The following material consists of selected comments transcribed during interviews, extracted from published (beginning in 1977) presidential addresses, or submitted to the Archives Committee as personal reflections for use in this text. The dates in parentheses are the years the authors served as ACG president. (See Appendix IX: College Presidents, 1932–2007.)

Conflict in the early days . . .
Did the College grow? During the 1950s and 1960s, growth was steady but slow. We were handicapped by the fact that Henry Bockus in Philadelphia and Jay Bargen at the Mayo Clinic (who was my chief) saw no need for a second GI unit. Indeed, Bockus told his residents that they would be blackballed from the AGA if they joined the College. As a matter of fact, Basil Hirschowitz, in his early days at Alabama, volunteered to submit four GI CPCs per year to The American Journal of Gastroenterology, and I secured a grant to cover the expenses of supporting this. When the AGA heard about this, he was told he would be blackballed unless he gave up the project. Consequently, he gave up the project and returned the grant to the College.

—John M. McMahon, MD (1966–67), Interview comments

Funds have been minimal in the extreme . . .
If committees are its heart’s blood, then money is the mother’s milk of the College. Efficient functioning, the operation of committees, the activities of officers, teaching programs, endeavors related to continuing or postgraduate education, and the promotion of research interest are all dependent on support money. That such funds have been minimum in the extreme is a handicap from which the College has long suffered.

—J. Edward Berk, MD (1975–76)

Speaking with an authoritative voice . . .
The American College of Gastroenterology speaks today with an authoritative voice in gastroenterology. It devolves upon us not only to
maintain but to strengthen and advance the stature of the College. This will require not only earnest effort but money as well. Perhaps even more, it will require devotion to excellence, pride in accomplishment, understanding, and open mindedness. Within our own ranks, as well as in our associations with sister organizations, all that may be desired is capable of being achieved by reasoning together in an atmosphere of good will and mutual respect. (Berk JE. Presidential Address. “Nor Yet the Last.” Am J Gastroenterol 1977; 67: 217–219)

—J. Edward Berk, MD (1975–76)

Broad representation in specialty societies encouraged . . .

Last, but of course not least, are the specialty societies. Here again, we have the opportunity of playing a major role in the settlement of many issues that are close to our heart. How many gastroenterologists should there be? Where should they practice? Should they be allowed to do primary medicine as well as secondary and tertiary care? How should they be paid and who should set the fees? Government agencies will attempt to settle these questions for the most part, and it is up to us to exert as much influence as possible on these agencies. As the major organization representing clinical gastroenterology, we, the American College of Gastroenterology, must make every effort to ensure that the clinician is adequately represented in these councils. . . . The American College of Gastroenterology now has a major voice in all of the councils involved with the digestive diseases. . . . We must develop strong leaders who will ensure that our voice is heard and that we are adequately represented in the national arena. (Nugent FW. Presidential Address. Am J Gastroenterol 1978; 69: 141–143)

—F. Warren Nugent, MD (1976–77)

ACG chooses to preserve identity . . .

There were tentative meetings with the AGA, AASLD, and the Society for the Surgery of the Alimentary Tract (SSAT), but the thrust of these meetings was that it would be inappropriate for us to amalgamate with the AGA, thus losing our identity.

—F. Warren Nugent, MD (1976–77)

Dissatisfaction with the doctor-patient relationship . . .

The gastroenterologist has become more and more preoccupied with procedures. They begin to occupy a significant portion of the work day. Scheduling and equipment maintenance become major activities. As a result, a proportionally smaller part of the day is available for the
traditional doctor-patient interaction. Whatever impressive findings are brought to light in the clinical laboratory, the radiology department, or in the endoscopy room, the patient is only aware of what is brought out during his discussion with the doctor. (Rosenthal WS. The Doctor-Patient Relationship: Its Present State. Am J Gastroenterol 1979; 71: 373–375)


An early retreat helps shape the College’s future . . .

