



CHAPTER 3

Making an Impact

The pace, stamina, and level of commitment required from ACG leaders have changed significantly over the years. During the late '70s and early '80s, meetings of the Board of Trustees were often scheduled between four-thirty and five o'clock in the afternoon and would often include dinner and run until eleven or twelve o'clock at night. The Credentials Committee report, one of the most time-consuming parts of the proceedings, would frequently last for two or three hours, and the training, education, commitment, and other qualifications of each person under review would be examined and assessed. The budget was usually a single sheet of paper passed out around ten o'clock, when everyone was exhausted and after some members had already drifted off.



Jerome D. Waye, MD, MACG

The Way to Change

Dr. Jerome Waye, who would ultimately be elected president of the ACG, had served previously as president of the ASGE and had a somewhat unique perspective on the problems of the College. In 1978, while serving as president-elect of ASGE and a trustee of the College, he attended a meeting of the ACG Board of Trustees. Having studied in great detail the budget and budgetary allocations of the ASGE, he applied what he had learned to evaluating the College's financial structure.

Having all these figures (from ASGE) swirling in my mind, I did a quick once-over of the ACG budget, which had been handed out. I was absolutely stunned by the lack of any money for committees to have meetings for the ACG. Less than one thousand dollars was allotted to each committee to have a telephone meeting or to meet during ACG week. There were no funds available for any committee to meet during the year. The committees did not have to meet because there was really nothing for them to do, since the executive director ran the entire organization.

The ASGE, by contrast, maintained extremely active committees that met frequently, had budgets of fifteen to twenty thousand dollars, and were an integral part of the vitality of the organization. On the other hand, ACG's operational expenses were absolutely staggering, the journal was losing money, and income from exhibits at the national meeting was practically zero. Dr. Wayne brought his perspective to the attention of the president, Richard Farmer, who rapidly reassessed the entire situation from his standpoint as chair and budget director of the Department of Medicine at Cleveland Clinic. The efforts of Wayne and Farmer set in motion a review of the entire committee and management structure and established the initial steps towards today's College structure of twenty-three active committees.

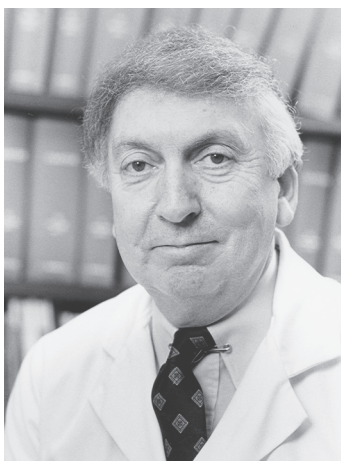
Restructuring: A Challenge Met Head On

During Dr. Richard Farmer's tenure as president (1978–79), the first retreat of the full Board of Trustees was held in 1979 at Hilton Head Island, South Carolina. This meeting signaled the beginning of a sustained, cooperative effort by the leadership to improve the organization. Dr. Farmer and a long line of presidents who followed him (Drs. F. Warren Nugent, Sidney J. Winawer, Burton I. Korelitz, Franz Goldstein, Jerome D. Wayne, and James L. Achord) took steps that accelerated growth and gave new direction to the College:



Drs. Farmer, Nugent, and Korelitz

- Appointing Arthur Liman as legal counsel to represent the College in the transition.
- Launching a national campaign to increase the membership in number and quality.
- Improving the recognition and authority of the Board of Governors.
- Composing a white paper on the goals of training in gastroenterology.
- Organizing cooperative sessions with the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy to provide a stronger voice in national affairs.
- Choosing a new publisher for *The American Journal of Gastroenterology*.
- Improving meetings and courses to better represent the mainstream of gastroenterology.



Sidney J. Winawer, MD, MACG

Years of Transition (1978–81)

Difficult transitional times under the presidencies of Drs. Farmer (1978–79), Winawer (1979–80), and Korelitz (1980–81) presented tremendous challenges for these three presidents and their boards of trustees and governors. Mr. Arthur Liman, a distinguished attorney who later served as chief counsel to a U.S. Senate committee during the Iran-Contra hearings, became involved in the ACG through his friendship with Dr. Korelitz. At that time, the Board of Trustees grappled with the challenges of transitioning from the legacy management style arising from the Weiss family to a broader-based management structure that could better address the College's increasingly diversified needs. Board and Executive Committee meetings were wrenching, with many longtime members strenuously opposed to any changes in the *status quo* out of a sense of loyalty to and friendship with Daniel Weiss. In the end these deliberations resulted in Mr. Weiss's relinquishing the responsibilities of executive director, and in turn the College made a commitment of resources for his retirement and health benefits.

The courage, commitment, and foresight of these three presidents in undertaking this difficult transition were truly pivotal in turning the ACG into a viable and progressive organization that has assumed its proper role as an organization that looks after both the practicing gastroenterologists and patients with gastrointestinal diseases. These leaders' steadfast pursuit of a larger vision for ACG laid the foundation for much of what has followed.

Management Change: A Pivotal Event in ACG's History

From 1983 to 1987 the ACG maintained a contractual relationship with Professional Relations and Research Institute Inc. (PRRI), a management organization with offices in Manchester, Massachusetts. This group had been managing the American Society for Gastrointestinal Endoscopy for many years. Mr. Gardner McCormick of that firm assumed the role of ACG executive director until 1987, with a brief period of involvement by Mr. Dan Barrett.

In October 1987 the Board of Trustees entered into an agreement with Association and Government Relations Management Inc. (AGRM) to assume all administrative functions of the College. Thomas F. Fise, Esq., president of AGRM, became executive director of ACG and for many years served the organization with unusual dedi-

cation, transparent accountability, and fiscal responsibility. It was during this time that ACG began the ascendancy to its current heights of success.

The Committees: Where the Hard Work Is Done

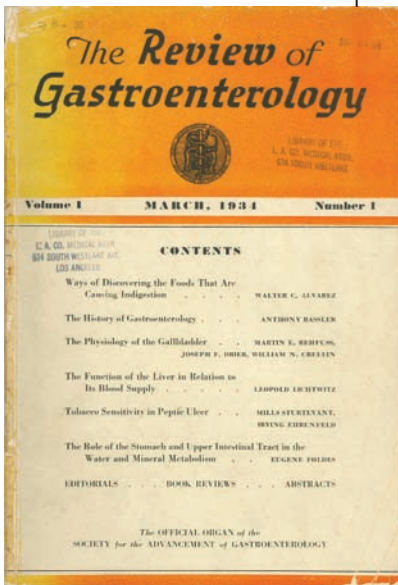
There are twenty-two working committees at the College. Ad hoc committees are established when necessary to achieve a short-term objective and either transition into a full standing committee or cease to exist when the objective has been accomplished or the need no longer exists. Committee responsibilities are delineated clearly in the ACG Bylaws (see Appendix I). Objectives change, sometimes annually, as new challenges occur, needs are recognized, and charges are issued by the Board of Trustees. A *Committees in Action* booklet is distributed to members on an annual basis; it includes a listing of responsibilities and objectives, a summary of accomplishments for the preceding year, and a statement of goals. See Appendix VI for a complete listing of committees, their responsibilities and objectives.

Daniel and Ida Weiss: A Posthumous Tribute to a Tenure Spanning Four Decades

The ACG's first executive director, Mr. Daniel Weiss, served the College for over 40 years, retiring in 1981. In addition to serving as executive director, he was also managing editor of *The American Journal of Gastroenterology* and organizer of all annual conventions, postgraduate courses, and postconvention trips. During most of these years the College headquarters was located at 299 Broadway in New York City. Most of the time it was a one-man operation, although occasionally Mr. Weiss had minimal additional help. During the latter years as executive director, his wife Ida was his chief aide. He had a hand in almost everything that happened in the College over those four decades, and it is clear that ACG would not be the organization it is today without his efforts.

The Journal

The evolution and maturation of the College is nowhere more evident than in its journal. A brief perusal of the initial issues reflects much about changes in medicine and society generally, as well as in the College and the field of gastroenterology.



ACG journal covers throughout the years: 1934, 1954, and 1994

From *The Review of Gastroenterology* to *The American Journal of Gastroenterology* (1934–54)

Almost coincident with its founding in November 1932, the Society for the Advancement of Gastroenterology undertook publication of a journal devoted to advancing patient care in the understanding and management of digestive disorders. In 1933 Samuel Weiss, MD, a charter member of the society, was selected as the first editor. The first issue of *The Review of Gastroenterology*, a quarterly publication, appeared in March 1934. A physician poll conducted in late 1938 indicated the desire to have the journal published more often, and the following year, publication was increased from four to six issues annually. In 1947, the number of issues published per year was increased to twelve, and the journal has remained a monthly publication for the past sixty years.

In the early years, because of the great number of members in Latin American countries, a Spanish language edition of the journal was initiated. Why it was discontinued after seven years is uncertain; more likely than not, cost was a consideration.

In 1954, *The Review of Gastroenterology* officially changed its name to *The American Journal of Gastroenterology* after permission was received from the publishers of a defunct journal by the same name. In the same year, the organization changed its name for the final time, to the American College of Gastroenterology.

Journal Editorship: Pruning the Family Tree

At the time Dr. Charles Wilmer Wirts of Jefferson Medical College in Philadelphia assumed the presidency in 1957, many on the Board of Trustees, with Dr. Wirts as leader, believed that the journal could be improved. It was the opinion of a number of College leaders that Dr. Samuel Weiss, who had been editor of the journal since its inception in 1934, should be replaced to allow for a fresh outlook.

Dr. John M. McMahan, ACG president from 1966–67, reports that his most vivid recollection of the College was the failed attempt to elect a new editor at the 1957 annual meeting. Dr. McMahan recalls that, although Dr. Wirts felt strongly about the need for a new editor, he made no specific recommendations for a successor candidate.

When the Wednesday noon meeting came, one of the items of protocol was to re-elect the editor-in-chief. And somebody made a motion that nominated Dr. Weiss and seconded it, and just like that, Dr. Weiss was back in office. With that, Dr. Wirts says, “I quit the College.” He got up and walked out of the room and we didn’t know where we were. Fortunately, Dr. Lynn Ferguson (1954–55) and Dr. Jimmy Nix (1955–56), two past presidents, and Dr. Joe Shaiken (1959–60), who would become President, all ran out after Dr. Wirts and brought him back in and made him reconsider. He fulfilled his year as president, and the crisis was over.

Dr. Weiss was replaced seven years later, in 1964.

A Great Tradition Begins with New Editors

From 1964 to 1972 the journal was edited by Dr. Milton Matzner, who was chief of gastroenterology at the Brooklyn Jewish Hospital in New York City. Throughout the early years, the journal published reviews, case reports, anecdotal material, and opinions of prominent gastroenterologists. In 1973 Dr. David Dreiling, a surgeon at Mount Sinai Hospital in New York, was chosen as editor and served in that role until 1978. He was highly respected in the field of pancreatology and made efforts through the Sinai group to increase author submissions and the quality of manuscripts. In 1979 Dr. Arthur Lindner of New York University became editor and changed the journal’s format from its small 6" x 9" dimensions to the traditional journal size with a new red cover that we now know as “The Red Journal.” Dr. Lindner, as one of the deans at New York University, further broadened the referral base of manuscripts. The journal went through a growth phase



Arthur Lindner, MD, MACG



Martin Floch, MD, MACG

at this time (1979–85), with increasing numbers of papers of higher quality.

