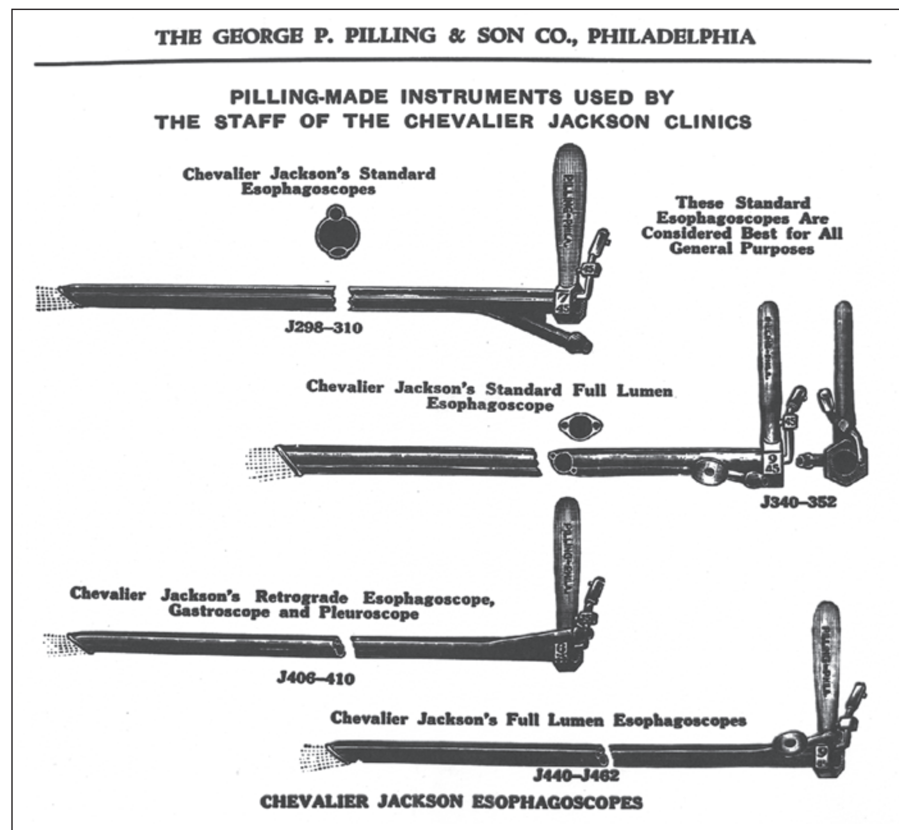
Boston, Baltimore, and New York Join the Movement

Within several years of the introduction of the Wolf-Schindler semiflexible gastroscope, Edward Benedict, a surgeon at Massachusetts General Hospital in Boston, and James Borland Sr. at Johns Hopkins Hospital in Baltimore were using the instrument and conducting trials to assess procedure effectiveness. Benedict embraced and enhanced the diagnostic potential of the gastroscope by developing a technique for performing mucosal biopsies. The New York proponents of the procedure included—in addition to Weiss—Max Einhorn, Elihu Katz (Weiss, Einhorn, and Katz were among the founders of the ACG), and Henry Janeway. Renowned physicians such as Chevalier Jackson of Philadelphia and others, already experienced in examining the trachea and bronchi with rigid instruments without lenses, saw a natural progression of the older instruments' capabilities in the use of the new semiflexible gastroscope to study the esophagus.

Meaningful Progress: Slow, Sustaining, Stage-Setting

Semiflexibility added improvements in ease of scope passage and slightly improved visibility, but the incidence of complications was still high. From 1932 to 1957, Schindler's contributions dominated the field of gastroscopy. He shaped the field of gastrointestinal endoscopy from a risky and seldom-practiced procedure into an essential of gastroenterology. His contributions and personal example were significant and crucial to the development of endoscopy prior to the introduction of fiber-optic technology.

Nevertheless, all endoscopies before what was to become known as "the flexible era" were associated with so many complications that there was little hope of endoscopy being accepted or utilized widely



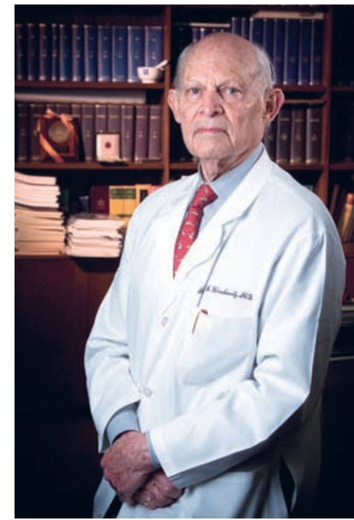
by either institution-based or community-based practicing gastroenterologists.

The Era of Flexible Fiber Optics

South African gastroenterologist Basil Hirschowitz, MD, FACG, while participating in a fellowship at the University of Michigan in 1954, picked up the thread of the concept of fiber optics dropped by Schindler and Heinrich Lamm in the 1930s. In 1927, while still a medical student, Lamm had actually made a crude fiber array and suggested its use in endoscopes to Schindler, but the idea was too premature and never used. Two letters in the January 2, 1954, issue of the journal *Nature* ("A flexible fiberscope using static scanning," Hopkins HH, Kapany NS; "A new method of transporting optical images without aberrations," Van Heel ACS) reported transmission of images through a flexible bundle of oriented glass fibers that Hopkins and Kapany, working in England, had called a "fiberscope." Dr. Hirschowitz visited Hopkins and Kapany in England to discuss their work-in-progress and the technical problems they were encountering, and then he returned to Michigan where he spent three years working with

C. Wilbur Peters, a physicist, and Larry Curtiss, their student, to develop glass-coated optical fibers into a working endoscope design. The first length of the coated spun optical fiber was collected by coiling it around the outside of a readily available cylindrical-shaped Quaker Oatmeal box. In 1957 Dr. Hirschowitz passed the first prototype fiber-optic gastroscope into his own stomach, thereby performing the first recorded auto-endoscope and the first clinical application of his innovative flexible instrument.

In May 1957, twenty-five years after Schindler introduced the semi-flexible gastroscope, the first laboratory prototype of a glass-fiber-optic gastroscope was presented to a meeting of the American Gastroscopic Society at the Broadmoor Hotel in Colorado Springs. (Hirschowitz BI, Curtis LE, Peters CW, and Pollard HM. Demonstration Of A New Gastroscope, The "Fiberscope." Presented at the Annual Meeting of the American Gastroscopic Society, Colorado Springs, Colorado, May 16, 1957). The prototype is now in the Smithsonian Museum of American History.