I described at least five publics that I felt required attention from the ACG: (1) ACG members themselves; (2) other digestive disease physicians; (3) other physicians, and particularly those involved in primary care; (4) the lay public; and (5) government. It has frequently been stated that the ACG represents the practicing clinical gastroenterologist. However, it is my opinion that the College still needs to define goals and objectives more clearly, and I noted that we must think how we represent the practicing clinical gastroenterologist. There are at least five ways in which we do this:

1. Educational activity by means of the annual meeting, the annual postgraduate course, other postgraduate course sponsorship, the journal, some public and patient education, some local involvement at hospitals, and some relationships with pharmaceutical and other industrial firms cosponsoring other educational activities. It is my opinion that additional efforts could be emphasized if we so desire.
2. A socioeconomic interest including utilization reviews, medical audits, cost containment and cost effectiveness, perhaps in conjunction with other organizations.
3. Some type of Washington presence for information gathering, member education, and perhaps a national liaison role. Here there could be a relationship with several lay organizations.
4. The area of patient education in digestive diseases has not been emphasized in the past and certainly could and should be.
5. There could be activity in clinical research to include registries so that individual practicing physicians could help supply the data for the incidence or other types of collaborative studies, as well as cooperative studies themselves. There has been some interest in the Research Committee to do this type of thing; again, funding could be from external sources, including pharmaceutical and industrial firms.

—Selected comments from personal notes summarizing a full Board of Trustees retreat held at Hilton Head Island, South Carolina, February 22–24, 1979. A complete analysis of that meeting and recommen-
izations can be found in Dr. Farmer's presidential address (Farmer RG. How the American College of Gastroenterology Might Better Serve Its Membership and Attract New Members. Am J Gastroenterol 1980; 73: 481–485)

—Richard G. Farmer, MD (1978–79)

Preserving our identity . . .
A major issue arose as to whether to join the AGA and ASGE in the spring at a meeting that later became the Digestive Disease Week, or to retain a separate meeting in the fall, which was the traditional meeting time for the College. This issue was much debated, and we agonized quite a bit over it during my tenure on the Board of Trustees. It was decided to retain a separate identity for the College, which in retrospect was an excellent decision. But how to change the structure of the College? That was a major question and one not easily answered.

I look back on those early days when I came to my first College meeting with great nostalgia. I look back at the days on the Board of Trustees and working with a group of presidents to help transform the College. I look back and remember all the people who worked so long and so hard to make the College what it is today and to position it for the future. The College is one of the world’s most prestigious gastroenterological societies, and it has worked hard on behalf of its membership and all those interested in digestive diseases to bring the highest quality of medical care to our patients. At the same time, along with other organizations in this country and around the world, the College has taken a leadership role in legislative changes that benefit many people. I am proud to be associated with the College, and I would like to express my appreciation to all those people with whom I have worked over the years to make this a wonderful organization. I expect that in the next seventy-five years the College will continue to have a leadership role in moving gastroenterology to horizons we can only dream of today.

—Sidney J. Winawer, MD, (1979–80), Personal reflections

A memorable ride through the mountains . . .
I remember as if it were yesterday a ride through the mountains in Denver. It was October, and the forty-third annual ACG meeting was to take place October 25 to 27, 1978. The ride was memorable for more than the scenery. With me were Drs. Warren Nugent (past president, 1976–77); Richard Farmer (president-elect), and Sidney Winawer (president, 1979–80). I didn’t know then that I would be the ACG
president from 1980 to 1981. Bill Rosenthal, the incumbent president, must have been involved in some intersociety squabble, or the car we rented could only hold four comfortably. We discussed past, present, and future issues related to the ACG. It may have been then that ideas for meaningful changes took on a recognizable shape. Consideration was being given to hiring Arthur Liman, a prominent New York City attorney, to help draw up a contract that would end the four-decade tenure of Danny Weiss as the first and only ACG executive director. We didn’t know then how difficult the transition would be, but it occurred, and the College is better for it.

—Burton I. Korelitz, MD (1980–81), Interview comments

Notable events mark years as president . . .

Three events stand out in my memory, all occurring during the years immediately preceding and during the time of my presidency. The College’s efforts to attract members paid off, inasmuch as membership seemed to quadruple over a two-year period. The publisher of our journal changed to Williams and Wilkins, and the cover color became its now familiar red—hence its moniker, The Red Journal. Arthur Lindner became editor in 1980. Finally, Arthur Liman was hired, facilitating important changes in the College.

—Burton I. Korelitz, MD (1980–81), Interview comments

A look back at our first fifty years . . .

