

The Joys of a Surgical Career
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Presidential Address ASCRS
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Thank you for the introduction.

Members and guests, friends, and family:

It has been a great honor to have been your president in the last year and I thank you for the privilege of being able to address you today. I have been a member of this organization for almost 30 years and I can think of no other surgical society with the expertise, collegiality and camaraderie of this special group.

As I started my surgical journey upon graduation from Boston University Medical School in 1981, I never would have thought that 36 years later I would be standing here giving this address. You see, most of us don't start off with an interest in colon and rectal surgery; I did not, and as you heard, my initial interests were in orthopedics. But, life takes interesting twists. Convinced that I would pursue a career in orthopedic oncology, I applied for an orthopedic residency program. I was rejected from my first and second choices and told, "I was a bit young" and was encouraged to re-apply when I had more "surgical seasoning." I clearly needed to look elsewhere. Fortunately, before I developed that "seasoning," I had the opportunity to spend six months at the Lahey Clinic on the colorectal service in 1984-- where they were doing a new operation for ulcerative colitis-- the ileoanal pouch procedure. This early experience solidified my interest in colon and rectal surgery (much to the chagrin of my mother who to this day regrets that I am not a plastic surgeon) and the rest is history.

My address today will be in two parts-- the joys of a surgical career and the state of our society with a focus on the last year.

A report on the state of the Society is also given at the business meeting-- the group is much smaller. What we have done this year represents the value of membership in the Society and I would like to share it with you today.

One hundred and eighteen years ago, in 1899, 13 Surgeons met in Philadelphia with the singular vision of forming a society to treat diseases of the colon and rectum, to spread their

knowledge, to educate and to relieve suffering in patients previously uncared for. The American Proctologic Society was thus formed with Dr. Joseph Matthews as our first President, and in 1973 we changed our name to the American Society of Colon and Rectal Surgeons. That vision still resonates today.

In 2017, we are now over 3,500 members (3,582) strong, our members come from all states (except Wyoming) and from 66 countries. This year we have 189 new members, 297 new candidate members and 118 members who will be elevated to fellow, including 53 international fellows and 5 honorary fellows. Twenty-three percent of our members are from outside of the United States.

Our meeting this year is a Tripartite meeting, a combined gathering of the American Society of Colon and Rectal Surgeons (ASCRS), the Association of Coloproctology of Great Britain and Ireland (ACPGBI), the Royal Society of Medicine, Section of Coloproctology (RSM), the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), the Royal Australasian College of Surgeons, Section of Colon and Rectal Surgery (RACS) and the European Society of Coloproctology (ESCP). Our society has seen the value of combined meetings for years and in 1924 the first joint meeting of the American Proctologic Society and the Royal Society of Medicine Section of Proctology was held. The meeting occurred in two sessions-- one in London and one in New York. We now meet every three years and ultimately every nine years in North America.

What makes these meetings so valuable? Our president, Robert Scarborough in 1964, noted that "Joint meetings help to promote peace, and provide an opportunity to strengthen the bonds of brotherhood in a profession dedicated to human service." I believe this is true today, but these meetings offer potential for friendship and international collaboration and for the sharing of different approaches and expertise with respect to surgical practice, training and education and the development of new surgical techniques.

Our tripartite meeting this year emphasizes quality of care and optimal colorectal surgical outcomes across the world, and I am grateful for the efforts of Rocco Ricciardi, the program chair, Sonia Ramamoorthy and Anjali Kumar, the vice chairs, in addition to Jamie Keck, our international liaison, and the program committee who have done a tremendous job putting together an outstanding program. Our program committee reviewed a record submission of 1,018 abstracts. Our meeting has a number of hands-on courses, symposia, and debates. We are attempting to go paperless with our mobile meeting app in place since 2014. We have been increasingly utilizing social media to disseminate information from the meeting as quickly as possible and have enhanced our social programs.

We have had a busy year and I thank the Executive Council. All of our committee members and our administrative partners at EAI for their hard work and dedication over the last year. In the last year, over one-half of our members and 64% of our fellows have been involved in some aspect of volunteer activity with respect to ASCRS.

We recently completed a membership survey. The results of the survey have informed the development of our strategic plan for the next three years, positioning us for ongoing success in the future.

We have revised and updated our bylaws under the leadership of Tracy Hull and Tom Read which will be voted on at the business meeting. In our new bylaws, members of the Society, in addition to fellows, may participate in committees. We have had a smooth transition of *Diseases of the Colon and Rectum* to our new Editor, Dr. Susan Galandiuk, new co-editors and editorial office. On behalf of the society, sincere thanks to Rob Madoff for 10 years of stellar leadership of *DC&R*. Under his stewardship, the *Journal's* stature and impact factor have increased considerably. I invite you all to read the June 2017 issue of *Diseases of the Colon and Rectum*, which is a Festschrift for Rob Madoff.

We have over 25 committees that are engaged in a number of projects with an incredible work output. Over 700 members and fellows participate in committees.

A few highlights of the committees and their accomplishments:

The Clinical Practice Guidelines (CPG) committee, under the leadership of Scott Steele, completed six new guidelines in the last year and has jointly developed an ERAS guideline with SAGES. CREST, the colorectal education system template, the online education portal, now has 117 modules, 63 of which are available for CME credit.

The CREST committee, under Josh Bleier, initiated the program director's module this year for residents and fellows to access CREST. We started quarterly webinars on timely topics in colorectal surgery from rectal cancer to Crohn's disease.

The Self-assessment committee, under Matt Mutch and now Charles Friel, completed CARSEP 9 which is now easily completed online and available for MOC credits. The third edition of the ASCRS textbook of Colon and Rectal Surgery was published last year and has rapidly become the standard text in our field for both residents and fellows in addition to practicing surgeons.

The 3rd edition of the ASCRS handbook is in progress and we will soon be planning the fourth edition of the textbook.

The Operative Competency committee has been integrally involved in technical skills assessment tools and has developed COSATS-- the colorectal objective structured assessment of technical skills-- and most recently, a video based assessment tool for the performance of laparoscopic right colectomy. Special thanks to Sandra deMontbrun, Helen Macrae and Brad Champagne. We are in discussions with the American College of Surgeons about implementing COSATS using the College's accredited educational institutes for administration of the examination.

The CME committee, under the leadership of Judith Trudel and David Maron, oversees all continuing medical education programs and had a pivotal role in the recent ACCME reaccreditation review, and we are optimistic about another maximal term of reaccreditation.

The Health Care Economics committee, chaired by Walter Peters, has advocated for our specialty and has kept us informed about changes in reimbursement, including MACRA and MIPS, bundled payments and APM's. Five members of our society were recently selected to serve on a CMS- GI disease medical management committee.

The Rectal Cancer Coordinating committee and the Fundamentals of Rectal Cancer committee, chaired by Steve Wexner and Conor Delaney respectively, have been integrally involved in the development of programs and educational modules which have been endorsed and accepted by the American College of Surgeons, