SAGES and surgery

Barbers, endoscopists, minimal access surgeons, interventionists

Dr. McFadyen, Dr. Marks, members and friends of SAGES, ladies and gentlemen. I want you to know that I sincerely appreciate this truly special honor. It is certainly not as deserved as Dr. McFadyen’s flattery might suggest but it gives me an opportunity to praise Dr. Marks as well as you, the members of SAGES, and, selfishly, an excuse to bask in the sunshine of your radiance. As Lord Bulwer-Lytton so aptly said:

When the high heart we magnify
And sure vision celebrate
And worship greatness passing by
Ourselves are great.

Thanks to the grace of the Almighty, a faithful spouse whose presence we also appreciate, and good fortune, Gerald Marks is alive and well, very much with us and ever forming other societies, probably even as we speak.

When Bruce McFadyen called to inform me that I had been selected to be the Gerald Marks lecturer for 1995 I was initially thrilled. But soon after the flattery of the invitation had worn off, I recalled that much exalted oratory in honor of Gerald Marks had already been delivered by giants in the endoscopic community, department chairmen, even the then president-elect of the American College of Surgeons. So what could be left for me to relate?

I have learned many things from Gerald Marks during our long association. Jerry begins every SAGES meeting by giving the audience some background, some historical perspective. And while I do not have his verbal fortitude nor flare for words—nor do I think you would allow me the same latitude you often give him for his so-called brief remarks—nonetheless, I will try to tell you the tale of SAGES: how we came to be and who we are (or think we are). Then I will try to show our relationship to the general community of surgeons, and, finally, point out where I think we might be going, if anywhere. I accept blame for any, hopefully minor, inaccurate recollections or omissions.

Most endoscopic surgeons rightfully point out the major and important involvement of surgeons in the early days of rigid endoscopy. Save for visionaries like George Berci and Walter Gaisford, precious few general surgeons, at least in North America, recognized the value of peritoneoscopy, and those of us who employed it in the early years were thought to be a bit out of focus compared to honest-to-goodness surgery.

When flexible endoscopy began evolving in the late 1950s and through the 1960s, gastroenterologists, by and large, were at the forefront. The pioneering efforts of two surgeons, Hirami Shinya and William Wolff, made the therapeutic possibilities of flexible endoscopy become reality, and a few surgeons dared to board a ship that was not yet licensed in either the port of medicine or the port of surgery. Most of the crew were, however, gastroenterologists. Many of you may not know that the academic gastrointestinal societies did not rush to embrace this renegade band of technologists. The American Gastroscopic Club, a group of pioneer gastroenterologist-endoscopists who had banded together in 1941 (and did include a surgeon, Edward Benedict of Boston), evolved into the American Society of Gastrointestinal Endoscopy, the ASGE. But as the practice, popularity, and pecuniary rewards of endoscopy began to escalate, so also did the territorial and political battles between surgeons and gastroenterologists. For the colon and rectal surgeons, the attempt to exclude them from use of the endoscopy suite threatened to weaken their ability to train fellows.

Now the birth of SAGES was on this wise. In preparing for this lecture I found in my own hand a note scribbled during a telephone conversation initiated by Gerald Marks in 1974, concerning the possibility of forming a surgical endoscopic society in 1975, and at that initial contact we discussed the names of several potential members.

Dr. Marks recalls that in approximately 1978 he began discussing the issue with Dr. Eugene Salvati and others of us who practiced mainly gastrointestinal surgery. While we did not think that our individual academic lives and practice fortunes were likely to be changed, we recognized that those of our colleagues, in and out of academe as well as surgeons in the near future, would indeed be threatened if they found the doors of their local endoscopy suites closed to them. It was at this time that Gerald Marks had a vision. Notice

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that I said a vision, not an idea, for as an old Native American chief allegedly once said: For Indians there were visions; for whites there were only ideas. Visions, in the Native American context, require action, and this action manifests itself in the community, enabling the people to go forward in confidence and obedience. The vision includes and covers everything, and there is no mistaking its applicability. Ideas, on the other hand, have only a limited relevance . . . and an idea never reaches the complete community. It only reaches those who have the ability to grasp it, leaving the rest of the community struggling for understanding. So Gerald Marks did have a vision. Among those involved in the early discussions were Tom Dent, the late Steve Hedberg, Ted Schrock, John Coller, John VanSant, John Dixon. We gathered in small, informal groups at national meetings to thrash out ideas and strategy.