At this fiftieth anniversary we can all look back with pride to many accomplishments in the areas of accurate scientific diagnosis and effective medical and surgical treatment of many gastrointestinal disorders. Yet we are also forced to defend ourselves against the remaining failures of medicine—for failing to identify the causes of and effective treatment for advanced gastrointestinal cancer; to treat effectively such diseases as late-stage alcoholic cirrhosis, alcoholic pancreatitis, or the many ailments of old age; and—increasingly—to rein in the high cost of the care that the public demands.

—Franz Goldstein, MD (1981–82)

We must do better in the national affairs arena . . .

However, the College has also entered the arena of national affairs and public relations. . . . In our efforts thus far to reform societal ills, to shape public opinion, and to adequately explain medicine’s point of view, we have not been greatly successful. The medical profession, despite its accomplishments, is not exactly the darling of the media, or
of the intellectuals, or of university faculties, the major shapers of
c public opinion. We must do better in this sphere of activities. (Gold-

—Franz Goldstein, MD (1981–82)

College restructuring sets stage for transformation . . .
With the departure of Mr. Weiss as executive director, President Franz
Goldstein received all of the records, logs, and paperwork from Mr.
Weiss's vacated offices. Dr. Goldstein performed the remarkable task of
keeping the College together from documents and records scattered
across his dining room table, which was not used once during his year
in office because of the needs of the ACG. Halfway through his term,
the ACG engaged Mr. William Maloney of PRRI (who also managed
the ASGE) to be the new administrator of the ACG. He appointed a
young associate, Mr. Gardner McCormick, who did a marvelous job in
reorganizing the ACG.

—Jerome D. Waye, MD, Personal reflections

The ACG—a leading light in clinical gastroenterology . . .
One need only look at the list of ACG presidents in the past decade to
recognize that they are the leaders in the field of clinical gastroenterol-
ogy. . . The ACG is rededicated to making the clinical gastroenterolo-
gist the best-informed and most knowledgeable physician in the field of
medicine. (Waye JD. The Clinical Gastroenterologist. Am J Gastroen-
terol 1984; 79: 83–84)

—Jerome D. Waye, MD (1982–83)

Emphasizing clinical research . . .
Research has brought our profession to our present position of emi-
nence. While we want to emphasize the clinical aspects of the activities
of the College, we do not want to appear to be against research or anti-
intellectual. We want to continue to concentrate on research applied to
the care of patients. Basic research, which provides the raw material on
which clinical research feeds, will be the purview of other equally vital
groups. We will encourage and support those groups but in our own
activities will continue to serve as a forum for applied research.
(Achord JL. Where Do We Go From Here? Am J Gastroenterol 1985;
80: 75–76)

—James L. Achord, MD (1983–84)
Growth of the College . . .
The activities I was involved with included bringing young, good people to the College. The College, years ago, had been labeled a New York organization, although there were members from other parts of the country, but I was one of those brought in from the Midwest. In turn, friends of mine, people on my Board of Trustees were involved in getting people from throughout the United States to become members. They gave us a broad appeal; they gave us insight into problems throughout the country and helped us to grow.

——Walter H. Jacobs, MD (1984–85), Interview comments

An oncoming wave of malpractice suits . . .
And in the area of socioeconomic controversies, our own Dr. Bernard Ficarra was on the program [of the 1960 annual meeting in Philadelphia] and warned of the increasing wave of malpractice suits to come. He particularly cautioned those of us who use new and unproved drugs, those who tried newer therapeutic procedures, and those who performed complex surgery. “If you are in those areas,” he said, “expect to be sued.” (Jacobs WH. Gastroenterology and the American College: A 25-year Evolution. *Am J Gastroenterol* 1986: 81: 213–217)

——Walter H. Jacobs, MD (1984–85)

Legislative issues occupy ACG’s attention . . .
As first chair of the National Affairs Committee, I made twenty-six presentations to Congress representing the American College of Gastroenterology and the gastroenterological community as a whole. At a legislative workshop held in the spring of 1986, numerous key leaders in the American College of Gastroenterology met legislators and legislative assistants to discuss the concerns of gastroenterology, resulting in the College being recognized as one of the leading groups for the practicing subspecialty physician.