Floch Sustains Journal on Upward Spiral (1986–91)

In 1985, Dr. Lindner's term concluded, and the role of editor was assumed by Dr. Martin Floch of Connecticut's Norwalk Hospital, a major Yale University School of Medicine affiliate. Dr. Floch had this recollection of how he became aware of his selection as editor: "I was attending the annual meeting in Toronto in 1985. At an exhibit in a Toronto museum, where I was relaxing after being interviewed by the journal editor search committee chaired by Dr. James Achord (College president 1983–84), someone suddenly came up behind me and said, 'You better do a good job!' That was how John Papp, College president (1985–86), let me know that the search committee had chosen me to take on the responsibility of building the journal to keep pace with the rapid growth of the College. I felt an awesome responsibility."

Given the large acceleration in the growth of ACG's membership, Dr. Floch and his associate editors adopted as a goal and model that *The American Journal of Gastroenterology* should be to the College what the *Annals of Internal Medicine* is to the American College of Physicians. They formally decided not to accept reports involving animal experimentation for publication and were determined to increase the quality of manuscripts. The journal was to reflect the high standards that the College was attempting to develop for the clinical practice of gastroenterology. During the years of Dr. Floch's tenure (1985–91), the journal's growth paralleled that of the College, and the *AJG* became highly respected. Not only did the number and quality of manuscripts improve greatly, but success was also reflected in its financial status: at one point during this period, the journal attracted more advertising pages than any other publication in gastroenterology. This was perceived as a challenge and stimulated changes in the most prestigious journal, *Gastroenterology*, as it sought to regain its leading advertising position.

As of the late 1980s the journal was publishing almost two thousand pages per year of high-quality manuscripts. In 1991 the search committee selected Rowen Zetterman, MD, of the University of Nebraska to replace Dr. Floch, and Dr. Zetterman further increased the quality of the manuscripts published. *The Red Journal* was beginning to challenge all other journals as the leading publication in clinical gastroenterology.

**Quigley and Elsevier Science Inc.
Spotlight The Red Journal (1997–2003)**

At the same time that ACG leaders were selecting a new editor, they set up a bidding process for a new journal publishing contract. Although at the beginning they expected to renew the contract with Williams & Wilkins, they received a very compelling offer from Elsevier, which outlined big plans for *The Red Journal*. Williams & Wilkins offered to match any offer, but the College finally decided on Elsevier, the world’s largest journal publisher.

Dr. Marvin Schuster recalls as one of the more pleasant jobs of his 1996–97 presidency the process of choosing the new editor of the journal. “It was a pleasure because of the talent that we had before us to choose from. It was sad because we were losing an absolutely superb editor, Dr. Rowen Zetterman (1992–97), but we replaced him with another superb person, who had been his associate and was recommended strongly by Dr. Zetterman as his replacement. Eamonn M. M. Quigley was chosen, and he really brought the journal to even greater heights in just one short year. We have been, for some time, the premiere journal among clinical gastroenterologists.” Dr. Quigley completed his six-year term as editor in 2003 and, with his staff of associate and contributing editors, sustained the high quality and outstanding attributes of the journal as the leading clinical journal in gastroenterology.



Eamonn M. M. Quigley, MD, FACC

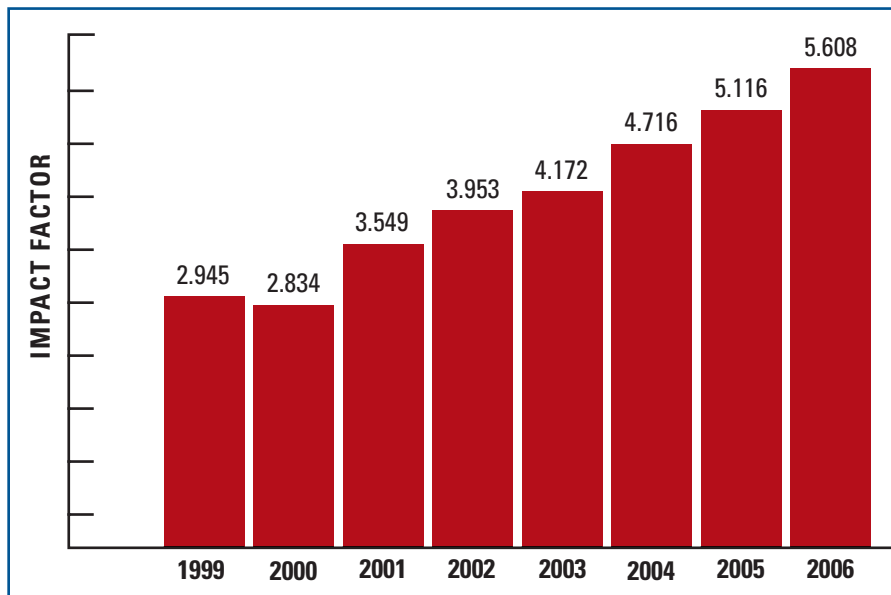


TABLE 1
The American Journal of Gastroenterology
IMPACT FACTOR
1999–2006



Joel E. Richter, MD, MACG



Nicholas J. Talley, MD, PhD, FACP

Co-editorship: A Decision with Positive Results

Late 2003 marked another unique benchmark, with Drs. Joel E. Richter, MACG, and Nicholas J. Talley, PhD, FACP, becoming the first coeditors and assembling an incomparable array of talent among the U.S. and international associate editors. They began their tenure with a new publisher, Blackwell Publishing, that provides full online access and greatly enhanced web presence, ushering in a brand new era of enhanced capability and mission for the journal. An editorial published in 2006 provides a review of recent journal successes (Richter JE and Talley NJ: *The American Journal of Gastroenterology* 2005: Another Great Year. *Am J Gastroenterol* 2006; 101: 683–685). Table 2 below presents the overall impact factor of the top ten journals in gastroenterology and hepatology for the years 2003 and 2004. The journal is the only one in the top ten for gastroenterology that has shown consistent improvement over the last four years, up from 3.549 in 2001.

Over the past seventy-five years the College's flagship publication has grown from a review article journal to what is now the leading clinical reporting and research journal in gastroenterology. The following tables reflect this progress.

TABLE 2

THE AMERICAN JOURNAL OF GASTROENTEROLOGY PUBLICATIONS, 1954–2006

Topic	Number	Years
Crohn's	697	1971–2006
Ulcerative Colitis	751	1957–2006
GERD	292	1982–2006
IBS	225	1967–2006
<i>H. pylori</i>	827	1990–2006
<i>C. pyloridis</i>	6	1987
Motility	408	1954–2005
Colon Cancer	122	1977–2005
EUS	76	1990–2006
Colonoscopy	645	1971–2006
Gastritis	489	1953–2006
Hepatitis	1307	1954–2006
Constipation	237	1956–2006
Anorectal Manometry	30	1980–2006
Pancreatitis	742	1955–2006
Esophagitis	457	1954–2006
Barrett's Esophagus	278	1978–2006

Resource: PubMed Search

TABLE 3

THE AMERICAN JOURNAL OF GASTROENTEROLOGY EDITORS

Editors-in-Chief	Years
Samuel Weiss	1934*–64
Milton J. Matzner	1965–72
David A. Dreiling	1973–79
Arthur E. Lindner	1980–85
Martin H. Floch	1986–91
Rowen K. Zetterman	1992–97
Eamonn M. M. Quigley	1998–2003
Joel E. Richter and Nicholas J. Talley	2003–present

*Published as *The Review of Gastroenterology* until 1954

Organizational Names Under Which the Journal Was Published

1934–35: Society for the Advancement of Gastroenterology

1935–37: National Society for the Advancement of Gastroenterology

1938–54: National Gastroenterology Association

1955–present: American College of Gastroenterology

Journal Names

1934–53: *The Review of Gastroenterology*

1954–present: *The American Journal of Gastroenterology*

Publishers

1934–80: American College of Gastroenterology

1981–97: The Williams & Wilkins Company

1997–2004: Elsevier

2004–present: Blackwell Publishing

Climbing the Hill (National Affairs)

Many ACG members have contributed remarkably to the College's efforts in advocacy and legislation. Leadership in this area has been exemplified by the time and talents dedicated by the individuals who have served as chairs of the ACG National Affairs Committee: John Papp, Edwin Cohn, Sarkis Chobanian, Michael Van Ness, Luis Balart, Jay Popp, Ron Vender, and now Edward Cattau. The National Affairs Committee's mission is set forth succinctly in ACG's constitution/bylaws: to coordinate "all activities between the College and professional and lay organizations, including government agencies at all levels."

Entering the Playing Field

By the early 1980s the signs were on the horizon that political issues were going to take on a fundamental role in defining the future of medicine, from the standpoint of both maintaining the viability of physician practices and providing quality patient care. The complexities of precertification, preferred providers, escalating malpractice costs, and managed care were unavoidable to those who were going to practice in the GI field. At this point ACG was growing, but it was still a small organization with only a few largely inactive committees.

In 1985–86, ACG president Dr. John Papp, a private practitioner from Michigan, had the vision to see that it was essential for the College to become more active in public policy issues. Dr. Papp took on the task of building a stronger ACG national presence in discussions that had the potential of influencing the social and economic aspects of medicine as they were to affect gastroenterologists and their patients. He recruited Dr. Edwin Cohn of Pennsylvania to assume the responsibility of chairing the National Affairs Committee, and Papp devoted huge amounts of his time in traveling to Washington, DC, to meet with legislators and regulators, and represent the College. In February 1989 the ACG Board of Trustees invited Rep. Henry Waxman (D-CA), one of the leading voices in the Congress on health care matters, to meet with the board at a meeting in Santa Barbara. By that time, Dr. Sarkis Chobanian had assumed the role of chair of the National Affairs Committee. Important relationships were being established, and the ACG was acquiring the skills to function with increasing effectiveness in the national affairs arena.

Learning the Alphabet: HCFA, RBRVS

From these beginnings, the demands on the College's National Affairs Committee expanded quickly, particularly when the federal government enacted major changes in Medicare payment, adopting a proposal to move from the traditional fee-based system to an approach called resource-based relative value scale (RBRVS) that had been championed by Harvard public health guru Dr. William Hsiao (who spoke at the 1989 annual meeting). In early 1991 the Health Care Financing Administration (HCFA) began the formal process of implementing the RBRVS and, at the same time, proposed to treat endoscopic services under a global fee. ACG's leadership aggressively urged all members to take an active role by submitting comments opposing the endoscopic global fee and the major GI reimbursement cuts. ACG's constituency filed several thousand comments with HCFA, the second largest volume filed on any single component of the entire Medicare fee schedule

rule. ACG president David Graham met with HCFA officials, and in the end the ACG position was adopted in significant measure as HCFA backed off on the global fee and provided some relief from major GI cuts. In October 1991 Rep. Waxman spoke at the ACG annual meeting in Boston and informed the audience that it appeared likely that HCFA would relent on its global fee proposal for endoscopy. By the close of 1991 ACG had delivered on its pledge to support the interests of practicing gastroenterologists in the political arena.