Basil Hirschowitz, MD, MACG

By 1960, American Cystoscope Manufacturers Inc. (ACMI), in Stamford, Connecticut, had turned out the first production model. In the first peer-reviewed article on the subject (Hirschowitz BI, Curtiss LE, Peters CW, Pollard HM. "Demonstration of a new gastroscope, the Fiberscope." *Gastroenterology* 1958; 35: 50–53), Hirschowitz proclaimed that "the conventional gastroscope has become obsolete on all counts." He was criticized, but his statement proved to be correct. Researchers performed numerous comparative studies on the new device. Some instruments with flexible modifications were easier to pass into the duodenum in many patients. The addition of a controllable tip further complicated matters by demanding a new level of skill, but the possibilities offered by flexible designs led to better skills, better designs, and an eventual disappearance of rigid GI scopes.

In 1960 the earliest commercially developed fiber gastroscopes were tested in Hirschowitz's laboratory in Birmingham, Alabama, at the University Hospital, leading after four modifications to the ACMI production model. The report of the clinical use of this instrument was published in *The Lancet* in 1961 (Hirschowitz BI, Endoscopic examination of the stomach and duodenal cap with the Fiberscope. *Lancet* 1961; 7186: 1074–1078), and a report on the first five hundred cases soon followed (Hirschowitz BI, Balint JA, Fulton WF, Gastroduodenal endoscopy with the Fiberscope. An analysis of 500 examinations. *Surg Clin North America* 1962; 42: 1081–1090). For the sake of comparison, it would have taken over twenty-five years to accumulate case notes on the use of the Schindler-type gastroscope on five hundred patients at that same institution.

Martin E. Gordon, MD, FACG, presents to Paul D. Webster, III, Chair of Medicine at the Medical College of Georgia, and his staff, in 1977, opening keys to the exhibit, *The Evolution of Gastroscopy—from the Magenkratzer to the Laser.*

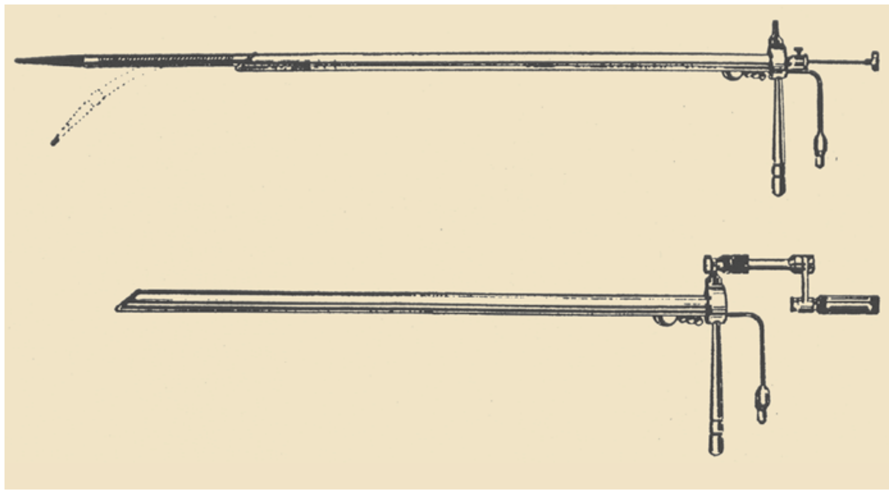
Following the introduction of the Hirschowitz fiber-optic gastroduodenoscope in 1957, instruments such as the Eder-Hufford (pre-fiber-optic, with flexible obturator) and LoPresti (flexible, fiber-optic) endoscopes were manufactured to facilitate endoscopic examination of the esophagus. Instrument design evolved rapidly, and in 1963 the first fiber-optic esophagoscope was developed.

Transition from lens optic to fiber-optic gastroscopes was slow, and as late as 1969 some members of the gastroscopic community still urged use of the conventional instruments. The ability to take better quality still and motion pictures in color for documentation and teaching helped the transition, which took most of the rest of the decade.

All other fiber-optic instruments and technically innovative accessories eventually followed, enabling practitioners to peer into the darkened recesses of the gastrointestinal tract. With access through variously sized apertures and tubular channels intubatable by endosope, catheter, or both, it became possible to recognize, diagnose, and remedy both the commonest and most complex of disrupting GI conditions.

The National GI Societies Debate Standards

Physicians specializing in caring for patients with digestive disorders acknowledged the absolute importance of adequate training in endoscopy and an acceptable level of technical skill. It was conceded without contention that fiber-optic endoscopy should only be per-



Eder-Hufford esophagoscope
Top: outer tube with obturator and light carrier

Bottom: obturator removed, telescope attached

formed when absolutely indicated. However, the lack of published, consensus standards made it impossible to determine what was considered "adequate training" or an "acceptable level of technical skill"—or for reaching agreement on identifying the indications for performing fiber-optic endoscopy.

Then, as now, the issue was not whether standards should be established and complied with but which organization would provide the leadership to ensure both. When standards of care and issues of peer review became hot items in the 1970s, the AGA assumed a self-appointed leadership role. Formed in 1897, it was the most senior of the three national GI societies, already thirty-five years old when the ACG was first chartered, and almost forty-five years old when the ASGE was established as the American Gastroscopic Society. Age has its privileges, and the AGA moved quickly in 1972 to begin setting standards by adopting the issue of fiber-optic endoscopy as an early focus of its ad hoc committee on patient care, which was just beginning to explore establishing patient care guidelines. The American College of Physicians looked to the AGA for leadership in establishing endoscopy use guidelines. The AGA view was that fiber-optic endoscopy should be used sparingly because rigorous scientific studies had not been conducted to demonstrate safety, diagnostic accuracy, effect on therapeutic choices, and influence on patient outcomes.

By 1973 the federal government, through its Medicare and Medicaid programs, had mandated the establishment of guidelines that could be used by professional standards review organizations (PSROs) when making decisions about reimbursement for professional services. Performance of endoscopic procedures was becoming a highly lucrative segment of gastroenterology practice, a fact evident to both users and

nonusers. The American Medical Association had established an intersociety council to assist in the development of these guidelines. The ASGE asked for a seat on this council, expressing the view that its members had the greatest experience with endoscopy and were therefore more qualified than other societies in the field to provide training standards and practice guidelines. Henry Colcher, MD, president of ASGE and a past president of the ACG (1969–70), had published an editorial in the *Journal of the American Medical Association* (225: 58–59, 1973) expressing concerns regarding the performance of endoscopy by untrained or undertrained individuals, emphasizing at the same time that "the benefit was evident" in the appropriate application of endoscopic procedures in the study of the upper and lower gastrointestinal tracts. Despite the uncontested credibility of the ASGE, the AGA, ACP, and other practitioner groups mounted a successful campaign against accepting the ASGE as a member of the council. Many council members, on the other hand, believed that intersociety cooperation was essential for the establishment of standards for training and practice.