——John P. Papp, MD (1985–86), Personal reflections

The best of times, the worst of times . . .
We also are in an age of unrest and revolution. There has been no comparable period in history that has seen changes of such magnitude in medicine. Indeed, it could be said that “these are the worst of times.” Not a week goes by without reading articles or hearing from colleagues lamenting unprecedented economic hard times, about PRO cookbook requirements, about loss of patients to “alternative delivery systems,” or as the AMA prefers, “custom medical care systems.”
These are indeed revolutionary times. I challenge you to be part of your future. Become involved in college affairs. Do not sit on the sidelines and let someone else do it. Become involved in the legislative process on the local, state, and national levels. Now is the time. Now is the best time of our lives. Do not let opportunity slip through your hands. (Papp JP. The Best of Times – The Worst of Times. *Am J Gastroenterol* 1987; 82: 114–116)

—John P. Papp, MD (1985–86)

**Role modeling for the future . . .**

We are the ones who must be the role models for college students, our medical students, and our residents. To again quote Dr. Eisenberg, “as physicians, we have a moral imperative to sustain the highest aspirations of the students we teach.” (Eisenberg C. It is still a privilege to be a doctor. *N Engl J Med* 1986: 314: 1113–4) We also have the obligation to practice our science and our art to the best of our ability. As John Papp (’85/’86) and others have stated, we must be our patients’ advocates. We are here to serve them, and must always do right by them regardless of outside forces. It is our obligation to preserve excellence in medicine. (Aufses, A. The Preservation of Excellence in a Hostile Health Care Environment. *Am J Gastroenterol* 1988; 83: 351–354)

—Arthur H. Aufses, MD (1986–87)

**A milestone in College administration . . .**

From 1987 to 1988 there was a question of who would be our executive director long term. Tom Fise had been on loan to us from another medical management organization, but they were terminating his contract, and we were saying to ourselves, “Do we want him and can we keep him, or do we seek help from an executive director elsewhere?” It was Arthur Aufses (who was president before me), Chesley Hines (who was president after me), and I who met over lunch to discuss this issue and its associated legal problems. We of course agreed one thousand percent that hiring Tom Fise as executive director was the direction we wanted to take the College. After three hours of pros and cons and a lot of discussion with the Board (it was right after the annual meeting, in New York), we were able to get through that Tom Fise would remain our executive director. He has given us camaraderie, a success story.

—Myron Lewis, MD (1987–88), Interview comments
Moving forward with Fise . . .
When Tom Fise took over the position of executive director, he did not even have an office, not even a fax machine. He would have to fax me materials by going to a local Kinko’s. He had not wanted to serve as our Washington liaison at that time because he felt that it would be too much of a job. However, Sarkis Chobanian—the chair of the National Affairs Committee—and I convinced him to take on that added responsibility one night in Washington, DC. In my opinion Tom Fise has been one of the most important factors in the success of the ACG in the past few years. He has provided the glue for the organization and has somehow held it together in a very diplomatic way without interfering with the ideas and dreams of various presidents.

—Chesley Hines Jr., MD (1988–89), Interview comments

Women in gastroenterology get College’s attention . . .
Women are making up an increasing percentage of physicians, and there are an increasing number of two-physician marriages, both of which have significant effects on the family. These issues will be addresses in the symposium “Parenthood and Practice,” sponsored by the new Women in Gastroenterology Committee. In addition, this committee is evaluating the impact of time lost (on education and certification) because of pregnancy occurring during GI Fellowship and will be creating guidelines in this area. (Barkin JS. The American College of Gastroenterology: Yesterday’s Accomplishments, Today’s Problems, and Tomorrow’s Challenges. Am J Gastroenterol 1991: 86: 396–400)

—Jamie S. Barkin, MD (1989–90)

Preparing to do battle on heavy seas . . .
The ACG has led the way in government relations. We have taken the tack that we must educate the rule makers and that we will not accept those rules we judge to be unfair or arbitrary. We have enjoyed early success, and our success has encouraged our sister societies to come forward also. We began as a single ship in heavy seas. The others have begun to leave port and to sail with us. This is not to say that we sail together, but, rather, we are responding to the same wind. We have continued to press issues the other societies declared
dead, and have had successes. We remain ready to do battle, and have served notice to that effect. (Graham DY. Gastroenterology Today and Tomorrow. *Am J Gastroenterol* 1992; 87: 559–561)