Hiring Skilled Legislative Representatives

Shortly after his election to the presidency in November 1992, Bill Clinton announced his intention to adopt a broad-based plan for health care reform, primarily to help address the problem of the 37 million Americans who were uninsured. President Clinton surprised the Washington establishment by appointing his wife, First Lady Hillary Rodham Clinton, to head up the health care reform effort. Having already seen huge cuts in payment when the Hsiao methodology was first enacted in 1992 and convinced that issues fundamental to the survival of private practice medicine were at stake, the ACG Board of Trustees took some bold steps when they met in March 1993 during the presidency of Dr. Lawrence J. Brandt. The Board accepted a proposal to retain the firm of Patton, Boggs as legislative counsel, with ACG's primary contact being Mr. Tom Scully, who had just joined the law firm after a stint as a leading health care adviser to former President George H. W. Bush in the post of associate director of the Office of Management and Budget.

An Action Plan Evolves

The board also adopted an action plan, which had as one of its fundamental tenets that ACG would work for enactment of a Medicare colorectal cancer screening benefit. The second part of the ACG's agenda, as Dr. William Carey (1993–94) recalled, was to attempt to mitigate the draconian alteration in the medical playing field in which managed care operations, owned by for-profit insurance companies, were increasingly successful in setting the rules of medical practice and reimbursement. This new playing field maximized value to shareholders rather than to the patients insured. Gastroenterologists and other physicians who actually performed the work were increasingly marginalized. Among the pieces of ACG's legislative agenda were attempts to modify a major initiative of the White House to deliver health care in such a way as to empower primary care providers and disenfranchise specialists. Lobbying in Washington became a high priority for Dr.



Drs. Brandt, Van Ness, Richter, and Carey with Tom Scully and well-known journalist Bob Novak at the ACG 1993 Annual Meeting in New York City.

Carey and for many other ACG leaders. ACG officers, the members of the Board of Trustees, and some members of the College spent valuable time speaking and advocating effectively with senators, representatives, and the White House on both the colorectal cancer screening bill and the HCFA practice expense component.

The board recognized that these efforts would be expensive, and the most controversial of its actions, in March 1993, was the enactment of a one-time mandatory special dues assessment of \$150 to help cover the costs of the College's efforts on behalf of its members and their patients relating to health care reform. The move was controversial: AGA and ASGE declined to join with ACG in this initiative, and over 100 ACG members resigned in protest. Also in 1993, executive director Tom Fise and the College's lobbyist, Tom Scully of Patton Boggs began to make inroads into the Washington scene. The College, with its presence in Washington, DC, increased communications with all members of the organization. At the 1993 ACG annual meeting in New York, this intensified commitment to national affairs was readily apparent as Rep. Pete Stark (D-CA), Senator David Durenberger (R-MN), and columnist/pundit Robert Novak spoke to the ACG audience.

ACG Leaders Visit and Educate Legislators

ACG members began to visit Washington more frequently, and they were surprised at how often a legislator or aide would mention a relative who had either been diagnosed or died from colorectal cancer. The state of knowledge on Capitol Hill was quite primitive—virtually no one knew what a flexible sigmoidoscopy was, or even how to pronounce *colonoscopy*. Many times during meetings, lawmakers or staff members would confuse colon cancer and prostate cancer. The ACG recognized the need to both educate and inform.



Tag teaming the House Ways & Means Committee Chair Rangle on colon cancer screening; from left: Arthur H. Aufses, Jr., MD, MACG; U.S. Representative Charles B. Rangle (D-NY); LaSalle D. Leffall, Jr., MD, FACS, FACG.

ACG's increasingly active role in the public policy arena during the 1990s has not been without controversy. Our strategies and tactics have occasionally been labeled overly aggressive by some individuals and, on a few occasions, even by other gastroenterological organizations. In 1991 our aggressive challenges to HCFA's efforts to both implement the physician fee schedule and establish a global fee for endoscopy brought complaints from



ACG officers and trustees at White House policy briefing, Old Executive Office Building, 1997.

some who thought that mobilizing members to submit large volumes of comments to HCFA was dangerous. Even after HCFA sifted through more than 1,500 comments from gastroenterologists and essentially decided to drop its endoscopic global fee policy, some of the more conservative voices in the GI field maintained that the policy change had been made despite the large volume of comments engineered by ACG, not because of them.

Conflict within the Gastroenterology Leadership Council

In 1993, some members of the Gastroenterology Leadership Council (GLC) raised questions about the hiring of Patton Boggs to represent the College. At least one of the other GI organizations objected that it was inappropriate to speak with legislators about physician reimbursements and payment levels. The challenge was a serious one, and the Honorable Edward Madigan, former congressman and secretary of agriculture, was engaged by the GLC to serve as a mediator of the dispute. Each organization presented a written brief of its position to Mr. Madigan, and a meeting was held to receive his feedback. His judgment was that his mother would probably be pleased to know that some physicians thought it inappropriate to speak to legislators about fees, but that if she agreed with those who opposed discussing fees with legislators, she would be wrong.

ACG Goes Head to Head with HCFA

The second major issue for which the College fought strongly, this time both independently and hand-in-hand with the other GI societies, was

the practice expense component proposed by HCFA, which would have resulted in a monumental redistribution of reimbursement among the various medical and surgical specialties. Congress had challenged HCFA's plan several years previously by performing a two-year study on the issue and deriving a formula for reimbursement based on that study. The study was never started, but numbers were still proposed because the congressional deadline loomed. Within one year this formula would have resulted in a 21 percent to 25 percent decrease in reimbursement to gastroenterologists and a similar decrease to cardiologists, surgeons, and some other specialists, whereas at the same time increasing reimbursement to chiropractors by 54 percent.

Around 1994–1995, in the matter of HCFA's practice expense proposal, ACG was asked by its sister organizations to help in fighting this battle. All groups agreed that it was important to work within a broad national Practice Expense Coalition composed primarily of medical and surgical subspecialties. ACG had independently already established and activated an action plan, and it invited its fellow GI societies to join in that effort. They decided not to participate, so ACG continued to pursue its plan while also committing its share to the National Practice Expense Coalition. ACG sent eight separate mailings to its members on this issue, and as a result HCFA received approximately 2,000 letters of objection from ACG members and their staffs, their family members, and GI patients opposing HCFA's proposed practice expense policy. ACG submitted a massive seventy-two-page set of comments to the Department of Health and Human Services on behalf of clinical gastroenterology.

The interim result of ACG's independent and combined efforts was that a change in reimbursement schedule was postponed for one year, allowing time for HCFA to have a study performed and to come up with appropriate figures that had been lacking. Included also was a four-year phase-in period for implementing the new rule. This move represents a compromise over the two-year delay proposed by the ACG and the coalition of GI societies.

Colon Cancer Screening Legislation: ACG Puts Patients First

ACG simultaneously carried out an extensive educational program to convince Congress to recognize the value of colorectal cancer screening as a way of reducing the impact of colon cancer in the United States. By now, and largely due to the efforts of ACG, there is widespread acknowledgment among scientists, health care policymakers, and legislators about the value of colorectal screening. At the time of these first legislative efforts, however, discussion of anything related to the colon was taboo, and there was no recognition of colorectal cancer as a pub-



ACG allied with patient advocacy group to lobby key health care player: U.S. Representative Henry Waxman (D-CA) is flanked by physicians and patients with an interest in digestive health. On the left is Michael VanNess, MD, FACC; David Fleischer, MD, FACC; and William D. Carey, MD, MACG. Behind the congressman is ACG's Tom Fise. Also pictured (front row, third from right) is Suzanne Rosenthal, founder of the Crohn's & Colitis Foundation of America and an active advocate for the Digestive Disease National Coalition. The others pictured are patients visiting Capitol Hill offices with ACG physicians.

lic health menace. In 1993 Medicare not only failed to reimburse for screening procedures, but physicians who offered such procedures for their Medicare patients were legally required to inform them that the tests were not medically necessary.

ACG delegations of members and patient-advocates began to visit regularly with members of Congress. Visits were coordinated by Tom Scully, who would go on to be appointed director of the Centers for Medicare and Medicaid Services by President George W. Bush (and after completing his stint of government service, recently returned, albeit a bit older and wiser, to work once more on behalf of ACG). The College received major internal support for these efforts from Michael Van Ness, chair of the ACG National Affairs Committee.

It was at this pivotal time that the College, long recognized for its competence in medical education, added a new feature to its mandate: to become a strident and vigorous advocate for the patient. As simplistic as this appears, the College insisted on doing the right thing for the patient—namely, pursuing colonoscopy as the most productive and effective screening method for colorectal cancer. In doing so, the College became a target for those corporations and organizations intent on seeing an x-ray exam as an equivalent Medicare benefit. The College steadfastly maintained its position in discussions with the leadership of our sister GI organizations and spent time, energy, and a considerable portion of our annual budget in Washington meetings with legislators.

In August 1997 ACG president Marvin Schuster was invited to the White House for the ceremony when President Clinton signed the bill that created the Medicare colorectal cancer screening benefit. Congressman Ben Cardin (D-MD), who had worked with ACG, introduced the

bill to make the change. On November 1, 1997, the secretary of the Health and Human Services Department published in the Federal Register regulations that are favorable to fiber-optic sigmoidoscopy and colonoscopy, although barium enema is allowed under some circumstances. Routine use of barium enema was discouraged by the requirement that the procedure must be ordered specifically by physicians, who must also document justification for its use.

Issues in the New Millennium

Reimbursement Relief for Colorectal Cancer Screening

Since 1997, when colon cancer prevention was identified as a congressional priority with the enactment of a screening benefit, the utilization rate for screening colonoscopy among Medicare beneficiaries has been slow to rise—according to one government study, there has been only a

1 percent increase. In part, at least, this appears to be related to the nearly 35 percent decrease in reimbursement for colonoscopy when performed in an ambulatory surgery center (ASC) or hospital outpatient department (HOPD).

The Colon Cancer Screen for Life Act of 2005, a legislative attempt to rectify this situation, remains the number one national affairs priority of the American College of Gastroenterology. In 2005, this legislation was first introduced in the House of Representatives by congressmen Phil English (R-PA) and Ben Cardin (D-MD) and in the Senate by senators

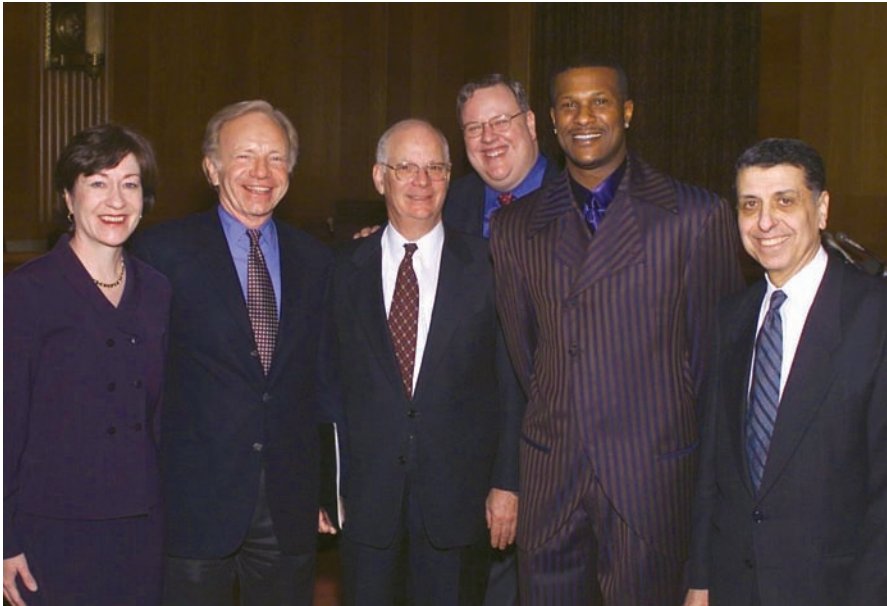
Rick Santorum (R-PA), Joe Lieberman (D-CT), and Susan Collins (R-ME); the bill is based on similar legislation to increase utilization of cervical cancer screening. It would:

- a. Increase reimbursement for physicians performing colonoscopy in a facility by 30 percent, and in an office setting by 10 percent;
- b. Cover the preoperative visit for a Medicare screening colonoscopy; and
- c. Waive the Medicare deductible for beneficiaries undergoing a screening colonoscopy.

