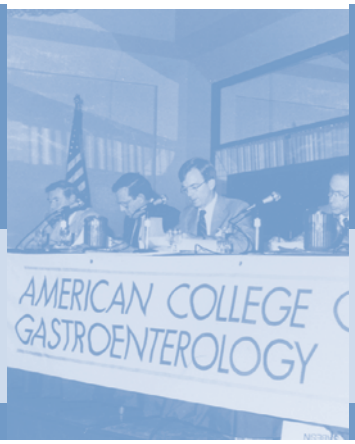
CHAPTER 6

Winds of Change: Challenging Issues



Interorganizational Relationships: When the Going Gets Tough, the Tough Stand Firm

The early 1990s marked an increased spirit of exchange and cooperation among the four major GI societies. In 1985 the American College of Gastroenterology, the American Society for Gastrointestinal Endoscopy, and the American Gastroenterological Association had held their first tripartite meeting, a practice that had continued and helped present a united front in dealing with issues important to health care in digestive diseases in the United States. The presidents and presidents-elect of ACG, AGA, and ASGE met formally during this period as the Gastroenterology Leadership Council (GLC), founded in 1992. The previously annual tripartite meetings (ACG, AGA, and ASGE) were expanded in frequency and size, and the AASLD—the fourth member of the GLC—began participating in the meetings as well.

GLC Considers Confederating

With the increased activity of the GLC came discussions of affiliation, confederation, or even merger. As was summarized earlier as background to the story of the ACG Institute, the AGA and the ASGE had around this time begun deliberations about the possibility of merging, and they broached the idea of a merger to other major GI professional societies, including ACG and AASLD. With the exception of ACG, all of these organizations were partners in DDW, where they had developed common purposes and solid working relationships. A plan formalizing some initial steps in the direction of confederation was put on the table for the GLC to consider.

ACG, Its Individuality at Stake, Discusses Confederation

The premise of confederation was that the GI community would be better served by having a single strong national organization through which legislative representation, education, research agendas, and most other core operations could be done more efficiently and effectively. Moreover, our members would benefit by not having to pay dues to multiple GI societies. It seemed to many within ACG, including Bill

Carey, who was then president (1993–94), that the case could be made as strongly that our members would benefit more by having several vibrant societies, each trying in a competitive spirit to outdo the other in providing the best services for its members. Nevertheless, this was a critical juncture in the world of organized gastroenterology. The stakes were high both for joining, and for failing to join if all the other organizations confederated. Discussions of affiliation, confederation, or even merger were bound to shake an institution to its core.

The College responded by focusing on defining itself, its essential and unique elements, and its mission. Deliberations by the Board of Trustees resulted in two initiatives to provide guidance. First, ACG conducted a detailed survey of its membership. This poll defined ACG members as young (38 percent under age forty), board certified in gastroenterology (75 percent), and engaged in teaching (75 percent) or research (40 percent). Physicians engaged in both research and patient care made up 40 percent to 51 percent of the membership. Most were also members of the AGA and/or ASGE. By a margin of three to one, ACG members found *The American Journal of Gastroenterology* the most useful of all of ACG's services in their clinical practice. Members showed some support for exploring more coordination with other GI societies, especially in the areas of public policy and public affairs.

Ad Hoc Confederation Committee Negotiates; Script on Napkin Settles the Issue

To further assist deliberations about confederation, the board appointed a blue-ribbon Ad Hoc Confederation Committee consisting of Drs. David Graham, Seymour Katz, Christina Surawicz, Rowen Zetterman, and Mr. Thomas Fise to meet with counterpart representatives from the AGA, ASGE, and AASLD to determine if, and on what terms, confederation of ACG with some or all of the three GI societies should occur. The committee was made up of incisive ACG leaders, all of whom had risen or would soon rise to the College presidency, and who would, therefore, have to live with whatever decision they would recommend. By the time of the ACG annual meeting in the fall of 1994, it was becoming increasingly clear that continuing to operate outside of a confederation was going to provide ACG members with the best value. At one crucial point in the deliberations, Drs. Don Powell, Tadataka Yamada, James Freston, and Mr. Robert Greenberg representing the AGA, and Dr. David Graham and Mr. Tom Fise representing the ACG, Dr. David Graham slipped a note to Dr. Powell that read, "If ACG agreed to defer to the AGA for leadership in basic science education, research, and academic issues, would AGA defer to ACG as to clinical education, political advocacy, and the ACG Board of Gover-

nors?" After some discussion among the AGA delegation, the napkin was returned with the word "NO" written on it, and it became clear that the ACG was not going to confederate. In the end the Ad Hoc Confederation Committee recommended that ACG not participate in the federation, and this decision was ratified by the Board of Trustees.