—David Y. Graham, MD (1990–91)

**On measuring success . . .**
I believe that numbers, in themselves, can be very deceiving as important gauges of any organization’s success, and that our focus should be more on developing methods for stimulating our membership so that they seek enthusiastically to become involved; ensuring that those members wishing to become involved can do so, whether on a local, regional, or national level; cultivating our members so that many will become our present and future leaders; examining critically what we actually do for our members, and developing ongoing systems for ensuring a high degree of member retention. (Rogers AI. Up Close and Personal: A President’s Perspective. *Am J Gastroenterol* 1993; 87: 1542–1546)

—Arvey I. Rogers, MD (1991–92)

**The new Gastroenterology Leadership Council speaks with one voice . . .**
Closer interaction with our sister societies was something we worked very hard to accomplish. The American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE), and the American Association for the Study of Liver Diseases (AASLD) interacted in a positive fashion through the newly formed Gastroenterology Leadership Council (GLC), a name which I proposed to then-AGA President Walter Hogan; the GLC was made up of the presidents and vice presidents of these four organizations. The major issues common to all these GI organizations at the time were (1) control of the volume of endoscopic procedures; (2) undertrained endoscopists; (3) RBRVS/physician payment reform; (4) postgraduate vs. primary care training; and (5) guidelines and requirements for CME accreditation from the Accreditation Council for Continuing Medical Education (ACCME). The GLC testified on these issues before the AMA, speaking with one voice rather than the heretofore divisive and counterproductive four.

—Lawrence J. Brandt, MD (1992–93), Personal reflections
A draconian alteration in the medical playing field . . .
Our agenda 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 they insured. Gastroenterologists and other physicians who actually performed the work were increasingly marginalized. Monitoring Washington became a high priority for me and for many other ACG leaders.

Among the prongs of our legislative agenda was an attempt to modify a major White House initiative on health care delivery that would have empowered primary care providers and disenfranchised specialists.

—William D. Carey, MD (1993–94), Personal reflections

Seaworthy leaders chart our future course . . .
Although the seas are rough, your vessel is well constructed. Mindful of the winds and the currents, your leaders will navigate us successfully through the maelstrom of change. The advice I leave the future leaders is that we never become smug in our current successes. The fossilized and skeletal remains of animals and plants, and the stories we can reconstruct from the geological strata in which they are found, have been the best evidence to support biological evolution. The landscape is littered with organizations that were maladaptive to a changing world. Evolution does not always occur at a glacial rate. The speed with which evolutionary change can occur can be frightening. (Carey WD. Humanism and Professionalism in Medicine’s New World Order. Am J Gastroenterol 1994: 89: 1932–1937)

—William D. Carey, MD (1993–94)

ACG Institute establishes a solid funding base for clinical research and education . . .
The ACG Institute for Clinical Research & Education is leading the way in establishing the College as one of the premier societies for promoting clinical investigation in gastroenterology.

—Joel E. Richter, MD (1994–95)

In discussing the federation of GI societies . . .
However, certain steps could not be achieved, consistent with the best interests of our respective memberships [AGA, ASGE, AASLD]. We explored cooperation in the area of fundraising, but the terms suggested involved relinquishing entirely the ACG’s ability to raise independently any significant amount of funds to undertake new projects—terms that
we could not accept. Similarly, we were not able to concur with the request that the ACG completely disband its National Affairs Committee and all independent ability to speak for the clinical practitioner at these crucial times. Conversely, the other societies declined recommendations from the ACG for a coordinated effort on educational meetings to converge around two major meetings, one in the spring and the other in the fall. Also rejected was the ACG’s recommendation for cooperative programs both on the solicitation of research protocols and public relations efforts geared toward presenting the value of our subspecialty to the patient public. (Richter JE: American College of Gastroenterology: A Pyramid of Strength for the Practitioner, Educator, and Clinical Investigator. Am J Gastroenterol 1996; 91: 632–636).