The College continues to work to get the bill passed by Congress. Reintroduced in the 110th Congress, at the time of this writing the bill enjoys the support of nearly seventy members of both the House and



Maryland constituent meeting on Capitol Hill: ACG Past President Marvin M. Schuster of Baltimore lobbies U.S. Representative Steny Hoyer (D-MD) on ACG's colorectal cancer screening priorities.



At the introduction of Screen for Life legislation in 2002: Senator Susan Collins (R-ME), Senator Joseph Lieberman (D-CT), Representative Ben Cardin (D-MD), Representative Phil English (R-PA), baseball's Eric Davis, a colon cancer survivor, and ACG's President Edgar Achkar, MD, FACC.

the Senate. ACG has conducted a number of legislative fly-ins to Washington, DC, and is making progress in garnering the support of members of the Senate Finance Committee.

Washington, DC, Legislative Fly-Ins

ACG has been aggressive in taking its public policy message to Capitol Hill. The immediate beneficiaries of these visits were the Colon Cancer Screen for Life Act bills in the House and Senate. Many of the cosponsors gained valuable background information as a result of visits by ACG members to their state's senators and members of Congress. The ACG Board of Governors fly-in in April 2005 was particularly successful, with more than forty ACG physicians participating. All told, ACG members, including committee members Dr. Cattau, Dr. R. Bruce Cameron, Dr. Raquel Croitoru, Dr. Robert Herring, Dr. F. Wilson Jackson, Dr. Harry Sarles, Dr. Colleen Schmitt, Dr. Scott Tenner, and Dr. Waring Tribble, visited more than three hundred congressional offices in 2005 over the course of five scheduled fly-ins. Nothing is more effective in educating legislators about ACG public policy concerns.

ACG Continues to Reap Benefits from Top-Notch Legislative Team

Much of ACG's success in gaining support for the Screen for Life Act by key members of the Senate and House can be attributed to the outstanding legislative team put together during 2004. Former Centers for Medicare and Medicaid Services administrator Tom Scully and his

stable of former Senate Finance Committee staff at Alston & Bird, LLP, have played an invaluable role in providing counsel on matters before Congress as well as CMS. The Washington lobbying firm of Fierce, Isakowitz & Blaylock is a powerhouse on Capitol Hill. Principal Mark Isakowitz and his associate Kate Hull provide access to and understanding of the congressional process. Of course, ACG continues to rely on the guidance of longtime representatives John Jonas, Martha Kendrick, and their health policy associates at Patton Boggs in the College's interactions with key legislators and administration figures.

Support Repeal of the Sustainable Growth Rate Formula (SGR)

ACG remains committed to working with organized medicine to reform the Medicare physician fee schedule and the sustainable growth rate (SGR) formula that annually threatens the Medicare reimbursements provided to physicians. The College joined numerous physician specialty societies and state medical societies in signing letters to Congress calling for a repeal of the SGR, removal of drugs from the physician payment formula, and the development of a new formula based on the Medicare Economic Index (MEI), which provides a more accurate picture of the actual costs of physician services. ACG also sent letters to Senators Jon Kyl (R-AZ) and Debbie Stabenow (D-MI) and Congressmen E. Clay Shaw (R-FL) and Benjamin Cardin (D-MD) praising them for introducing legislation in their respective chambers to provide Medicare payment increases to physicians while Congress and/or CMS develops a replacement for the SGR.

Pay-for-Performance/Value-Based Purchasing

The most talked-about Medicare trend in recent years has undoubtedly been pay-for-performance (also known as P4P) or value-based purchasing. Legislators in both the House and Senate have advanced P4P proposals, as has CMS, backed by the Bush administration. The National Affairs Committee continues to closely track these bills, since Congress is eager to couple them with payment reform legislation, i.e., elimination of SGR. However, current proposals do not include any additional overall funding for the Medicare program but would instead shift funding allocations according to conformity with certain basic quality measurements. Both the Congressional and CMS proposals would initiate information technology and data collection requirements, and it is still unclear whether—and if so, how—funding would be provided to physician offices for these mandates. Nevertheless, the committee and a select ACG Task Force on Quality are working with independent quality organizations, such as the National Quality Forum, as well as our fellow GI societies to develop appropriate qual-

ity performance measures for key gastroenterological practices and procedures.

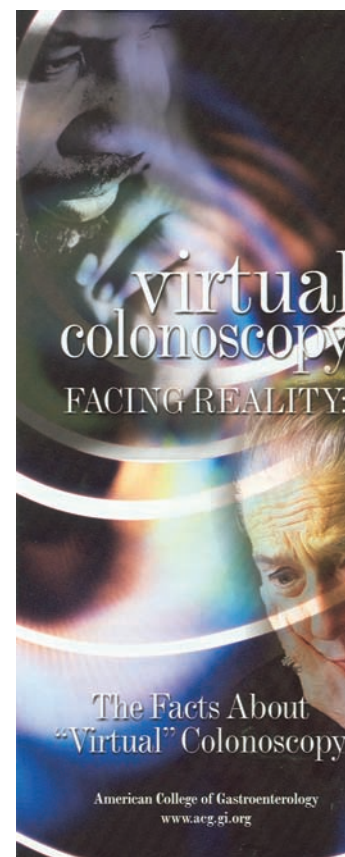
Five-Year Review of Current Procedural Terminology (CPT) Code Values

Recently Medicare's periodic review of procedure codes called for review of CPT 45378 (diagnostic colonoscopy) and CPT 45330 (diagnostic sigmoidoscopy). CMS also included a few key endoscopic base codes in its mandatory five-year review process underway in 2005, including 43235 (upper GI endoscopy, diagnosis) and CPT 43246 (place gastroscopy tube). ACG took its case directly to key CMS officials in Baltimore and Washington in order to underscore that the College believed GI endoscopic codes were already significantly undervalued and, furthermore, that the existing five-year review process would do nothing to ameliorate the current payment inequities but could deal an additional serious blow to the utilization of colorectal cancer screening. Of particular concern was ACG's past experiences with CMS surveys and processes in valuing the work and practice expenses associated with GI procedures (as has been noted in ACG's annual comments to CMS' physician fee schedule rules since the initial implementation of the RVRBS valuation system).

CT Colonography ("Virtual Colonoscopy") and the Future of Office-Based Imaging

The National Affairs Committee continues to monitor the advancement of CT colonography and, in particular, the efforts in many states to expand the indications for its approved use by private payers. Randy Saliars, MD, FACG, ACG governor and Medicare's Carrier Advisory Committee (CAC) representative for Wisconsin; R. Bruce Cameron, MD, FACG, ACG governor for northern Ohio and National Affairs Committee member; and former ACG president Douglas K. Rex, MD, FACG, were all very helpful in formulating a timely response to a draft local coverage decision (LCD) on the appropriate indications for use of CT colonography in the Wisconsin Physicians Service (WPS) health insurance territory. The committee expects to see more of these LCDs in the years ahead.

ACG recently joined the Coalition for Patient-Centered Imaging (CPCI), a multispecialty coalition primarily concerned with physicians' retaining the ability to provide office-based imaging services. A 2005 Medicare Payment Advisory Commission (MedPAC) report on Medicare Part B (physician services) program cost increases leveled criticism at imaging services in general, claiming that 18 percent of the increase in Medicare spending was due to increases in imaging services.



One of the first brochures ACG created that highlights the differences between standard colonoscopy and virtual colonoscopy and why standard colonoscopy is considered the gold standard in screening

However, there was no evidence in the report that inappropriate provision of imaging services was the cause of the increase, especially as many of the services are moving to the less expensive office setting. Drs. Cattau and Roy Wong, MD, FACG, participated in a CPCI-organized fly-in to Washington in July 2005 in order to advocate for the continued ability of physicians to own and operate imaging equipment and read the scans in their offices.

Site of Service

The site-of-service differential that reduces practice expense payments for services provided in a facility has been fully implemented by CMS. Nevertheless, ACG continues to seek a remedy to reverse this misguided policy. Some highlights of the flawed assumptions of the site of service changes include:

- a. The U.S. Government Accountability Office (GAO) released a flawed site-of-service study in October 2002, claiming, among other things, that they found no difference in the level of safety among office-, ASC-, and HOPD-based procedures—based on a single study of physicians' offices in France.
- b. A September 2003 study in the *Archives of Surgery* contradicted the GAO study. The study, which was conducted in Florida, found that certain GI endoscopic procedures (as well as other, non-GI procedures) were much less safe in office settings as compared to ASCs.

The College has also consistently filed comments at CMS articulating the College's argument in opposition to the site-of-service policy.

ACG National Affairs Website and Online Advocacy Tool

ACG has unveiled a new national affairs section of the ACG website where members can download the College's testimony before congressional committees, comments to federal agencies, and briefs on key policy issues. The site enables members to email their state and federal representatives about health legislation and other medical policy matters. This new tool ensures that ACG members are educated on key policy issues and can amplify the College's message in the halls of Congress.

Medical Liability Reform

ACG's National Affairs Committee agenda includes ongoing monitoring and activities in support of medical liability reform legislation on the federal and state levels.

COMMITTEE CHAIRS

1984–85	John P. Papp, MD, MACG
1985–86	Edwin M. Cohn, MD, MACG
1986–87	Edwin M. Cohn, MD, MACG
1987–88	Edwin M. Cohn, MD, MACG
1988–89	Sarkis J. Chobanian, MD, MACG
1989–90	Sarkis J. Chobanian, MD, MACG
1990–91	Sarkis J. Chobanian, MD, MACG
1991–92	Sarkis J. Chobanian, MD, MACG
1992–93	Michael M. Van Ness, MD
1993–94	Michael M. Van Ness, MD
1994–95	Luis A. Balart, MD, MACG
1995–96	Luis A. Balart, MD, MACG
1996–97	Luis A. Balart, MD, MACG
1997–98	John W. Popp Jr., MD, FACG
1998–99	John W. Popp Jr., MD, FACG
1999–2000	John W. Popp Jr., MD, FACG
2000–01	Ronald J. Vender, MD, FACG
2001–02	Ronald J. Vender, MD, FACG
2002–03	Ronald J. Vender, MD, FACG
2003–04	Ronald J. Vender, MD, FACG
2004–05	Edward L. Cattau Jr., MD, FACG
2005–06	Edward L. Cattau Jr., MD, FACG
2006–07	Edward L. Cattau, Jr., MD, FACG

The Many Faces of ACG Clinical Research Support

Founded in 1980, the Research Committee oversees, in the ambitious words of the ACG constitution, “all research projects of the College including, but not limited to, the development of clinical research activities and the establishment of a clearinghouse for scientific studies and investigations in the field of clinical gastroenterology.”