In 1974, the ACP asked each group to provide guidelines for consideration. An ad hoc committee on endoscopy appointed by the AGA worked with the ad hoc intersociety committee of the AMA regarding guidelines for training and practice in gastrointestinal endoscopy. The standards accepted were mainly those of the ASGE, albeit slightly modified, but their acceptance did little to quell associated controversies. Only when all of the major societies—ACG, AGA, ASGE, AASLD, and the Society of American Gastrointestinal Endoscopic Surgeons (SAGES)—recognized that the resolution of these controversies required a spirit of cooperation and serious intent was any resolution realized. Membership in the ASGE and the requirement that a specific number of procedures had to be performed before an individual could be judged competent were not included in the consensus guidelines. Requirements for formal training in endoscopy did become more clearly defined, although mechanisms for judging competency for performing endoscopy in the hospital setting still varied among medical staffs across the country. Under the auspices of the ASGE, regional endoscopic societies had been established in 1973, with the most intense focus and activity in southern California. However, the establishment at the level of national societies of appropriate indications for the performance of diagnostic and therapeutic endoscopy evolved gradually, and only gradually gave gastroenterologists performing endoscopy the credibility they sought and believed they deserved.

It was rough going for those physicians in community-based,

nonacademic settings who were performing endoscopy regularly and in increasing numbers. Common perceptions frequently distort reality, and endoscopists were viewed by many in the academic echelon as money-grubbing, untrained, or inadequately trained physicians who overused the technique and were impatient with the slow process of gathering and analyzing scientific data that could serve to justify what they were doing—and what many endoscopists felt required no justification other than a simple examination of outcomes. The attitudes of both groups were partially correct. Technological advances, the passing of time, the maturity and mellowing of the combatants, the expanding endoscopy experience in academic settings, and the careful accumulation and objective examination of data obtained from controlled studies would ultimately confirm to be partially correct what each adversarial group had maintained all along.

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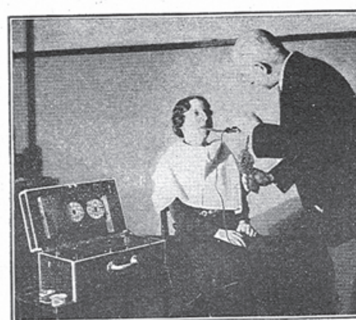

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An ad appearing in an early issue of the *Review of Gastroenterology*

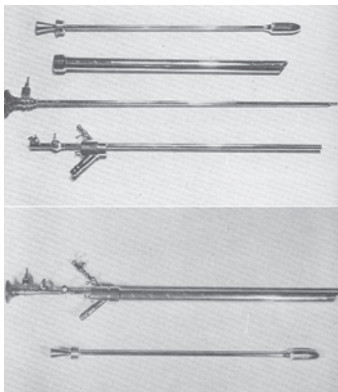
Randomized Placebo-Controlled Trials: The ACG Contribution

Randomized controlled trials (RCTs) are the gold standard in clinical research for the evaluation of new drugs, both for safety and efficacy. Utilization of endoscopy in clinical research had to await the development of instruments capable of examining the entire upper GI tract or colon and able to produce an image clearly showing mucosal detail. The first instrument to meet the needs of clinical researchers eager to study the effects of various drugs, especially NSAIDs, on the gastric mucosa was the Olympus GTF-A, which combined a side-viewing gastroscope with a gastrocamera. The first RCT using this device was performed in 1975 by Lanza et al. comparing the gastric mucosal injury seen with aspirin, ibuprofen, phenylbutazone, and indomethacin to observed placebo. The next twenty years saw the development of forward-viewing endoscopes capable of reaching the distal duodenum with excellent optics and external 35 mm cameras, which produced high quality photographs for documentation of findings.

A large number of RCTs were performed with these instruments: evaluating GI mucosal toxicity of the various NSAIDs introduced during

that period and the protective properties of various drugs commonly administered with NSAIDs (misoprostol, proton pump inhibitors, H2 receptor antagonists. Drs. Frank Lanza and David Graham, both future presidents of the College, were prominent investigators in this area as were Jeffrey Raskin, Naurang Agrawal, Richard Hunt, Michael B. Kimmey, and Loren Laine. Nonmembers who were nevertheless important figures in this work were Kevin Ivey, Fred Silverstein, and Gabrielle Bianchi-Porro.

Another area of intensive research using endoscopic observation is the study of the efficacy of drugs in the healing of peptic ulcers, esophageal erosions, and inflammatory bowel disease. A landmark study on this topic was published in *The New England Journal of Medicine* in 1977 by a group of researchers headed by Dr. John Fordtran, now an honorary member of the ACG, who used endoscopy to assess healing of duodenal ulcer treated intensively with antacids. Subsequently, all RCTs for ulcer healing were monitored endoscopically, a trend that began with cimetidine in the late 1970s and has been the gold standard for assessing healing of ulcers with all subsequent H2 receptor antagonists, proton pump inhibitors, sucralfate, and other purported ulcer-healing agents. Similar studies were carried out when it became time to evaluate the various proton pump inhibitors for the healing of erosive esophagitis. Today, no RCT is carried out for the healing of peptic ulcer or erosive esophagitis, which does not require endoscopic evaluation. The medical literature of the last twenty-five years contains literally thousands of RCTs looking at all aspects of mucosal injury and healing. Needless to say, many members of the ACG have figured prominently in these studies and are too numerous to mention.



Top: Sigmoidoscope disassembled, showing (from top to bottom) obturator, sheath, telescope and lighting system, and irrigating system.

Bottom: The obturator has been removed and the telescope-irrigator assembly is shown in position for examination.

Endoscopic Ultrasonography and Video Endoscopy: ACG Members Participate in Advancing and Applying New Technologies

Advances in endoscopic instruments in the latter half of the twentieth century revolutionized the diagnosis and treatment of gastrointestinal disorders. Great change began with the development of fiber-optic upper endoscopes in the late 1960s, and colonoscopes and endoscopic retrograde cholangiopancreatography in the early 1970s. Endoscopic ultrasonography (EUS) continued this amazing array of new technology, and video endoscopy followed in the early 1980s. The work of some members of the College was pivotal in the development and clinical application of video endoscopy and EUS. This discussion traces the development of EUS and video endoscopy.

Endoscopic Ultrasonography

In 1980, Eugene P. DiMagno and associates James L. Buxton, ACG member Patrick T. Regan, R. H. Hattery, D. A. Wilson, J. R. Suarez, and P. S. Green attached an 8-cm-long linear array ultrasound probe to the tip of a side-viewing ACMI endoscope. That same year they reported its safe use for viewing canine stomachs at the Fourth European Congress of Gastrointestinal Endoscopy in Hamburg, Germany. At that same meeting, W. D. Strohm and his associates J. Phillips, F. Haggenmuller, and Meinhard Classen reported their experience in eighteen patients using a prototype radial scanning ultrasonic endoscope manufactured by Olympus. In 1982 DiMagno and associates published their EUS human clinical experience later followed by DiMagno's hallmark report, in which he described the structured layers of the gastrointestinal wall, served to advance the development of EUS.

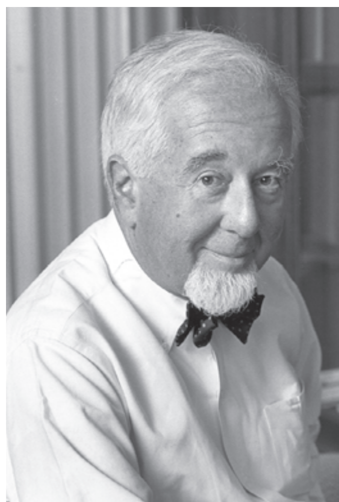
There is a long learning curve for EUS, in part because the anatomy is portrayed as spatial images that are generally unfamiliar to endoscopists. ACG members Kenneth Chang and Richard Erickson were among the first to develop a teaching aid for endoscopists interested in learning EUS. They produced the first CD-ROM of the anatomy seen on EUS images. The initial use of EUS was solely as an imaging modality; however, its imaging modality alone could not differentiate between some benign and malignant lesions. With the subsequent development of endosonography-guided fine-needle aspiration (EUS-FNA), EUS became a more accurate diagnostic technique. The details of this new method were reported in two simultaneous publications in 1994 by Chang and associates, and ACG member M. J. Wiersema and associates. Both groups validated increased efficacy with EUS-FNA.

Other researchers making contributions to the advancement of EUS include K. Akahoshi, J. F. Botet, G. A. Boyce, G. C. Caletti, M. Giovannini, T. W. Rice, P. Vilmann, and L. M. Wiersema, and ACG members M. S. Bhutani, D. L. Carr-Locke, D. Fleischer, R. H. Hawes, C. J. Lightdale, and J. Siegel. This list, though incomplete, does highlight some who have made significant contributions.

Video Endoscopy

In 1983, the initial description of electronic video endoscopy by ACG members Michael Sivak and David Fleischer appeared in a journal abstract, and in 1984 the details of its use were published in three separate reports by Sivak and Fleischer, M. Classen and J. Phillips, and M. Schapiro (a member of ACG) and M. O. Auslander. Another ACG member, Jerome D. Waye, was also among the first to use the new

technology. All the researchers agreed that it had advantages over fiber-optic endoscopy.



Howard Spiro, MD, MACG

Notable Quotes and Comments Underline Difficult Times

A few comments and quotations gleaned from information provided to the Archives Committee of the College illustrate some of the difficulties encountered and gains experienced by ACG, ASGE, and unaffiliated practitioners who were forging ahead to prove what they knew then to be true or what would ultimately be proved as true regarding the role of endoscopy in the care of patients with suspected or proven digestive disorders:

- Howard Spiro, then chief of gastroenterology at Yale, published two editorials in the *New England Journal of Medicine* in 1974; in the first, he claimed to be able to diagnose ulcers by history alone and argued therefore that the only worth of endoscopy was the $150 the endoscopists were paid for each procedure. The second editorial addressed technology: "Anyone can be an endoscopist today, and indeed almost everyone is . . . but they may have to abandon some of the . . . glittering instruments piled upon each other in their offices and laboratories like dung at the aboriginal hut." (Spiro HM: *New Engl J Med* 1974: pages 567–579; 1070–1072)
- In spite of the frequent criticisms and derogations directed to endoscopists, progress toward universal acceptance was evident by the mid-1970s, which prompted Angelo Dagradi, MD, (President, ACG, 1973–74) to comment during his ASGE presidential address in 1976 that "the ugly duckling has become the swan." (Presidential Address, ASGE Annual Meeting 1976, Miami, Florida)
- At the annual meeting of the AGA in 1976, president Fred Kern, when discussing the issue of colonoscoping everyone with a colon polyp, said, "I can visualize an endless chain of people colonoscoping each other end to end, like elephants in a circus." The implications and inferences seemed clear to his audience. He also quoted internist Michael Halberstam as saying "Mallory climbed Everest because it was there, but I'll be damned if all my patients' orifices have to be cannulated because they are there." (*Gastroenterology* 1976; 71: 537–541)
- Warren Nugent, in his ACG presidential address in 1977, said "With fiber-optics we have now literally opened a window into the inside of the patient." (*Am J Gastroenterol* 1978: 141–143)
- (McCray, R.—Past President Council of Regional Endoscopic Societies) "Yes, we would have preferred a little more endorsement, but

this was certainly enough to convince many academic gastroenterologists to ask us to treat their patients, even though the NIH could not bring themselves to agree that endoscopic therapy had already been shown to save surgery and lives. So I believe we had finally arrived in 1989 and could not have done so without the real help of the ACG. Even before this, the ACG let me present my paper on neodymium-YAG laser palliation of rectosigmoid cancer (1984) and another one, which was the first on office endoscopy (1979), at their annual meetings."

- The NIH Consensus Conference on Gastrointestinal Endoscopy for gastrointestinal hemorrhage in 1980 concluded: "Endoscopy is an excellent tool for the differential diagnosis of upper GI bleeding. The lack of demonstrated effect on overall mortality, however, strongly suggests that the major current task is to use the diagnostic information gleaned by endoscopy as a stimulus for further vigorous investigations of different and newer therapies for the different lesions causing upper gastrointestinal bleeding." (Endoscopy in Upper GI Bleeding. NIH Consens Statement 1980 Aug 20–22 3(5):1–5)
- In 1989 the NIH released updated recommendations on the use of endoscopy in ulcer patients (Proceedings of the NIH Conference on Therapeutic Endoscopy in Bleeding Ulcers. Gastrointest Endos 1990; 36: S1-S65). The NIH reported that more than 100,000 ulcer patients a year bleed from peptic ulcers; that the ulcer mortality rate had not changed in thirty years; that bleeding stops spontaneously in 70 percent to 80 percent of patients (needs reference); and that persistent or recurrent bleeding with a large initial blood loss and active bleeding or a pigmented protruberance (visible vessel) at endoscopy implies high risk. The NIH also concluded that heat probe and multipolar electrocoagulation were the most promising modalities for endoscopic therapy; that, in the hands of qualified therapeutic endoscopists, the rate of complications is acceptably low, but endoscopic therapy should be used only in patients who are at high risk; and that the clinical efficacy and safety of endoscopic therapy should be assessed further by multicenter, randomized controlled trials.

Conclusion: Persistence, Proof, and Patience Pay Off

Acceptance of endoscopy and endoscopists by the gastroenterology community at large was a wrenchingly slow process whose outcome depended upon creative advances in technology that facilitated the easier and safer passage of the endoscope into the structures of the upper GI tract as well as the enhancement of its visualizing capability and diagnostic reliability. Only when technical barriers were surmounted and resolved did endoscopy, endoscopic procedures, and endoscopists gain wider acceptance; earn the trust, recognition, and respect of colleagues; and develop an increasingly larger following among both practicing and academic gastroenterologists. The establishment of training guidelines and standards of practice added the scientific dimension necessary for the acceptance of endoscopy in academic settings. Controlled, prospective, randomized studies have strengthened some firmly held views and weakened others. ACG, ASGE, and the AGA have been at the forefront of these studies and continuing progress in endoscopy. An important and sustained collaborative relationship has developed between ACG and ASGE; the two organizations have cosponsored regional postgraduate courses, coedited publications related to ensuring competence in endoscopy, established evidence-based quality measures through the ACG/ASGE

Task Force on Quality in Endoscopy, and created the ASGE-coordinated Endoscopy Corner at the ACG annual meeting.

Integrating into the GI and Non-GI Medical Community

For many years, there was opposition to the College from many prominent academic gastroenterologists. This conflict had its basis in turf issues, personality conflicts, and concerns that the public voice of academic gastroenterology would become less audible when the opinions of nonacademic gastroenterologists were voiced. Beginning in the mid-1960s and continuing through the 1970s—principally through the conciliatory actions initiated by presidents Maxwell Berry, Murrel Kaplan, John McMahon, and others—relationships between the College and other organizations devoted to gastroenterology have progressively improved. The result has been closer ties and a spirit of cooperation that has enhanced our specialty.

Working with AGA, ASGE, AMA, and Others

Joseph E. Walther, MD, MACG

At the same time, the American Medical Association invited representation from the several specialty societies. In 1970 twenty-three section councils were created at the AMA, and Dr. Joseph Walther was chosen to represent ACG on the GI Section Council. In 1972 the American College of Gastroenterology and the American Gastroenterological Association were given a shared delegate and alternate delegate to the AMA House of Delegates. In 1977 each of the gastroenterological societies received separate representation of delegates and alternate delegates. Dr. Joseph Walther remained as delegate, and Dr. William Millhon became alternate delegate.

The College has also been represented in other national organizations both public and private, such as the American Association for the Advancement of Science, the American Society for Internal Medicine, the Council on Specialty Societies of the American College of Physicians, the American Digestive Disease Society, and the National Foundation for Ileitis and Colitis (now the Crohn's & Colitis Foundation of America).

Dr. Ed Krol (ACG president in 1962–63), Dr. Donald Collins, and several other prominent members of the College were involved in an attempt to form a new organization, the American Board of Abdominal Surgery. This movement caused an immediate furor in the surgical community, with many surgeons expressing violent opposition to the formation of this board. Opposition to the founding of ABAS in 1957

led to antipathy toward the College, and it took several years for these feelings to ebb. The ABAS remains in existence today.

In 1975 a joint committee consisting of members of ACG, the AGA, and ASGE was formed to cooperate with the American Medical Association in rewriting the guidelines in gastroenterology for use by professional standards review organizations (PSROs). Under a subcontract from the AMA, the College administered the work of the combined committee. This committee was subsequently called upon by the American Medical Association to join with surgical societies to revise the *Criteria for Surgery in Gastroenterology.*

In 1979, the College considered *Guidelines for the Management of Patients with Gastric Ulcers*, which were submitted by the American Society for Gastrointestinal Endoscopy. These were approved by the College and widely promoted.

In 1981 the College, as a member of the Federation of Digestive Disease Societies, was the host organization for the Inter-American Society of Gastroenterology Meeting, which was held simultaneously with the annual convention of the College in Bal Harbour, Florida. Many attendees from Latin American countries were present for a highly successful scientific session.

While the Federation of Digestive Disease Societies eventually became defunct, several parallel structures have evolved over the years to improve coordination and communication among the American College of Gastroenterology, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy. In 1985 the three societies held their first tripartite meeting, a practice that continued and helped present a united front for many years.

ACG was beginning to grow in earnest, and disappointment with Digestive Disease Week was developing among practicing physicians. The leadership of AGA varied in their reactions to ACG. Dr. Walter Harvey Jacobs recalls working productively with his good friend Dr. Norton Greenberger, president of the AGA, and leadership cooperation truly began during Dr. Greenberger's tenure. Unfortunately, it did not always continue. The societies talked about joint programs and about avoiding sponsorship of programs that would compete with those of other organizations, but the record of both organizations has veered between competition and cooperation.

A Close Relationship with ACP and ASIM

A number of very distinguished leaders in the American College of Gastroenterology (ACG) have been associated with the American Society of Internal Medicine (ASIM). Their interests in the socioeco-

nomic aspects of medicine—and particularly gastroenterology—naturally led to their involvement with ASIM, and they were leaders at both the state and national levels.

Dr. William A. Millhon, MACG, was the first internist in the central Ohio area to pursue an active interest in the socioeconomics of internal medicine. He served as president of the Ohio Society of Internal Medicine in 1971 and as a trustee of the American Society of Internal Medicine from 1971 to 1979. A practicing gastroenterologist in Columbus, Ohio, Dr. Millhon sat on numerous ASIM peer review committees. He joined ACG in the early 1960s and became a fellow, then a trustee, and then vice president in 1982–83. He remained a delegate to the ASIM from the ACG for many years.