The efforts to find common ground continued through 1994 and 1995 with a series of meetings that included four representatives from each of the four major GI organizations. Hard work resulted in hammering out some areas of cooperation: joint efforts on national affairs projects, combined studies of GI practice costs and GI manpower, and cooperation on practice guidelines and combined sessions for GI program directors. But there were also significant misunderstandings. After ACG's Board of Trustees met and unanimously affirmed a series of proposals for areas of cooperation among the independent societies that had emerged from the quadripartite negotiations, they received a letter the following day announcing that the three other groups had established a different working plan and had established the Federated Societies in Gastroenterology and Hepatology. The ACG was given the option of joining the newly established federation or being expelled from membership in the GLC. ACG reaffirmed its prior decision and declined to join. Shortly thereafter the Gastroenterology Leadership Council was abolished, and new modes of communication were forced to evolve.

While discussions continued intermittently, the ACG perceived the unique nature of its own annual meeting, its commitment to the agendas of the practitioner and the clinical investigator, and the importance of having an independent voice in such areas as the shape of legislative proposals on colorectal cancer screening. In this last area the College was soon to learn that it had a powerful role to play as the voice of the clinical gastroenterologist and as a respected representative of patients' rights.

A Vote against Confederating Strengthens College Resolve and Relationships

For more than eighteen months during the terms of Drs. Schuster (1996–97) and Chobanian (1997–98), the Board of Trustees intermittently debated the federation issue. Some College leaders were very much in favor of joining the other societies in such a confederation. Others had been very much opposed, mainly because they believed that the primary focus of the ACG as the leading organizational voice for the concerns of the clinical gastroenterologist would be lost amidst the larger, academically oriented confederation dominated by the AGA. In a final close vote in June 1997, the board decided that the ACG would remain independent of the federation.

Many observers predicted the College's demise after the board's vote, but the ACG continued to grow, exceeding 6,000 members for the first time during this period. The organization had learned its lessons well and was ready to set the pace for new approaches in patient advocacy, policy advocacy, and service on behalf of the practicing gastroenterologist. The door was left wide open for future activities with our sister organizations, albeit with the caveat that our primary mission not be compromised.

Much has now been resolved through mutual respect and understanding. History has borne out the notion that several healthy organizations can both collaborate and compete in constructive ways that improve the services offered to our members. The Federated Societies of Gastroenterology and Hepatology has since dissolved. The College, however, not only continues to pursue its mission but also maintains dialogue with other organizations, which has often resulted in unified positions and initiatives among the four main GI societies on key issues.

Colon Cancer Screening Legislation: Choosing Sides

Eric Davis, colon cancer survivor, meeting with legislative staff on Capitol Hill to promote the importance of colorectal cancer screening.

The strongest opinions averse to ACG's efforts in the political arena came to the fore with what at first appeared to be an innocuous issue—the establishment of a Medicare colorectal cancer screening benefit (see Chapter 5: Climbing the Hill). The effort in support of this benefit began on a chilly day in January 1994 when ACG representatives Dr. Marvin Schuster, Mr. Thomas Fise, and Mr. Thomas Scully, former ACG legislative counsel from Patton Boggs, visited Representative Ben Cardin (D-MD) in Baltimore. Rep. Cardin agreed to take a lead role in the effort to secure the new Medicare benefit, and he introduced legislation into Congress to accomplish this objective. ACG began to educate legislators and others about its position, and the goal of attaining the benefit was soon endorsed by virtually every group in the GI field. Disagreement only emerged when a company involved in the sale of products used in administering barium enemas indicated that it would work aggressively to defeat any colorectal cancer screening program that did not create a role for barium enema. In November 1995, Senator John Breaux (D-LA) introduced to the Senate a version of the bill that Rep. Cardin had introduced to the House. Senator Breaux's proposal permitted barium enema as an alternative for both average and high-risk patients.