Clinical Research Comes Alive

In 1980 the ACG was a small organization with a limited budget. Despite these difficulties, however, the visionary leadership made the commitment to move in new ways to support the present and future needs of the clinical gastroenterologist. The first Research Committee chair, Dr. Francis Tedesco, charged the committee to find out how it could function most effectively in the College and to identify what it should be doing and where its energies should be placed. Options

included surveys, clinical trials using the membership as the base to enter cases, and the soliciting and funding of clinical research proposals.

The first serious approach was to try to identify areas in which questionnaires could be used effectively. Drs. John Papp, Eric Lee, Simmy Bank, Frank Lanza, Richard McCallum, Esam Dajani, Jerome Waye, Martin Lipkin, Michael Mogadam, and Richard Wechsler were early and active members of the Research Committee. The initial meeting in 1981 produced a number of protocols for discussion, including suggestions for studies on acute pancreatitis, peptic esophagitis, liver biopsy, and percutaneous biliary drainage.

Graham Provides Needed Leadership

One evening in 1980 Dr. David Y. Graham received a phone call from Dr. Burton Korelitz, then president of the ACG (1980–81), who asked him to become involved in the College's Research Committee. Dr. Korelitz exercised considerable foresight with his invitation to Dr. Graham, who had a secure reputation as a respected investigator.

Dr. Graham accepted the chairmanship of the committee in 1982. The first projects to get off the ground were two clinical projects to which the membership could submit cases: the ACG Barrett's registry and a study of the natural history of colon polyps containing invasive carcinoma. Despite the committee's enthusiasm, it soon became clear that the membership's support of the prospective studies in Barrett's esophagus and colon polyps was less than expected, and those projects were reluctantly discontinued. Nonetheless, support for clinical research within the College flourished. The committee began to take on a life of its own, and new members included Drs. James Achord, Scott Brooks, Thomas Humphries, James Borland, and Michael Sivak.

Dr. Achord suggested a program in which the ACG could award grants for original clinical research in gastroenterology, and the Board of Trustees adopted the suggestion. Forty-eight grant applications were received, and the board approved three grants upon recommendation of the Research Committee. In 1983 the ACG was able to announce the recipients of three \$5,000 research awards: "The cholesterol-octonate breath test" by Steven Cole, University of California at San Diego; "The effect of thickened feedings on infant gastroesophageal reflux" by Susan Orenstein, University of Tennessee Health Science Center; and "Endoscopic-hematoporphyrin derivative detection in early neoplasia and ulcerative colitis, Barrett's esophagus, and villous adenoma" by Gustavo Machicado of UCLA.

Members Reach into Their Pockets

In the late 1980s the College started a program whereby members could add an amount for direct support of clinical research to their

annual dues assessment. In 1988 that program raised \$37,209, a figure that increased to \$49,965 by 1990, and the initiative has continued to be successful. Under the chairmanship of George Rankin, the Ad Hoc Committee on Research developed a sophisticated formula that balanced the desire for strong support for research with the need to preserve and invest some of the principal contributed by members to assure a long-term income stream that can be committed in an ongoing fashion.

Initial Foray into Outcomes Research

In the early 1990s the College became heavily involved in attempting to ensure that HCFA's proposed regulations on reimbursements would accurately reflect the work done by the members taking care of patients. A study commissioned from the Battelle Memorial Institute on multiple endoscopies provided the needed information to show that the government's numbers were inappropriately skewed downward. This study, which might be considered ACG's first foray into outcomes research, focused in great depth on historical usage and claims information from gastroenterologists. We learned that a full two-thirds of the revenue stream for gastroenterology practices came from procedures, and that just five CPT codes accounted for 50 percent of all practice revenue. These data were shared with the other gastroenterology societies and were also provided to HCFA. By this time the leadership of the Research Committee had passed to Lacey Smith, and his committee provided research awards that totaled \$72,000 in 1991, including two awards for \$10,000 each, eight awards for \$5,000 each, and six awards for \$2,000 each.

ACG Institute Adds a New Face and More Financial Resources

In 1994 the ACG Institute for Clinical Research & Education was formed to provide additional funds and opportunities for clinical research. In the mid-1990s the institute set up the GI bleeding registry in another attempt to tap the members and their practices as sources in the collection of crucial data. Perhaps because of the increased size of the College and the increasing interest in clinical research, this effort was more successful than previous ones had been. The Research Committee, headed by Linda Rabeneck, MD, approved projects and provided grants that totaled more than \$2 million from 1997 to 2000.

In 2002 the board recommended that the Junior Faculty Development Grant program be increased, and the institute has continued to increase to the current level of a two-year grant at \$75,000 each year. The College has actively sought research funding from corporate sources; in 2001, for example, grants from five different pharmaceuti-



ACG publishes a patient education brochure on IBS in 2002.

cal companies (AstraZeneca, TAP Pharmaceutical Products Inc., Wyeth-Ayerst, Novartis, and Schering)—along with member contributions—supported the ACG program in research.

Also in 2002, the institute began a capital campaign to raise sufficient endowment to provide sustainable support for clinical research. The drive has attracted the enthusiastic support of the officers and leadership of the College, many of whom have made major commitments in the form of named awards and lectureships. The Berk/Fise Clinical Achievement Award has been established, together with the David Y. Graham Lectureship, and future support for clinical research by the College appears secure. (See Appendix VII: Clinical Research Awards.)

TABLE 4
HISTORY OF ACG RESEARCH FUNDING (1983–2007)

Year	Grants	Total Clinical Award	
1983	3	\$15,000	
1984	3	\$15,000	
1985	4	\$20,000	
1986	2	\$10,000	
1987	4	\$18,000	
1988	2	\$20,000	
1989	4	\$35,000	
1990	4	\$37,500	
1991	14	\$62,000	
1992	12	\$83,000	
1993	17	\$108,500	
*1994	17	\$122,000	
1995	32	\$323,232	
1996	33	\$401,520	
1997	34	\$540,830	Junior Faculty Award starts
1998	32	\$610,331	
1999	32	\$669,243	
2000	31	\$609,549	
2001	28	\$507,012	
2002	24	\$574,437	
2003	16	\$667,943	
2004	20	\$621,498	
2005	17	\$497,568	
2006	18	\$707,538	
2007	14	\$950,688	
Total Awards	417	\$8,227,389	
		\$7,803,389	Dating to 1994, when institute was founded

*Institute is founded

2005 includes \$100,000 for the Colorectal Cancer Prevention Action Plan Grant

2007 includes \$264,652 for the Colorectal Cancer Prevention Action Plan Grant

RESEARCH COMMITTEE CHAIRS

2006–07	Nicholas J. Shaheen, MD, FACP
2005–06	Sapna Syngal, MD, FACP
2004–05	Sapna Syngal, MD, FACP
2003–04	Sapna Syngal, MD, FACP
2002–03	Dawn Provenzale, MD, FACP
2001–02	Dawn Provenzale, MD, FACP
2000–01	Dawn Provenzale, MD, FACP
1999–2000	Linda Rabeneck, MD, FACP
1998–99	Linda Rabeneck, MD, FACP
1997–98	Linda Rabeneck, MD, FACP
1996–97	Donald O. Castell, MD, MACG
1995–96	Donald O. Castell, MD, MACG
1994–95	Donald O. Castell, MD, MACG
1993–94	J. Lacey Smith, MD
1992–93	J. Lacey Smith, MD
1991–92	J. Lacey Smith, MD
1990–91	J. Lacey Smith, MD
1989–90	Daniel H. Present, MD, FACP
1988–89	Robert R. Schade, MD, FACP
1987–88	Richard H. Hunt, MD, FACP
1986–87	Richard H. Hunt, MD, FACP
1985–86	Richard H. Hunt, MD, FACP
1984–85	Stephen J. Sontag, MD, FACP
1983–84	David Y. Graham, MD, MACG
1982–83	David Y. Graham, MD, MACG
1981–82	Francis J. Tedesco, MD

Inflammatory Bowel Disease: Impact on Patient Care

Readers may wonder why this is the only freestanding section about a clinical topic in a text devoted to important issues and events in the College's seventy-five-year history. Why did the Archives Committee solicit this particular topic to appear in a chapter titled "Making an Impact," knowing that the College strongly supported clinical research and education through publications and national presentations on a multitude of subjects, and had made clinically significant contributions in the areas of *Helicobacter pylori*, functional gastrointestinal disorders, neurogastroenterology, and gastroesophageal reflux disease? Perhaps it was because inflammatory bowel disease (IBD) was a hot topic in the 1970s, one that provoked lively and controversial discussions at ACG's annual meetings and that attracted to the podium notable clini-

cal investigators who were skilled in baiting their copanelists and had the ability to stimulate the audience. Through the topic of IBD, the College was beginning to make a name for itself and its leaders past and future. Many of you will smile when you read what follows because it will help recall fond and perhaps forgotten memories of colleagues and events. We hope that others who did not live through or may not yet have even been born during these early years will find the information interesting and capable of evoking a sense of pride about what preceded you.

Perspective from the Patient's Bedside

A large proportion of the practice of most clinical gastroenterologists is devoted to the diagnosis and management of patients afflicted with inflammatory bowel disease. With a membership dominated by clinicians, the American College of Gastroenterology may well be said to have a vested interest in this digestive disorder. Nor can it be disputed that the organization continues to play an important role in improving the care of patients with IBD, a role fulfilled through the initiatives of its leaders and the wealth of publications and presentations in post-graduate educational activities conducted in local, regional, national, and international settings.

Our understanding of IBD pathogenesis and pathophysiology, the appropriate roles for the clinical application of conventional fiber-optic and wire capsule endoscopy, the development and expansion of our therapeutic armamentaria with broadened effectiveness to induce and sustain remissions as well as prevent or delay relapses, advances in identifying patients at risk for developing colorectal or small bowel malignancies, the emergence and application of new theories to prevent cancer occurrence, and improved surgical options and techniques have all evolved during the past several decades. These advances have moved rapidly to the bedside or close enough to make a difference in patient care. The ACG and its members have made and continue to make that difference.

Many national digestive disease organizations have made unique contributions to enhancing our understanding of IBD. By relying on the special talents of physician-scientists conducting basic research, industrial engineers modifying endoscopic performance capabilities, endoscopists applying technological advances in the endoscopic and operating suites and at the bedside, and clinicians conducting clinical research, each organization can take pride in those unique contributions to the care of patients with IBD. The Crohn's and Colitis Foundation of America contributes funding and the voluntary efforts of dedi-

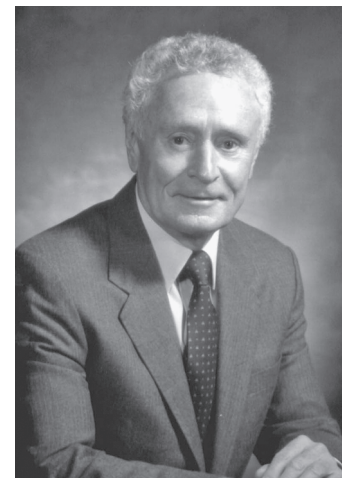
cated doctors, investigators, and clinicians to the goal of finding the cure. The ACG is a solid partner in these efforts.