Bergein F. Overholt, MD, MACG

Dr. Bergein F. Overholt, MACG, served on the ASIM board of trustees from 1984 to 1987 and from 1988 to 1990. Dr. Overholt's vigorous input earned him the nickname of Rambo, and his championing of the cause of gastroenterology resulted in spirited debate and discussion. Dr. Overholt was an aggressive advocate of the high valuing of procedural services during a time when ASIM believed that cognitive skills should receive greater reimbursement than procedural skills.

Dr. Ronald L. Rucker, FACG, served on the ASIM board of trustees from 1989 to 1996 when the resource-based relative value scale (RBRVS) was being hotly debated, pitting the general surgical subspecialties against the internists on the issue of reimbursement. Dr. Rucker remembers that while there were clear differences of opinion between the general internal medicine group and the gastroenterology subspecialists, a high level of camaraderie and collegiality prevailed.

Dr. Richard D. Ruppert, FACG, served as a member of the board of trustees of ASIM from 1984 to 1994. During that time, he was president of the Medical College of Ohio in Toledo, Ohio. During his ASIM tenure, he served as chair of the finance committee, and as secretary/treasurer from 1987 to 1991. Dr. Ruppert spearheaded the move to purchase a building for the headquarters of ASIM rather than to continue renting space in Washington, DC. The building on Pennsylvania Avenue served as an excellent setting for the congressional efforts of the ASIM/ACP on behalf of internal medicine. Dr. Ruppert became president of ASIM in 1992, and his efforts led to an improved financial position for ASIM at the time of its merger with the American College of Physicians.

Dr. Bernard M. Rosof, FACG, served as trustee of ASIM and became president of ASIM. After the ASIM/ACP merger, he became a trustee and subsequently the chair of the Board of Regents of the newly merged organization.

Dr. John P. Papp Sr., MACG, served as trustee of ASIM from 1995 to 1998. After the ASIM/ACP merger, he served as a member of the membership committee of the newly formed organization from 1998 to 2000. He was president of the Michigan Society of Internal Medicine from 1983 to 1985. He became a member of the National Affairs Committee of the College under the leadership of Dr. Warren Nugent in 1980, and its chair from 1981 to 1985. In 1985, he became president of ACG. Dr. Walter Harvey Jacobs, MACG, was the ACG representative to ASIM for a number of years.

Rowen Zetterman, MD, MACG, served simultaneously as chair of the Board of Regents of the ACP and president of ACG during 2000–01. Numerous members of ACG have served as presidents of their states' internal medicine societies. Dr. James Borland, Jr., was president of the Florida Society of Internal Medicine and in 1973 was honored by ASIM as Internist of the Year.

John P. Papp, Sr., MD, MACG, testifies on Capitol Hill in 1986 regarding proposals for methods by which Medicare would pay physicians.

Interorganizational Collegiality Benefits ACG Members

The American College of Gastroenterology is grateful to have had outstanding leadership from the above physicians in the arena of the socioeconomics and politics of medicine. These members have served the American College of Gastroenterology and medicine as a whole with distinction. Throughout the years the College has had many fine officers who have, through their leadership, always sought to make ACG more responsive to the needs of the membership. Those officers and other leaders, representatives, and volunteers have cooperated with other societies to strengthen the specialty and will continue to do so.

Regional Contributions: Up Close and Personal

Philadelphia

The origins of the ACG in Philadelphia are now well recorded. In the 1930s, when the predecessor organization of the ACG was founded, gastroenterology, like most subspecialties, was small and gastroenterologists were few. One ACG member reported that when he trained at the Department of Medicine and Gastroenterology in the Graduate Hospital of the University of Pennsylvania, there were no more than twelve gastroenterologists in the Philadelphia region, most of them trained by Dr. Henry L. Bockus, head of the department. Bockus's influence on area gastroenterology was enormous and extended not just nationwide but worldwide. At that time, young gastroenterologists

were instilled with the impression that it was important to join the older, more established AGA. The story that often filtered down to trainees, rightly or wrongly, was that it was critical to join the older group first, and that if you joined the College first, you would not be accepted into AGA. Few then joined the College.

The American College of Gastroenterology started and thrived in New York, to a great extent dependent upon the large pool of New York physicians, some trained in Europe or in informal settings in this country, who were not accepted by the AGA. By making board certification a precondition to membership, older, more established medical societies in several specialties excluded many well-qualified physicians. The College offered these physicians a forum for advanced learning, representation and association with like-minded colleagues, and other benefits that a group membership promised to provide. The situation was quite different from that prevailing in Philadelphia, where similar pools of prospective members did not exist or were much smaller. The presence and potential vitality of ACG first became more prominent in Philadelphia when the division chief at Jefferson Medical College, the much revered Dr. Charles Wilmer Wirts, was about to become president of the ACG. He never told his colleagues much about the College and his role in it; decades later Dr. Franz Goldstein, who would himself become president of the College, recalls that his colleague Dr. Wirts never asked him to join, and Goldstein didn't until much later (1971–72). College events in Philadelphia centered on perhaps two College conventions in the 1960s at which Charles Wirts and Franz Goldstein presented papers. Meetings were small by comparison, few papers were submitted and presented, most papers were invited, and most of the discussion was provided by a panel of two College-appointed experts. To keep matters in perspective, meetings of the AGA in that era attracted several hundred attendees (not thousands as they do today), and papers submitted for presentation numbered no more than fifty, but admittedly there was then a substantial difference in the quality of papers and discussions.