In December 1995, ACG representatives met with the lobbyists for the company. The prospects for a negotiated solution broke down at that meeting when the company insisted that any legislation must permit barium enema alone as an equivalent alternative for high-risk patients. Company lobbyists even displayed artwork for an advertising campaign planned to disparage the safety of colonoscopy. ACG knew that the legislation desired by the company would compromise the best interests of high-risk patients, and communications soon made it clear that the ACG was much more strongly opposed to carving out a role for barium enema than the other GI societies were. Some of these organizations circulated an open letter to members, criticizing the ACG for an article in *ACG Update* stating that it appeared ACG would be fighting alone against these industry interests. An article appeared in *The New York Times* outlining the battle between ACG and the barium company. The barium wars continued for nearly two years. A critical point in the controversy emerged in early 1997, when most groups in the GI field, the American Cancer Society, and even some GI patient organizations endorsed a bill introduced by Senator Bob Graham (D-FL), S. 311, which was quite similar to the prior Breaux bill. It was unclear how much of the support for S. 311 was generated by scientific or political reasons and how much stemmed from concern about the mischief that the lobbyists for the barium company might cause if dissatisfied. The prevailing wisdom was that enactment of a colorectal cancer screening benefit, even an imperfect one, was better than no benefit. It was clear that some of the groups supporting S. 311 feared that any lack of unanimity or public discussion of different viewpoints on how screening should be done would cause Congress to drop the benefit entirely.

A House-Senate conference finally considered two bills in the summer of 1997. The House bill included the three tests that ACG favored—the fecal occult blood test, flexible sigmoidoscopy for the average-risk patient, and colonoscopy for the high-risk patient—with an allowance that barium might be added if and when it secured an affirmative decision from the Secretary of Health and Human Services. The Senate bill (S. 311), which did not get out of committee, would have sent all tests to the Secretary of Health and Human Services for a decision on what was appropriate. Prior to the conference, all the other GI organizations, the American Cancer Society, and the American College of Radiology had supported the Senate bill, but ACG had opposed it. The conferees decided to go with the House bill. At least on that day, the principle that the ACG had held so dear prevailed. In working to ensure appropriate testing that may save thousands of lives, the Col-

lege defined its new role as a potent voice for patients. For this achievement in championing the primary role of endoscopy in such a devastating and pervasive disease, the College can be justly proud.

Administrative Restructuring: Once Again

In 2001, then President-elect Edgar Achkar, MD, FACG, like his predecessors, recognized the strong role of Association and Government Relations Management Inc. (AGRM) in the ACG administrative structure and the in-depth knowledge Mr. Thomas Fise had contributed as executive director. As presidents and members of the Executive Committee came and went, Mr. Fise had provided continuity in leadership since 1987 and had become the repository of the College's corporate memory. While Dr. Achkar cherished this solid support to his presidency, he was concerned about the dependence of the College and its vulnerability should the relationship with AGRM cease abruptly for any reason.

Immediately after assuming the presidency in October 2001, Dr. Achkar approached Mr. Fise with his concern. He did not want to suggest any breach of confidence and had no personal interest in disturbing the effective relationship between the two organizations. To his relief, he found Mr. Fise equally concerned about the future and personally committed to ensuring that ACG's welfare would not suffer in any way. Having established mutual trust, the two parties were able to proceed quickly to a lengthy discussion about details of the transition from AGRM support to an ACG-based administrative structure.

An Agreement Smoothing the Transition

After intense negotiations, and with the help of legal counsel on both sides, an agreement was submitted to the Executive Committee and then to the Board of Trustees. Having gained approval, the two parties signed an agreement in December 2002 that outlined the transition process with notice and implementation deadlines. The agreement included:

- Financial terms dictating the transfer of assets
- Details concerning personnel and asset transfer
- A series of option dates for activating a transition plan
- The appointment of a chief operating officer
- The commitment from AGRM to help ACG recruit three or four individuals for key administrative positions.

One of the key features of the contract was that AGRM had the option, at any of several stipulated fixed points in time, to renew its current arrangement with ACG or announce its desire to trigger the transition, allowing ACG a full year before the actual transition would take effect. During the years following the signing of the transition agreement, a member of the Board of Trustees acted as administrative liaison with ACG and assisted with recruitment and administrative reorganization. Mr. Bradley C. Stillman was recruited as chief operating officer, and the administration of ACG's affairs continued without any negative effect. Indeed, it was during this period that the College conducted its highly successful capital campaign.