—Joel E. Richter, MD (1994–95)

As the debate raged on Capitol Hill regarding the best first (i.e., fundable) choice of a diagnostic screening test for colorectal cancer, Seymour Katz, MD, had this to say in his presidential address in October 1996:

A commercially funded venture posed the barium enema as an acceptable alternative to colonoscopic diagnoses and treatment, without any demonstrated basis in science, tested data, or supportive peer-reviewed literature. This barium x-ray lobby exercised its muscle with extraordinarily successful inroads into the executive as well as legislative branch of government. What was so distressing and unique was the concept that, if accepted, a totally commercial interest would dictate the care of Medicare patients and would wrest control from the partners of a sacred interchange, i.e., the patient and his/her physician.

—Seymour Katz, MD (1995–96)

And commenting on federation . . .

We are strong and vital enough to stand alone in our quest for excellence and choice. Nevertheless, I personally believe that a coordinated approach with our sister societies will serve us best. The virtue of speaking with one voice is laudable, indeed enviable, and will be achieved, albeit by a process of deliberation and incrementalism. This is a process that ultimately will recognize and represent all of its component parts equally and appropriately, be they investigators, administrators, or practicing clinicians. (Katz S. Aequanimitas, . . . and then some. Am J Gastroenterol 1997; 92: 199–203)

—Seymour Katz, MD (1995–96)
Strong position achieves desired end but antagonizes some . . .
One of several major issues we faced was the colorectal cancer screening benefit, for which we fought very hard and successfully. We got it passed, pretty much in the language that we had supported. However, it was not an easy process because we were opposed not only by the radiology group but by the barium enema lobby, which wanted to give the barium enema priority and equivalence to both fiber-optic sigmoidoscopy and colonoscopy and to make it part of the screening, like any endoscopic procedure. The data is against that, and we fought the issue. Unfortunately, we were also opposed by some of our sister societies, who felt that if you fight that issue, or fight at all, you’re going to lose it all, which is not the history of the way things are legislated.

—Marvin M. Schuster, MD (1996–97), Personal reflection

Enter a new era in ACG’s relationship with the federal government . . .
My initial active involvement in the College began in 1988 when President Myron Lewis (1987–88) asked me to chair the National Affairs Committee. Myron was aware that I had been a staff gastroenterologist at the National Naval Medical Center in Bethesda, Maryland, and a physician to quite a few congress members, senators, and Supreme Court justices and that I had also been involved in a small way with the care of President Reagan. The College was on the verge of making a major push into the legislative arena, and Dr. Lewis surmised that such connections might be of some benefit. It was readily apparent that major changes were about to occur with respect to Medicare patients, and indeed this did come to pass with the devolution of the usual and customary payment methodology to the so-called resource-based relative value scale that we labor under to this day.

—Sarkis J. Chobanian, MD (1997–98), Personal reflection

Speaking for women in gastroenterology . . .
What can we do now for gastroenterology? We can encourage adolescent girls and boys and minority boys and girls to consider the field of medicine by outreach programs at the middle- and high-school level (as we are doing here in Phoenix on Wednesday morning at Alhambra High School). We can encourage women residents to consider gastroenterology, as we did at the ACG meeting last year in Boston. We can make GI a comfortable profession where diversity is recognized and celebrated. We can all be better mentors—in practice, in academics. We can look for better paradigms to combine work and life goals—this will only improve our profession as a whole. And finally, we can
recognize the role of specialty societies as an important component of this process. While strapped for time and financial resources, women are less likely to join specialty societies. This was well documented by Deborah Allen. Her study, while not looking at GI specialty societies per se, documented why women do not join such societies: lack of time (dual career couples but major home and/or family responsibility), lack of opportunity, feelings of inadequacy, or lack of interest. Yet here is just the place where mentoring and nurturing of careers can occur on a more global scale, with individuals who are not in direct competition with you. Our societies need to be representative of our MD population. One of the benefits of specialty society membership is having a voice in making policy. Let’s encourage women to join the ACG, where they will reap the benefits of mutual support, development of leadership skills, ability to accomplish projects and set policy on a rapid track, and learn new models for achievement and for meeting and becoming mentors. (Surawicz CM. Scopes, Hopes, and Learning the Ropes. *Am J Gastroenterol* 2000; 95: 345–348)

—Christina M. Surawicz, MD (1998–99)

**A modest proposal to remedy a personnel shortage . . .**

At last year’s ACG annual meeting, I made a point of attending the job forum, and my unofficial count was that the number of jobs available outnumbered the number of individuals seeking a position by twenty to one. What are we to do for the next few years, and how do we intelligently address our future needs? This is a challenge that we must face and solve. Here are some ideas for the future: first, I believe that there is a need for a manpower study for the new millennium. I propose that the four societies of gastroenterology and hepatology commission a new study. This study should begin to think outside the box by looking at what a gastroenterologist may be doing in the next ten to fifteen years and then incorporating the findings into formulating predictions. We need to take a serious look at certification for hepatology, particularly in transplantation; perhaps this should be a separate subspecialty.