A big change for the ACG in Philadelphia occurred in 1973 when Dr. Bockus was chosen to give the ACG Distinguished Lecture in Los Angeles and became an honorary fellow of the College. Dr. Bockus was impressed with what he saw, and somehow the message reached gastroenterologists in Philadelphia that the College was a high-quality organization worthy of membership. Since then the majority of clinical and increasingly gastroenterologists in academic practices have joined the College and some have taken on leadership positions. Dr. Goldstein noted particularly the late James L. A. (Jim) Roth, who served on the

ACG Board of Trustees and also received the College's highest award, the Clinical Achievement Award; Harris Clearfield, long-time Board of Trustees member and director of the GI Division at Hahnemann University Hospital; and Barbara Frank, outstanding governor for eastern Pennsylvania and a leader among women in American gastroenterology. While not in the strictest sense of the word a Philadelphian, Dr. J. Edward (Jack) Berk has been a lifelong distinguished associate of Philadelphia-trained gastroenterologists. He brought Dr. Bockus into the College, and many others followed. ACG leaders recognized Jack Berk's enormous contributions by naming an important lectureship in his honor. The David Sun lectureship honors another product of the Bockus Philadelphia school, and a distinguished ACG fellow. Dr. Franz Goldstein, in recounting his long and happy association with the College (culminating with the presidency in 1981–82), recalls trying several times to bring the annual convention to Philadelphia again, but somehow the plan did not work out, largely because the city lacked proper facilities for hosting such a meeting. The College is strong in Philadelphia; gastroenterologists know that the College offers them the best clinical information and the best meetings and courses as well as representation, and Dr. Goldstein's premonition that "perhaps someday the omission of Philadelphia as a meeting site for the ACG annual meeting may be corrected" has come to fruition with the 2007 annual meeting.

J. Edward Berk, MD, MACG

Florida

Dr. Arvey I. Rogers, ACG president in 1991–92, recalls that had it not been for Dr. Robert Berger (see chapter on the Board of Governors), he and others in Florida would probably never have become members of the American College of Gastroenterology. In the early 1960s the longer-established AGA was still considered the most prestigious national organization of gastroenterologists, especially for the university-based and academically oriented. Dr. Rogers became a member of the full-time faculty in the Department of Medicine at the University of Miami (UM), having just completed a two-year fellowship in gastroenterology in 1964. Sometime in the 1970s, the GI division at the University of Miami and the medical staff at Memorial Hospital in Hollywood, Florida, submitted a joint request to the state of Florida to receive grant support from resources made available through the newly established Community Hospital Education Act. Its purposes were to encourage staff physicians in community hospitals to contribute to and derive mutual benefit from participation in the training of future practitioners of medicine. The grant was approved, and Dr. Rogers, as

Arvey I. Rogers, MD, MACG

director of the GI training program at UM, along with trainees and faculty, was thereby brought into frequent contact with Dr. Robert Berger. Dr. Berger, a one-time vice president of ACG and an active, respected practitioner of clinical gastroenterology in southern Florida, believed firmly in the principles espoused by the College, principles that were being spread widely in both community and institution-based clinical circles. One of the first trainees to rotate through Memorial Hospital was Jamie Barkin, who joined the College because of Dr. Berger's influence, and when Dr. Rogers joined soon thereafter, a solid foundation for the College in south Florida was established.

The Florida Gastroenterological Society involved College leaders in its annual meetings, bringing their expertise to practicing gastroenterologists who in turn became increasingly involved in the College as members, governors, committee leaders, and members of the Board of Trustees. Drs. Jamie Barkin and Arvey Rogers ultimately served the College as presidents. The Fontainebleau Hotel on Miami Beach was the site selected for several annual meetings of the College, first in 1985 and then again in October 1992 when Rogers was ACG president. Although the College controlled the site selection, it could not control the weather: it was around that time that Hurricane Andrew unleashed Category 4 force on south Florida. According to Dr. Rogers, ACG's relationship with the AGA and ASGE was on solid ground, so it was easy to eliminate them as responsible for this catastrophe. Many homes and buildings were destroyed or sustained significant physical damage, including the Fontainebleau, and Dr. Rogers spent the days before his presidential address cleaning up debris in his own damaged home. The roof of the ballroom at the Fontainebleau was practically blown off by the hurricane's fury, but it was repaired before ACG attendees arrived. The Practice Management Syllabus assembled by Phil Grossman and the Practice Management Committee was one of the few items Grossman hand-carried when he was forced to abandon his home, which was largely destroyed. But spirits survived, and the meeting went off as expected, with excellent attendance at both the postgraduate course and the conference itself.

Jamie Barkin, MD, MACG

By providing leadership and innovation, Florida has played a significant role in the history and progress of the College. Membership in the College now numbers more than 10,000, with more than 650 of whom are registered Floridians, nine of which are masters (MACG). It is expected that Florida will continue to contribute to the growing recognition of the College as a major player in local and national arenas.

The South

The reflections of those who have experienced years of history are by

definition personal and subject to defects of memory and even inaccurate interpretation of remembered events or facts, themselves sometimes quite wrong. With that preamble Dr. James Achord contributed his reflections of the College and its evolution in the South during the years leading up to his presidency in 1983–84.

When he finished his training and joined the faculty of Emory University in Atlanta in 1962, Dr. Achord was naturally interested in joining the appropriate professional societies. At that time the AMA listed fewer than 500 to 600 physicians in the whole United States who considered themselves primarily gastroenterologists (there had been only 400 listed when Dr. Achord chose our subspecialty in 1960). The American Association for the Study of Liver Diseases (AASLD) had a very small membership and drew less than one hundred attendees to its annual meeting in Chicago. Like many other trainees, Dr. Achord had submitted research abstracts to and attended the meetings of the American Gastroenterological Association (AGA), so he applied for membership in both these organizations. He was accepted for membership in the AASLD but refused membership in the AGA because he had not passed his boards in internal medicine (a requirement that was changed in the 1970s). Achord remembers that he also asked his associates—all academics—about joining the American College of Gastroenterology (ACG), an organization that he remembers hearing about through then-current president, Dr. Max Berry of Atlanta (1965–66), who was immediately followed as president by Dr. John McMahon (1966–67) of Birmingham, Alabama. Dr. Achord's colleagues told him in strong terms to not consider joining this organization because it was "an old boys' club with poor scientific interests" and "almost anti-intellectual," and that membership could hinder Achord's academic career. Thus Achord did not pursue membership in the College at that time.

James Achord, MD, MACG

Dr. John Galambos, director of the gastroenterology division at Emory, told Achord around 1967 that he had had conversations with several prominent academic colleagues who felt that practicing gastroenterologists in the U.S. had no vigorous forum in which their clinical interests and concerns could be addressed. The national organizations concentrated heavily on research results that had little or no immediate application to the care of patients with gastrointestinal diseases. Further, the stringent time requirements for membership in the AGA excluded the large majority of practicing gastroenterologists, although they were encouraged to attend the annual meetings as guests. The ACG was at that time viewed as an ineffective organization, but it was the consensus of these conversations that the College potentially satisfied all the requirements of an organization that could meet the professional needs of the practicing gastroenterologist—in

fact, one of its original stated purposes was to address the continuing education of practicing physicians. What seemed to be lacking was leadership sufficiently experienced in continuing education to attract practical but scientific presentations for annual meetings and to renovate its existing governors' structure into a conduit for participation by gastroenterologists in the local communities. Academics, as a group, have three defined duties: education, research, and patient care. It seemed logical, therefore, to recruit experienced academics who recognized the national need for subspecialty continuing education in patient care in gastroenterology and were willing to contribute their efforts to invigorating the ACG for this purpose. Galambos and several others—including Dr. Jack Berk, who played a prominent role—began these efforts, and Dr. Achord joined the ACG in 1970 and was appointed governor of the Southeastern Region, consisting of Georgia, Alabama, and Mississippi. (Governors are now elected by the memberships of each state.) In 1976 the College sponsored the first of its regional postgraduate courses in Mobile, Alabama.