Jerry’s vision was that with a formal organization we could launch a more effective campaign against what was initially perceived as mainly a battle on issues of turf. With much trepidation but also much resolve we decided to put a positive spin on this vision. It took some long, late hours to come up with the acronym you now take for granted and Jerry’s special artistic talent to craft the credo we now so proudly wear, cravats with the symbols of the arena in which we operate, our old and new tools emblazoned upon them, to emphasize our surgical (as distinct from medical) involvement. While we had the support of a few friends in several, even disparate, camps, we faced overwhelming obstacles from many quarters. There was anticipated antipathy from most gastroenterologists. But we were astounded at rejection by some leaders of established surgical organizations, whose members at that time were overly and, I believe, too narrowly, concerned about referral patterns, and by some who thought that endoscopic technology was somehow infra dignitatem, forgetting that surgeons do usually work with tools. With a few notable exceptions, we were understandably slighted by many in industry who were fearful of which way the wind might blow. Many (in both medicine and industry) took a wait-and-see attitude, swayed perhaps by Sophocles’s caution that “one must wait until the evening to see how great the day has been,” but SAGES organizers were clearly more inspired by the likes of Eric Partridge, the lexicographer who said “It is better to travel than to arrive—not that arrival fails to bring on a lively gratification”—such as we have here today.

Among the original board of governors in 1981 there was heavy commitment from colon and rectal surgeons, and without the likes of men like Alejandro Castro, Eugene Salvati, Herand Abcarian, and the others on the original board, our organization might never have been launched. Early in our history we established firm communication with the American Board of Surgery, which resulted in recognition and a requirement that endoscopy (including peritoneoscopy, I might add) be an important part of the training of surgeons. Thanks to the efforts of Tom Dent, our present American College of Surgeons governor, we have developed strong and effective bonds with that organization. There has been some cross-fertilization with the ASGE leadership over the years, but unfortunately, most of the workers in the field still see us as competing farmers, not only in the acreage of flexible endoluminal endoscopy but even in some fields of laparoscopic intervention.

As a fledgling organization with minimal funds we could not have survived without the financial discipline and careful stewardship of John VanSant, our first treasurer, and I regret that he could not be with us here today.

Nor can the story of SAGES be fully recounted without recognizing Barbara Saltzman Berci and her wonderful staff which has supported us, for as we have grown, so have they, not only in number but in commitment, loyalty, professionalism and esprit de corps. They have continued to cope with us, educating us, nagging us when we need it but ever sustaining us. To work with a group of virtuosi and mavericks such as this band of endoscopic surgeons is a test of their fortitude, and it must be lauded. Other SAGES presidents have outlined our progress over the years in addressing education and training, promulgating guidelines for credentialing and practice, communicating new information through our journal, and establishing a unique relationship with industry through our Corporate Council, one of the special strengths of this society and, therefore, of endoscopic surgery in general. However, there was one event in 1989 that changed our organization forever. It occurred as surgeons nationwide were lamenting the inroads being made into general surgery by subspecialties in surgery and by other disciplines. In fact, at that time many surgical leaders felt that they should warn their constituencies that general surgery was in its death throes. During this dark and depressing age, it was the videotape that our good friend Jacques Perissat showed at the SAGES meeting in Atlanta and managed to display in a corner at the 1989 meeting of the American College of Surgeons, around which throngs gathered, some in amazement, some in dismay, some amused, but most affected—it was that singular event that changed the course of SAGES and surgery, perhaps for all time. If we had had the patience and wisdom then to step back and take stock we would have realized that at that point in time, there were actually several developments coinciding: (1) the ability to produce enlarged and virtually color-true images of work being performed remote from the hands of the operator, allowing the operator’s vision to be shared with other members of the operating team, thus enabling their meaningful participation; (2) improved anesthetic techniques; (3) more precise preoperative diagnosis through better imaging technology, thus leading to more directed and less exploratory operations; (4) improved understanding of nutrition in the surgical patient; (5) better patient education and therefore better compliance; and (6) more rapid dissemination of surgical technical developments in the media.

Having that year grown to a membership 1,000 strong, SAGES was now the natural landing strip for