A bolder proposal would be to look into creating partnerships with those most involved in the practice of gastroenterology: you, the practitioners. A private practice group could help fund a fellowship at its favorite medical school in return for identifying an individual who will agree to enter that practice once finished with training. This would be a winning situation for the practice, the trainee, and the medical school. All of these efforts must be undertaken together with the other gastrointestinal and liver societies, and I call on the presidents of the ASGE, AGA, and AASLD to join the ACG in the rebirth of the Gas-
Increasing membership and interorganizational collegiality . . .
So where do we go from here? I think that we need to look at our opportunities as a membership organization, as one of the GI societies representing joint memberships, and as one of the constituents of the Federation of Medicine. Our opportunities will include enhancing member and patient education; developing care guidelines; improving the structure of the health care system for the gastroenterology patient; and providing educational opportunities for your employees, including your midlevel providers, nurses, and office managers. These are important opportunities for us. We will need the collaboration of other organizations. To accomplish some things, we will need to enhance the endowment of our research institute. I am convinced that if we are to maintain the growth of clinical research in this country, it is going to be the responsibility of each of us to do so.

How do we get to these successes? We will need to identify more members that want to be involved, mentor them, and develop their leadership skills to increase their participation in College activities while the College maintains and develops relationships with other gastroenterology organizations to leverage our combined membership on legislative and regulatory issues. (Zetterman RK. Where Do We Go From Here? Am J Gastroenterol 2002; 97: 1099–1101)

—Rowen K. Zetterman, MD (2000–2001)

Strategies to ensure a secure future . . .
One of the most important achievements of this year was the development of a strategic plan to guide ACG in the next three to five years. I had the privilege of chairing a diverse group from the College to analyze its strengths and weaknesses, predict future challenges, and establish a plan to meet these challenges. We started by asking what makes ACG unique. Although we knew that it was important to recognize and address our weaknesses, we understood that no strategic plan would be effective if it did not build on our existing strengths. The report on strategic planning includes specific recommendations on education, research, patient education and public relations, ACG governance, and administrative structure. From these recommendations, the group selected six priority items:
1. Double the annual funds granted by the ACG Institute of Research & Education
2. Conduct an in-depth evaluation of the annual meeting and implement appropriate changes in content and format
3. Increase the level of administrative support
4. Strengthen the role of the Board of Governors
5. Increase the impact of *The American Journal of Gastroenterology*
6. Explore opportunities for interaction with other medical societies and nonprofit organizations

The Board of Trustees has adopted the strategic plan as presented and has already assigned specific tasks to various groups. The Board of Governors is in the process of establishing a reform plan to increase the participation and influence of Governors in the College’s affairs. The Educational Affairs Committee will present a report on the annual meeting in the summer of 2003. The emphasis on improving the journal will be stressed to the new editor when he or she will be selected later this year. (Achkar E. Advocacy and Public Interest: Are They Compatible? *Am J Gastroenterol* 2003; 98: 527–529)

—Edgar Achkar, MD (2001–2002)

**Does recertification ensure clinical competence? . . .**

During 2002, a combined ACG/ASGE committee was established to respond to complaints from many of the younger members subject to recertification that the examination was onerous, time-consuming, and expensive. An even greater concern was that the American Board of Internal Medicine stated that it no longer considered those who failed to recertify as board certified. It was feared that this action would lead to deletion of many physicians from expert panels and revocation of privileges by credentialing bodies, especially those of third-party payers. The ACG and ASGE published a joint statement on recertification in the July 2003 issue of *The American Journal of Gastroenterology* in an article titled “The Role for Board Certification and Recertification as One Mode for Demonstrating (and Quantifying) Capacity to Render High-Quality Patient Care.” The essence of the statement was that while performance on a recertification examination may provide an indication of knowledge level, results cannot be equated with clinical competency and should therefore not be utilized as a prerequisite for extension or maintenance of medical privileges. Recertification was only one way to assure that continued medical education was taking place, but clinical privileging is a local process guided by local policies, established guidelines, and high-quality institution-based programs.