Influence of College Leaders

Burton Korelitz, MD, director of gastroenterology at Lenox Hill Hospital in New York City and a past president of the ACG, wrote the following when asked to provide his perspective on what impact our organization had on inflammatory bowel disease: “My approach—reviewing previous documents written on the history of the ACG—was not helpful. If only I had earlier thought of looking at the list of presidents and other officers of the ACG I need not have been concerned, since the contributions of many to IBD and to the College were unique and remarkable.” A brief look at some of those who have had an impact on IBD education and patient care follows.

Richard Marshak, MD, a gynecologist turned radiologist, was president of the ACG from 1972–73 and the only radiologist ever to serve in that capacity. With Mount Sinai Hospital as his base beginning in the 1950s, and while sharing office space with Drs. Burrill Crohn and then Henry Janowitz, Dr. Marshak acquired an incomparable breadth of knowledge of the diverse radiographic manifestations of IBD. He transferred his knowledge on the performance and interpretation of GI tract radiography to gastroenterologists who were performing these studies in their offices in the era before flexible and fiber-optic endoscopy. In addition, he was an accomplished educator in the post-graduate arena, whatever the location, and he coauthored with Arthur Lindner, a dean at New York University and a future editor of *The American Journal of Gastroenterology* (1980–85), a classic text, *Radiology of the Small Intestine*, published in 1970.

F. Warren Nugent, MD, a Nova Scotia expatriate who trained at McGill University and became chief of gastroenterology at the Lahey Clinic in Boston, served as ACG president from 1976 to 1977. He was an IBD specialist who contributed a great deal of meaningful information to the gastroenterology literature in the 1970s, '80s, and '90s. An area of controversy to which he contributed revolved around the issue of recurrent ileitis in the ileostomy stoma whether colectomy was performed for ulcerative or granulomatous colitis. Nugent maintained that ileitis was not a recurrent problem, whereas Marshak and Korelitz found a 47 percent recurrence rate when the colectomy was necessitated by granulomatous colitis. One of Nugent's most productive areas was the outcome of dysplasia when found on surveillance biopsies for ulcerative colitis. While all of his lectures were memorable, Korelitz remembers one, “Crohn's Disease of the Colon Comes of Age,” as par-



F. Warren Nugent, MD, MACG

ticularly outstanding. Korelitz recalls: “In fact, on many occasions, Nugent, Farmer, and I joined in symposia on IBD, often in conjunction with annual meetings of the ACG, and these proved to be among the highlights of our ACG experiences. We had so much fun together.”

During the 1976–77 tenure of Dr. F. Warren Nugent, the Inter-American Association of Gastroenterology (AIGE) met jointly with the College in Miami. The combined meeting succeeded in attracting representatives from North, Central, and South America to discuss techniques and advances being made in the field of gastroenterology and IBD. So successful was this venture that Dr. Nugent was elected president of the AIGE. He subsequently delivered his AIGE presidential address at a combined ACG-AIGE meeting held in Miami in 1981.

In 1978 another colorful leader in gastroenterology—and specifically IBD—became president. Richard Farmer, MD, was chief of gastroenterology at the Cleveland Clinic for many years before he became the director of medicine, a position he held at the time of his election to the presidency. He was one of the first physicians specializing in IBD to establish a database. Through his collaboration with Drs. Turnbull, Hawk, and Whelan, he provided colleagues with unprecedented observations on the natural history of inflammatory bowel disease, including indications for surgery and its outcome.

Burton Korelitz became the ACG’s president in 1980. Among the most notable of his many contributions to the field of IBD, both in publications and teaching, was his classic paper coauthored with Daniel Present et al. and published in the *New England Journal of Medicine* (1980; 302: 981–987). Patients with Crohn’s disease from two private physicians’ offices fared better on long-term 6-mercaptopurine (a metabolite of azathioprine) than when receiving placebo; side effects were not limiting. The authors concluded that the drug was both effective and safe, but the AGA was critical of the study and the conclusions drawn by the authors. The National Cooperative Crohn’s Disease Study conducted by lead investigator John Singleton had concluded that azathioprine was therapeutically ineffective and too toxic to use. Present and Korelitz prepared an editorial published in *Gastroenterology* in which they wrote that azathioprine had been judged guilty in the absence of a fair trial. “Many gastroenterologists accused us of using a toxic drug in the treatment of a benign disease,” said Korelitz. “It was the ACG that provided us with a forum for discussion on our observations and that increased our opportunities to share our findings with gastroenterologists around the United States.”

Franz Goldstein, MD, of Philadelphia, who became president of the ACG in 1981, was the first to provide a learned critique of the National Cooperative Crohn’s Disease Study by showing the errors



Franz Goldstein, MD, MACG

that had been made in arriving at the conclusion that immunosuppressants were ineffective. Goldstein concluded that toxic doses of azathioprine were utilized and that patients were not administered the agent for the length of time required to demonstrate benefit.

Jerome Waye, MD, served as College president in 1982–83. The forum of the ACG has provided him the opportunity to teach colonoscopy and video-endoscopy to generations of GI clinicians both in the U.S. and overseas. In the field of IBD he was among the first to describe endoscopic findings with dysplasia and approaches to its management, and the recognition of other premalignant lesions complicating the course of chronic ulcerative colitis.

In 1986–87 Arthur Aufses, MD, then chief of surgery at Mount Sinai Hospital in New York, served as president. Dr. Aufses, one of the nation's most respected and experienced GI surgeons, made significant contributions to the surgical literature on the management of IBD. His predecessors, John Garlock, Samuel Klein, and Albert Lyons, who had been pioneers in this area, probably influenced his ideas.

In 1992–93 Lawrence D. Brandt, MD, then chief of endoscopy and subsequently chief of gastroenterology at Montefiore Medical Center in the Bronx, was president of the ACG. In addition to his accomplishments for the College in many different spheres of activity, he is well known in the field of IBD for his observations in elderly populations, complications of pregnancy in IBD patients, and the differential diagnosis of colitis due to inflammatory bowel disease and ischemia.

In 1995–96 Seymour Katz, MD, whose focus has been on inflammatory bowel disease, became president and made many contributions to progress in both IBD and the College. Dr. Katz, a practitioner in Long Island and clinical professor at NYU, continues to improve patient care for IBD patients and to educate physicians who provide that care by providing annual updates on medical therapies in ulcerative colitis and Crohn disease.

Rewards for Making a Difference

Progress in IBD and the success of the ACG has not been limited to its presidents. Named lectures in IBD have been given over the last twenty years by Henry Janowitz (Stuart Lecture, 1986), who became a member after having served as president of the AGA; David Sachar (Baker Lecture, 1989; Berk/Fise lecture, 2005) who followed Henry Janowitz as director of gastroenterology at Mount Sinai and is now director emeritus; Guido Tytgat from Amsterdam who spoke in 1996 at the Stuart Lecture (now the Berk Distinguished Lecturer) on conditions mimicking Crohn's disease; Joseph Kirsner (1977), also a past president of the AGA and considered an early innovator in IBD research in the United



Jerome Waye, MD, MACG



Arthur Aufses, MD, MACG

States; Richard P. MacDermott (Stuart Lecture, 2001); Steven Hanauer (David Sun Lecture, 1999); and Rodger Haggitt (David Sun Lecture, 1996). Below is a complete listing of awards, awardees, and lecture titles (when known).

Baker Presidential Lectureship (awarded to a member of the College with a distinguished career in teaching and investigation)

- 1974 F. Warren Nugent, MD, MACG: *Crohn's Colitis Comes of Age*
- 1980 Richard G. Farmer, MD, MACG: *Factors in the Long-Term Prognosis of Patients with Inflammatory Bowel Disease*
- 1984 Burton I. Korelitz, MD, MACG: *Pregnancy, Fertility, and IBD*
- 1989 David B. Sachar, MD, FACG: *IBD—Back to the Future*
- 1991 Lawrence J. Brandt, MD, MACG: *Colitis in the Elderly*
- 1993 Daniel J. Present, MD, MACG: *Immunosuppressive Therapy for Inflammatory Bowel Disease*

J. Edward Berk Distinguished Lecturer (formerly the Stuart Lecturer)

- 1969 Richard Marshak, MD: *Ulcerative, Granulomatous, and Ischemic Colitis*
- 1976 Basil C. Morson, MD: *Biopsy of the Colon and Rectum in IBD*
- 1977 Joseph Kirsner, MD: *The Biomedical Problems Presented by IBD*
- 1986 Henry D. Janowitz, MD, FACG: *The Natural History of IBD and Therapeutic Decisions*
- 1996 Guido Tytgat, MD: *Conditions Mimicking Crohn's Disease*
- 2001 Richard P. MacDermott, MD, FACG: *Immunology and Therapy of IBD*
- 2002 Roger Williams, CBE, MD: *Improved treatments for decompensated liver disease including liver support devices*
- 2003 Eamonn M.M. Quigley, MD, FACG: *Demystifying motility: Gut motor dysfunction in clinical practice*
- 2004 Brian P. Saunders, MBBS, MD, MRCP: *Colonoscopy in evolution*
- 2005 Bruce R. Bacon, MD, FACG: *Hereditary hemochromatosis: What we have learned since the discover of HFE*
- 2006 Joel E. Richter, MD, MACG: *Eosinophilic esophagitis: new disease or old friend in disguise?*

David Sun Lectureship in Postgraduate Education

- 1996 Rodger Haggitt, MD: *Dysplasia in Ulcerative Colitis: A Twenty-Year Odyssey*

- 1999 Stephen B. Hanauer, MD, FACG: *New Therapies for the Treatment of IBD*
- 2002 Christina M. Surawicz, MD, FACG: *The Differential Diagnosis of Colitis*
- 2003 Lawrence J. Brandt, MD, MACG: *Superior mesenteric arterial emboli in acute mesenteric ischemia: An update*
- 2004 Richard E. Sampliner, MD, FACG: *Current controversies in Barrett's esophagus*
- 2005 Douglas K. Rex, MD, FACG: *Optimizing the impact and safety of colonoscopy in colon cancer prevention*
- 2006 Anthony N. Kalloo, MD, FACG: *Natural orifice transgastric endoscopic surgery: dawn of a new era*

Berk/Fise Clinical Achievement Award

(formerly the ACG Clinical Achievement Award): Awarded in recognition of a career in gastroenterology characterized by significant contributions in patient care, clinical science, clinical education, technological innovation, and/or community service.

- 1992 Henry D. Janowitz
- 1993 F. Warren Nugent, MD, MACG
- 1996 Burton I. Korelitz, MD, MACG
- 2003 Arthur Aufses, Jr., MD, MACG
- 2005 David B. Sachar, MD, MACG
- 2006 Seymour Katz, MD, MACG

David Y. Graham Lecturers

- 2004 David Y. Graham, MD, MACG: *Helicobacter pylori and gastric cancer: The problem—the solution*
- 2005 Francis K.L. Chan, MD, FACG: *Use of NSAIDs in a COX-2 restricted environment*
- 2006 Amnon Sonnenberg, MD: *The incredibly simple solution to the cohort phenomenon of peptic ulcer*

Education through Publications

The College established and published guidelines for the diagnosis and management of ulcerative colitis and Crohn's disease. These have been distributed widely and have established a standard of care against which actual care can be compared.

The American Journal of Gastroenterology includes in its monthly issues a section devoted to inflammatory bowel disease. Numerous publications related to IBD have appeared in the journal since 1957: 751 articles on ulcerative colitis from 1957 to 2006, and 690 articles on Crohn's disease from 1971 to 2006.