ACG's Executive Director Brad Stillman with retired Executive Director Tom Fise at the ACG headquarters in Bethesda, Maryland.

A Smooth Transition Bodes Well

In October 2004, Mr. Fise announced his decision to trigger the transition provided for under the contract. Legal counsel took over the details of the transition, the transfer of assets proceeded smoothly, and the majority of AGRM employees were assimilated into the new ACG administrative structure. By October 2005, the administrative transfer was completed. Mr. Stillman became the executive director of ACG, and Mr. Fise—as indicated in the contract—remained on staff with more focused responsibilities as a consultant and director of policy and strategic initiatives.

The Move to Bethesda: New Digs for the College

While details of the transition were evolving, the Board of Trustees was addressing the future location of ACG headquarters. AGRM occupied office space in Alexandria, Virginia, and was willing to assist the College in negotiating a renewal of the space's lease, which was to expire in 2005. Recognizing the overcrowding and the lack of potential for growth in the Virginia location, the Board of Trustees asked the treasurer and the Finance and Budget Committee to study the issue and make some recommendations for future ACG office space. The committee recommended that an immediate search be undertaken for a new location and suggested studying the option of leasing as well as buying a building to house the administrative offices of the College.

In October 2003, the Board of Trustees approved ACG's entering into a partnership for the acquisition of an office building in Bethesda, Maryland. The arrangement allowed the ACG to renovate and furnish ample office space for its present needs and—more important—for

ACG moved to its new headquarters in Bethesda, Maryland, in 2005.

future growth of not only administrative personnel but also the Institute for Research & Education and *The American Journal of Gastroenterology*. ACG provided a percentage of the costs of the 75,000-square-foot building's acquisition and enjoys a 40 percent interest in the building's equity ownership, appreciation, and profits. The College has the protection of a stop loss against responsibility for any operational losses for the building. All occupancy, leasing, maintenance, and management issues are solely the responsibility of ACG's partner in the building, which is a Maryland-based development company.

The transition to an independent ACG administrative structure has taken place for the most part with amazing ease. Both the administrative structure and the office headquarters provide the College with the support necessary to assist its leadership and its committees quickly and effectively; to sustain its commitment to clinical research; to promote a premier, editorially independent scientific journal; and to entertain new projects, particularly the expansion of educational and research activities such as the creation of a web-based education program.

The Future of the ACG

The College was born out of the need recognized by its founders for an organization that truly understood, reflected, and served the needs of its constituency—clinical gastroenterologists and their patients. This is the prism through which decisions about the activities and direction of the College has always been viewed. The result has been the formation of an extremely strong and resilient foundation for the College as it moves forward.

The field of gastroenterology has always been at the forefront of identifying and perfecting ways to use technology for the benefit of improving patient care and treatment. This dynamism, which comes from being at the intersection of scientific and technological discovery, has helped keep gastroenterology among the most exciting specialties in medicine. The College is a critical resource for taking these exciting discoveries, both medical and technological, and developing practical, scientifically sound clinical applications that can be integrated into the practices of the community GI clinician. It is this critical role, one of practical education that meets the needs of the College membership, that will continue to be the hallmark of the organization into the future.

The College's Mission Statement provides a map for the future of the College, just as it provides a measuring stick for the activities from the last 75 years. It focuses on:

- advancing knowledge of gastrointestinal disease;
- educating specialists in gastrointestinal disease;
- representing the interests of the clinician practicing in the field of gastroenterology;
- ensuring quality in patient care; and
- promoting patient education on gastrointestinal conditions and digestive health.

It is the College's unique structure, with its focus on grassroots representation and a leadership model that provides a two-way conduit of information between the membership and the leadership, in addition to representative leadership from all corners of clinical practice, that will help ensure that the outstanding arc of growth will continue long into the future. These structures will help assure that the College maintains its clear focus on being an unsurpassed high-quality educational resource for GI clinicians and their patients and an untiring advocate for the practitioners of clinical gastroenterology with public and private policy makers. The College and its programming and advocacy reflect the needs of clinical gastroenterologists in all practice settings because the leadership represents the entire field. To see the future of the American College of Gastroenterology, one must only look at the journey the organization has taken. Upon doing so, the membership can feel secure in the knowledge that the College will continue to be the premier clinical professional society in gastroenterology.