—Frank L. Lanza, MD (2002–2003), Personal reflections
Undertrained endoscopists threaten quality of care . . .
A second issue I want to discuss is the troublesome and increasing problem of undertrained endoscopists. This problem is one that varies substantially by region, being no problem at all in many areas and in others substantially threatening the quality of endoscopic care. In some locales, primary care groups have hired undertrained physicians to do endoscopy, and then expect the local gastroenterologists to do only those cases that they cannot handle and to take emergency room call. In others, hospitals have hired undertrained physicians to do endoscopy to replace volumes lost when gastroenterologists open ambulatory surgery centers, with the result of an increase in failed procedures and complications.

Past efforts to deal with this problem have had mixed results. ACG has directly warned hospitals across the country about the liability they incur when they credential inadequately trained physicians. However, the financial incentive for some hospitals and some physicians outweighs, from their perspective, the risks that patients incur from encounters with inadequately trained endoscopists.

A new approach that ACG is taking this year to this problem is to educate the public directly on this issue. We must begin to inform the public about the value of subspecialty training in gastroenterology and endoscopy. Our Public Relations Committee this year developed a brochure entitled “You’ve Been Scheduled for an Endoscopic Procedure: What Questions Should You Ask the Doctor?” that helps patients identify qualified endoscopists. This brochure is available on the ACG Web site, and I encourage you to download these brochures and put them in your office waiting rooms, so that these ideas begin to disseminate in your communities. We have also developed newspaper ads, which can be used by any of our members to help educate your community on the value of subspecialty training. (Rex DK. Three Challenges: Propofol, Colonoscopy by Undertrained Physicians, and CT Colonography. Am J Gastroenterol 2005; 100: 510–513)


Advancing the ACG’s roles in education and research . . .
On another educational front, I am excited to announce the development of the ACG Education Universe, an Internet-based program which will allow members to access lectures, self-assessment questions, abstracts, journals, and textbook materials in what will largely be a self-directed multimedia CME initiative, enabling practitioners to advance their learning in a manner compatible with their schedule. This is truly groundbreaking for the busy clinician who still needs to earn CME credits or prepare for recertification exams as it will allow
individuals to earn credit from literally anywhere in the world with Internet access. We plan to continually add new materials from meetings and publications, as well as original presentations created especially for this platform.

Under Edgar Achkar’s leadership we were pleased to announce this morning that we have met the first phase of our capital campaign goal of $12 million, which we set at last year’s annual meeting. This will enable the institute to continue supporting clinical research in the form of Junior Faculty Development Awards while also committing substantial funding to patient educational initiatives and programs for practitioners that present the latest and most effective standards of practice and patient care. Many physicians and other partners in the GI community remain poised to add their support to this effort, and that will serve to generate greater success in achieving the institute’s important objectives for clinical gastroenterology. (Popp JW Jr. It All Depends on You. Am J Gastroenterol 2006; 101: 2–5)

—John W. Popp, Jr., MD (2004–2005)

You can make a difference . . .

In the almost 20 years I have been involved in ACG activities, I continue to be amazed at the strength of our association. Our unique organizational structure encourages grass roots involvement from practicing gastroenterologists. By your commitment, you make a difference. Individual College and committee members via the Board of Governors recognize the issues and guide the Trustees and the elected executive leadership. The blend of private and academic gastroenterologists, researchers, and teachers, makes the ACG the premier GI clinical organization. (You Make a Difference. Presidential Address. Am J Gastroenterol 2007; 102: 2–5)


The public arena is such that we must always be alert. The Colon Cancer Screen for Life Act remains our legislative priority. One small part that waives the deductible for our patients has been enacted, but much needs to be done to make this legislation a reality. . . . Your leadership and governors, led by National Affairs Chairman, Dr. Edward Cattau, had several successful legislative fly-in visits this year and are making a difference. You can make a difference as well by answering the call to get involved on these critical public policy issues. (You Make a Difference. Presidential Address. Am J Gastroenterol 2007; 102: 2–5)