The membership began to grow and the annual meetings to improve in quality. Training program directors started to encourage their trainees to join the College and to submit abstracts of their research. Dr. Galambos served as president in 1974–75, and for Dr. Achord, this period marked the more obvious era of change in the ACG. On the solid leadership and example of southerners like Drs. Berry, McMahon, and Galambos, the acceptability of membership and active participation began to establish credibility for ACG on a national basis. During the tenure of Richard Farmer, Mr. Danny Weiss, the ACG's first executive director and son of one of the College's founders, reached retirement age, and a new executive director was employed after a careful search. With this move the College was essentially reorganized with monumental efforts of the Executive Committee under the direction of Dr. Farmer. During this time, the finances of the College were analyzed and presented to the membership in easily understood terms for the first time; previously financial data had been reported with a lesser degree of specificity by the executive director. The Board of Governors was, for the first time, given a stronger voice in the direction of the College, and governors were now elected, not appointed. The College tried with varying degrees of success to reach out to other subspecialty societies and attempted to form a society coalition that took several more years to be realized in any form. AGA leadership, we learned during this period, was not even aware that the ACG had annual national meetings. In the eyes of the GI community, the reputation of ACG had reached a real turning point for both practicing physicians

John T. Galambos, MD, MACG

and academicians. A reputation, however, is slow to change, especially one that is less than positive.

When Dr. Achord rose to the position of president-elect in 1982, then-President Jerry Waye began including the president-elect in all the president's plans and discussions. Since then, it has been customary for the president-elect to serve with the president rather than passively waiting his or her turn in office. It was Dr. Waye, building on the efforts of those before him, who emphasized the role of the ACG in clinical gastroenterology, and according to Dr. Achord, "My tenure as president was simply to try to implement all of Jerry's many excellent plans."

ACG has had many members from southern states active in the leadership of the College, both in elected and nonelected roles. Governors in all the southern states have very active state societies, and many have served on various committees. In addition to those presidents already mentioned, Myron Lewis (Memphis, 1987–88); Chesley Hines (New Orleans, 1988–89); David Graham (Houston, 1990–91); and Sarkis Chobanian (Knoxville, 1997–98) have all served the College with distinction and continue to contribute at both the local and national levels. In association with AGA and ASGE and with the efforts of many representing the College, ACG now testifies before Congress and regularly visits key senators and congressmen on legislation of concern to all gastroenterologists. The College initiated a research institute supporting the clinical research of applicants, which prospered with the strong direction of past President Joel Richter (1994–95), who is a southerner transplanted first to Cleveland, Ohio, and more recently to Philadelphia. The reputation of the College is now generally recognized as one deserving of respect. All members should be immensely proud of the College and its activities in support of education, research, and the practice of gastroenterology, not just in the South but throughout the nation and beyond.

California

The four-year period leading up to the 1994 World Congress of Gastroenterology in Los Angeles represented a model of cooperation and productive interaction among the leading GI societies in the planning of what would become the premiere worldwide event for practitioners of gastroenterology and endoscopy. The input and cooperation of ACG leadership greatly aided the processes of academic planning and logistical organization; the established base of College members in and around Los Angeles willingly and freely devoted time to the organization of this event. As nearly all the individuals in the local area who made a significant commitment were ACG members, it is not possible

Dr. and Mrs. Berk

to name each of them. However, several individuals should be singled out. (For the preparation of this report, the late Dr. Eric Lee, a prominent master of the College, former chair of the Archives Committee, and a contributor to the success of the world congresses, has provided important historical information concerning members of the College in the southern California area.)

Dr. J. Edward Berk, who has been honored with the Samuel S. Weiss Award for service to the College, played a key role in the development of the concept, the winning of the award, the implementation of the event, and ACG's participation in the congress. Without his leadership it is doubtful that the event would have occurred.

Dr. Albert Svoboda served as the liaison to the secretary general and carried out important elements of much of the logistical planning. Of special note is his leadership in the development of the Young Clinicians Program, an innovative component of the congresses that has become a valuable tradition. Dr. Melvin Schapiro represented the ACG in all aspects of coordinating this international undertaking.

Other southern California–based members have made notable contributions both to the field and to the work of the College. Angelo Dagradi completed his medical training in New York City and subsequently moved to California, where he spent most of his career at the Long Beach Veterans Hospital. His many years of practice were devoted to numerous publications and presentations at medical meetings. An active participant in the ACG and the ASGE, one-time president of both societies, and a Samuel S. Weiss Award honoree, Angelo Dagradi was a superb clinician who trained and inspired many future gastroenterologists and ACG members.

The late Dr. William H. (Bill) Bachrach, though not an active member of the College while he was in Los Angeles, encouraged its activities. Later, when he was the leader of the FDA GI drug division, he promoted the creation of the College's FDA-Related Matters Committee, which exists to this day and has proved highly important to the continued medical education of the College's membership.

Rudolph Schindler, the father of endoscopy, one of the founders of the ASGE, and contributor to a number of professional organizations, immigrated to the United States in the late 1930s. Initially he worked in Chicago, and after a brief stay in Brazil he worked in Long Beach, California. There he had a busy private practice and devoted a great deal of his time to the Long Beach Veterans Hospital. His teaching at the V.A. produced many fine endoscopists (and members of the ACG), some of whom achieved national prominence. Although a strict disciplinarian in the endoscopy unit, he was gentle and kind toward his colleagues and his students.

The rich tradition of the society and its members in the southern California area therefore provided a valuable base for the planning and support of the World Congress of Gastroenterology in 1994. The academic success, the attendance of more than twelve thousand individuals, and the subsequent financial reward provided to each of the consortium societies were due in no small part to the participation of the American College of Gastroenterology.