Left to right: Drs. Crohn, Ginsburg, and Oppenheimer

Conclusion

Clinical awareness of colitis predates the founding of the ACG in 1932 and the classic *JAMA* publication (99: 1323–1328) by Crohn, Ginsburg, and Oppenheimer describing granulomatous ileitis the same year. Knowledge and experience of the disease has grown exponentially since then, which has led to a better understanding of many aspects of IBD by an increasing number of well-trained clinical gastroenterologists. At the same time, there are more questions being asked than there are ready answers. Clinical investigators and educators from both the academic (institution-based) and nonacademic (community-based) sectors strive to be certain that the right questions are asked and that the data generated from research studies are sufficient to provide answers. The ACG continues to make contributions in the clinical arena through its leaders, publications, postgraduate education efforts, and the conducting of and/or participation in well-designed clinical research protocols.

Since 1932 our organization and its leaders have contributed to advances in understanding the diverse clinical manifestations and complications of inflammatory bowel disease and how best to manage them. ACG has accepted and fulfilled the responsibility to teach important principles of patient care to physicians providing that care on the front lines, and we honor physician colleagues whose research efforts have led to important discoveries and clinical observations. The College's history offers many examples of leadership that establishes and teaches high standards of patient care, and this mission will continue in the future.

Membership Growth

During the first several decades of the College's existence, membership grew slowly. At the first Board of Trustees retreat in 1979, College president Richard Farmer announced that membership totaled 1,360. Annual membership growth had averaged 10 percent for the preceding four years according to Mr. Dan Weiss, the organization's executive director. Attracting a larger number of members and stimulating interest in the ACG were constant themes among the significant topics and issues addressed during the three-day retreat. A questionnaire poll of a thousand practicing physicians, including four hundred members of the College, was conducted during 1979, and the results were presented in Dr. Farmer's presidential address, delivered October 22,

1979, at the Forty-fourth Annual Meeting in Anaheim, California. Questionnaire response rate was 40 percent from a single mailing. Members and nonmembers alike expressed greatest interest in the practical educational benefits derived from belonging to such a clinically oriented organization. The organization should provide (1) clinically relevant meetings and courses with CME accreditation, (2) a journal oriented toward clinical interests, and (3) organized representation for clinicians on social and political issues related to standards of care in digestive diseases. Over the next many years the ACG would undertake all these tasks, and it has done them well.

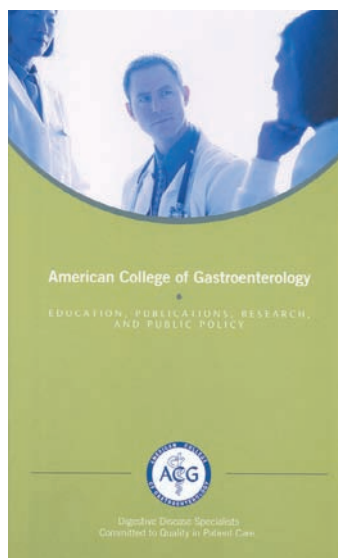
More likely than not, a number of circumstances contributed to the ACG's significant growth in the years that followed. Some were fortuitous and perhaps destined; most were the result of establishing realistic goals, a growing financial base, a sharper focus, strategic planning, talented and committed leadership, and changes in executive directorships. Last but not least, individual members who believed in the College's mission and potential donated many hours of invaluable thought and work.

From 1988 to 1998, ACG's membership more than doubled from almost 2,600 to nearly 6,900. Since 1998, membership has grown by 1.45 times, with membership at more than 10,000 at the beginning of 2007. Our rapid growth in membership is a testament to the positive work the College has done over the years.

Reaching Across Borders and Oceans: The International Relations Committee

The ACG International Relations Committee (originally an ad hoc committee, then made a standing committee after 1997) was charged by the Board of Trustees to develop materials and program concepts that would address the needs and interests of the College's international membership and to promote the ACG in the international gastroenterology and hepatology community. Under the leadership of chairpersons Jamie S. Barkin, Arnold Wald, Rowen K. Zetterman, V. Alin Botoman, Sudhir K. Dutta, and Fumiaki Ueno the twenty-five to twenty-eight members of the committee have over the past decade made major contributions to the international gastroenterology community. More specifically, the accomplishments of ACG in international gastroenterology may be summarized as follows:

- ACG's membership outside North America has increased from 150 in 1990 to 269 as of January 2006. Furthermore, 605 ACG



ACG revamped its membership brochure in 2005 to highlight many of the new benefits offered to members.

members among a total of 7,553 (8%) have international addresses, according to ACG files in 2002.

- The number of abstracts presented at annual meetings by international members increased to 107 (12 percent of the total 871 abstracts) in 2000 compared to 21 abstracts in 1990.
- The College has supported fellowships in clinical gastroenterology and hepatology research in the United States for sixteen carefully selected international gastroenterologists, mostly from developing countries. A six-month international fellowship for study in the U.S. continues to be sponsored. Most fellows have participated and presented their abstracts at ACG annual meetings, and it is important to note that the awardees—true ACG ambassadors—have returned to their home countries to utilize their recently improved skills and pursue their careers.
- The College approved and successfully participated in various international postgraduate courses and gastroenterology/hepatology meetings by coordinated collaboration of the Educational Affairs Committee and International Relations Committee. The latter, through the leadership of its many international members, has successfully cosponsored meetings with the United European Gastroenterology Week, the World Organization of Digestive Endoscopy, the Canadian Association of Gastroenterology, and various Latin American gastroenterology societies. The Mexican Association of Gastroenterology, through the leadership of Fernando Mundo, MD, FACG, ACG governor for Mexico, is the first ACG affiliate society. Shortly thereafter, through the leadership of the ACG governor for Italy, Massimo Crespi, MD, FACG, the Italian Society of Hospital Gastroenterologists became the next affiliate. These affiliations have an established record of ACG cooperation in educational and clinical research activities.
- In recent years the number and quality of papers from international authors published in *The American Journal of Gastroenterology* have significantly increased. This success can be attributed to the journal's immediate past editor Eamonn Quigley; his successors Nicholas Talley and Joel Richter; and the integrated and well-organized efforts of the other editorial board members and the College's Publications Committee.
- The College developed a brochure specifically directed to international membership. This brochure was translated into Italian and distributed to participants during Digestive Disease Week in Italy in December 2001. Similar efforts will be coordinated with other countries in the coming years.

- The College website is evolving to assist the educational needs of ACG international members.

In summary, the committee continues to work on a variety of fronts, recognizing ongoing opportunities for coordination of gastroenterology education and clinical research with similar international activities worldwide. What follows are three separate contributions from Canada, Mexico, and Jordan, countries with whom the ACG has developed meaningful personal and professional relationships.

North of the Border: Canada

During the first half of the twentieth century, departments of medicine in Canada discouraged subspecialization in internal medicine. At the same time, in most major cities, many physicians and surgeons—besides practicing general internal medicine or surgery—developed a special interest and expertise in the field of digestive diseases. After World War II, controlled clinical investigation and techniques allowing nonsurgical intra-organ observation and biopsy resulted in better understanding of the pathophysiology of digestive diseases. This new knowledge inspired Canadian gastroenterologists and gastrointestinal surgeons to attend the exciting scientific meetings of the American Gastroenterological Association (AGA). At these meetings, Canadian attendees from coast to coast tended to congregate, started to become better acquainted with each other, and initiated discussions about the possibility of establishing a Canadian Association of Gastroenterology (CAG), which was founded in 1962 under the presidency of Dr. Richard McKenna. However, while the AGA and its meetings played an important role in getting the CAG started, few Canadian physicians in the 1960s knew much about the American College of Gastroenterology (ACG). The College started to actively involve Canadian practitioners at the time of its first meeting outside the United States, held in Montreal, Canada, in October 1972. John Galambos of Atlanta, Georgia, and Jacques Kessler of Montreal served as co-chairs of the course. Co-organizers were Donald Berkowitz from Philadelphia; Vernon Smith of Baltimore, Maryland; Edward Berk of Irvine, California; and Angelo Dagradi from Long Beach, California. The course faculty included many distinguished teachers from both the United States and Canada, and Canadian physicians reported this meeting of the College to be outstanding.

At the time of this meeting, Dr. Ivan Beck, who joined the College in 1971, had recently completed his term as president of the Canadian Association of Gastroenterology and was nominated to chair ACG's



Ivan Beck, MD, MACG, receiving his Masters designation from David Y. Graham, MD, MACG, in 1991

Research Committee. Dr. Beck served as vice president of the College between 1979 and 1980 and as a governor from 1983 to 1989. While serving in these capacities, Dr. Beck recalls thinking about the many common goals and differences between the College and the CAG. The common ground was the enthusiasm to support clinical research and the commitment to educate gastroenterologists; the difference was the College's justified involvement with the grassroots political interests of its members. In Canada medical insurance, administered locally by the provinces, was provided to all Canadians, and there was little need for a national physicians' organization to discuss remuneration. In contrast, with the multiplicity of health care programs in the United States, many discussions of the Board of Trustees or the Board of Governors related to financial issues and lobbying.

The most positive reason for Canadians to join the College was to get to know outstanding U.S. and international colleagues in closer relationship than one could within the steadily growing and fragmented American Gastroenterological Association. In contrast to the AGA's meetings, which have become so big that interaction amongst physicians who are not entirely in the same field has become extremely difficult, one was certain to meet close friends and make new acquaintances at the meetings of the College. Dr. Beck states,

It was a pleasure to get to know colleagues in various areas of educational or research interest. I mention several (impossible to name all) who became good friends: James Achord, Arthur Aufses, Luis Balart, Peter Banks, Jamie Barkin, Edward Berk, Lawrence Brandt, William Carey, June and Donald Castell, Sarkis Chobanian, Henry Colcher, David Dreiling, Richard Farmer, Tom Fise, Martin Floch, Barbara Frank, John Galambos, Franz Goldstein (with whom I shared the vice presidency), David Graham, Chesley Hines, Walter Jacobs, Seymour Katz, David Kaufman, Burton Korelitz, Robert Kravetz, Myron Lewis, Warren Nugent, John Papp, Joel Richter, Arvey Rogers, William Rosenthal, Edward Schneir, Marvin Schuster, Christina Surawicz, Albert Svoboda, Jerome Waye, Sidney Winawer, Rowen Zetterman, and many others. Interaction with these scientists and teachers helped me to improve my own research and teaching.

While serving as vice president of the College in 1979, Dr. Beck succeeded in persuading the trustees to hold another annual meeting in Canada. Because the locations of meetings were then set four or five years in advance, the soonest that a meeting could be scheduled in Canada was 1984. This second Canadian meeting was held at the Har-

bour Castle Hilton Hotel in Toronto, and Dr. Beck was asked to organize the postgraduate course. Rather than having a general approach, the course focused on alcohol- and drug-induced diseases of the gastrointestinal tract, including the liver and pancreas. The basic scientists and clinicians that made up the faculty came from Canada, the United States, Portugal, and France. The late Dr. Andre Robert addressed the group, describing his original discovery of prostaglandin-induced cytoprotection of the stomach after alcohol challenge.

Although the scientific meeting had internationally known participants, exhibitors from the U.S. experienced difficulties because of differences in drug approvals by Health Canada and the U.S. Food and Drug Administration (FDA). Drugs that were approved in the U.S. but not in Canada could not be advertised, while certain pharmaceutical products approved by the Therapeutic Products Program of Health Canada had different names and made little impact on American participants. Finally, problems arose over the importation of exhibits that contained drugs. Before the beginning of the meeting, some—but not all—of these issues managed to get resolved.

A recent attempt to organize a regional meeting in Quebec also ran into administrative obstacles. After considerable work by the local organizers, the meeting had to be canceled because of problems in coordinating with the counterpart governor, who had been charged to recruit speakers from the U.S.

Canadian participation at the College has steadily increased, although data on Canadian membership are available only from 1987. The lack of information is due to a vague definition that prevailed for many years within the College archives: a member from either Canada or the U.S. would be designated as North American, and a member from outside the U.S. and Canada was designated as international. There were no membership directories in the ACG collection for the years between 1932 and 1979. According to the memory of Dr. Edward Schneir, between 1932 and 1979 there were only nine Canadian members of the College. If so, from 1979 to 1987 the number of Canadians increased from nine to thirty-seven. This increase may have been the result of the annual meeting held in Toronto in 1984, which showcased for Canadian physicians the high standards of the College's meetings. Canadian fellows of the College were approached after the Toronto meeting and asked to recruit deserving Canadian colleagues to join the College. Meetings held in Canada seem to increase Canadian interest in ACG membership. If the College wants to involve more Canadians, major efforts should be made to organize local regional meetings in different parts of Canada.

In 1988–89 the number of Canadian governorship regions was increased from one to four: Maritime provinces, Quebec, Ontario, and Western provinces. With that change, Dr. Beck's role shifted from that of governor for Canada to governor for Ontario until 1989. Dr. Larry DaCosta was elected to represent Ontario, Dr. Noel Williams was elected from the Maritime provinces, Dr. Suzanne Lemire represented Quebec, and Noel Hershfield represented the Western provinces. Franzjoseph Schweiger replaced Dr. Williams in 1997. Quebec elected Dr. Elliott Alpert in 1997 and then Dr. Raymond Bourdages in 1999. After Dr. DaCosta, Ontario elected Dr. Aubrey Groll, who was replaced by Dr. Joe Anderson and in 2003 by Dr. Vinod Sharma. In the Western provinces Dr. Hugh Freeman was elected after Dr. Noel Hershfield, to be followed in 1998 by Dr. Alan Thomson. These governors worked extremely hard, and 103 Canadians had become members by 2002. Considering that the Canadian Association of Gastroenterology in 2002 has 984 members, many of whom are basic scientists, 681 are clinicians, and 416 are gastroenterologists. Accordingly, about 25 percent of Canadian gastroenterologists are also fellows or members of the College.

Canadian practitioners have made many contributions to the College as committee members and committee chairs. As noted previously, Dr. Beck chaired the Research Committee and was a member of the Awards Committee and the International Relations Committees. Dr. Williams chaired the Constitution and Bylaws Committee and was a member of the Research Committee. Dr. Lemire was a member of the Committee of Women in Gastroenterology, and Dr. Freeman served on the Membership Committee. Dr. Linda Rabeneck of Toronto is the sole Canadian gastroenterologist who has served on the ACG Board of Trustees. To date, the College has honored three Canadians with the master title: Ivan Beck, Suzanne Lemire, and Noel Williams.

South of the Border: Mexico (Fifteen Years of Collaboration)

What has been the practical result of the ACG's international outreach? Dr. Fernando Mundo, chair of the gastroenterology department at Hospital Angeles Pedregal in Mexico City, served several terms as ACG governor for Mexico. He recounts a meeting in Cuernavaca, Mexico, with Dr. Jamie Barkin, who was serving on the guest faculty during the annual meeting of the Asociación Mexicana de Endoscopia Gastrointestinal (AMEG). Before that day Dr. Mundo had never heard of the ACG, but he found out much from Dr. Barkin about its philosophy and the advantages to becoming a member. Dr. Mundo joined the College as an international member in 1991 and became a fellow in 1996.

There are several tangible measures of the College's increased



2005–2006 President Jack A. Di Palma, MD, FACC, greets a group of attendees at the International Member Reception held during the 2006 Annual Scientific Meeting and Postgraduate Course.

responsiveness to colleagues in Mexico and Central and South America. First of all, the number of Mexican members and fellows is increasing; many of these physicians are leaders in their communities and use ACG teaching materials. Another important accomplishment was the affiliation of the Sociedad Mexicana de Gastroenterología and the American College of Gastroenterology for the purpose of academic exchange. Drs. Edgar Achkar and Alin Botoman believed in the society and were enthusiastic about this project. The ACG Board of Trustees established guidelines to determine reporting rules and to identify what was and was not included in the affiliation, which formally took place in Villahermosa, Mexico, in November 2000. Dr. Alin Botoman was witness of honor for that celebration. At both the 2002 and 2004 annual meetings, Latin American physicians gathered for an educational breakfast to present clinical experience of local diseases and how they are managed, a timely topic given the continued migration of Latin American citizens to the U.S.

The Middle East: Building Bridges of Cooperation

One looks back at the beginning of a friendship and feels profound gratitude and reverence for what it has come to symbolize. The bridges ACG continues to strengthen between our organization and physicians in the Middle East and Africa reflect how cooperation and dialogue may triumph over the isolationist—sometimes even paranoiac—attitudes plaguing current global affairs. Indeed, with our small steps the world becomes a better place. Throughout the development of his

career between 1967 and 2002, Dr. Ziad Sharaiha, the College's former governor from Jordan, has acted on the view that doctors should be physicians of the world, limited only by humanity's needs. Following some key steps in his career itinerary can give us a view of the ACG's impact even in a small country with few members.

In the mid-1960s Dr. Sharaiha left Jordan to attend St. George's Medical School in London, from which he graduated in 1967. After securing his degree and earning the titles of master and fellow of the Royal College of Physicians, he retraced his steps back to Jordan and served as a doctor at the Royal Medical Services in the Jordan Armed Forces. A few years later he was sent to train at Baylor College of Medicine in Texas, where he became exposed to the U.S. health sector and its extensive benefits and advanced organization. Following those two years at Baylor, Dr. Sharaiha applied for and received his ACG fellowship.

Back in Jordan again, he formed the first advanced GI unit at the Royal Hussein Medical Center, which has become a leading referral center for gastroenterology in the region. During his stay at Baylor he had become familiar with how medical societies operated in the U.S., an experience that set the tone for his career and practice as a gastroenterologist in the Middle East. In 1988 he helped charter the Jordanian Society for Gastroenterology, whose objectives were to enhance core competencies region-wide and to provide a platform for knowledge sharing. The society began helping other medical associations develop progressive operational strategies that would establish uniform procedures for the whole region, although the onset of the Gulf War set things back for some time.

He sought help from ACG to take surer steps toward enlarging its membership umbrella to include international fellows, and to expand its cooperative role in international regional congresses. ACG's early member participation with the Jordanian society was a sign of an existing will and desire to expand the College's role in the region, and to implement a more ambitious strategy for establishing global cooperation. ACG doctors have gained insight into Middle Eastern diseases and priorities, helping physicians in Jordan and elsewhere in the Middle East to develop a keener understanding of their organizational and disease management skills.

Over the years, as specific initiatives and their costs were discussed, there were those who questioned what benefit ACG would derive from international affiliations, but in the end, the goal of advancing the field of clinical gastroenterology and the needs of patients worldwide drove most decisions. ACG's tremendous wealth of knowledge in gastroenterology serves as a vital resource for physicians around the world.

Today it is common for the College to be involved in regional meetings in other countries, and ACG cooperates in managing gastroenterology diseases and problems by sharing clinical experiences and by bringing doctors in all regions of the world up to date with important advances.

Together, medical communities across borders can explore new methods of mutual support and information sharing. The technological advances of broadband connectivity, web-enabled devices, and ubiquitous Internet access have arrived just in time to help meet the higher aspirations of physicians across the globe.

Ad Hoc Committee on International Relations (1985–96)

1985–86	J. Edward Berk, MD, DSc, MACG
1986–87	J. Edward Berk, MD, DSc, MACG
1987–88	J. Edward Berk, MD, DSc, MACG
1988–89	J. Edward Berk, MD, DSc, MACG
1989–90	J. Edward Berk, MD, DSc, MACG
1990–91	J. Edward Berk, MD, DSc, MACG
1991–92	Jamie S. Barkin, MD, MACG
1992–93	Jamie S. Barkin, MD, MACG
1993–94	Arnold Wald, MD, MACG
1994–95	Arnold Wald, MD, MACG
1995–96	Arnold Wald, MD, MACG

International Relations Committee (became a standing committee in 1996–97)

1996–97	Arnold Wald, MD, MACG
1997–98	Rowen K. Zetterman, MD
1998–99	Rowen K. Zetterman, MD
1999–2000	V. Alin Botoman, MD, FACG
2000–01	V. Alin Botoman, MD, FACG
2001–02	V. Alin Botoman, MD, FACG
2002–03	V. Alin Botoman, MD, FACG
2003–04	Sudhir K. Dutta, MD, FACG
2004–05	Sudhir K. Dutta, MD, FACG
2005–06	Fumiaki Ueno, MD, FACG
2006–07	Fumiaki Ueno, MD, FACG

The 1994 World Congress of Gastroenterology

In 1994 the World Congress of Gastroenterology returned to its country of origin, thereby celebrating forty years and the tenth international

convention of this prestigious quadrennial event. A competitive vote of the Organisation Mondiale de Gastro-Entérologie (OMGE) member organizations determines the host of each world congress, and the American College of Gastroenterology played a major role in developing the concept, capturing the award, and presenting the congress. The many efforts devoted to this outcome date to 1986 and are worthy of recounting.

Following the Eighth World Congress of Gastroenterology in Brazil in 1986, Dr. Melvin Schapiro, then a member of the ACG Board of Trustees as well as a past president of the ASGE, initiated discussions with the leadership of the major U.S. gastroenterology societies to explore the concept of celebrating the tenth world congress in its country of origin. Representatives from the ACG, AGA, ASGE, AASLD, Society for Surgery of the Alimentary Tract (SSAT), and the Society for Colorectal Surgery formed a consortium to provide financial support and leadership representation. The initial representatives appointed by the ACG to this consortium were Drs. Chesley Hines (New Orleans) and Jerome Waye (New York City). Dr. J. Edward Berk (Orange, California) was also instrumental in bringing the Congress to the United States. His leadership was integral to the success of the project.

The consortium held a series of meetings to define the steps necessary to persuade OMGE members to award the honor of holding the event to the U.S. In Sydney, Australia, in 1990, while facing formidable competing bids from Canada and the Netherlands, Los Angeles was overwhelmingly selected as the site for the 1994 World Congress. Representatives from each of the consortium societies were present at the award announcement. Dr. David Graham (Houston) assumed the role of lead representative from the College, and Dr. Waye continued his ACG representation as well as assuming the additional important role of secretary-general of the congress. Dr. Schapiro received the honor of being named congress president.

The organizing group undertook intensive preparations, with support by each of the consortium societies. In the case of the ACG, the logistical arrangements were most important, as the date selected for the event was close to that of the College's annual meeting. The College suggested presenting its meeting on a reduced schedule in San Francisco just before the congress in order to allow participation at both events for physicians able to attend both meetings.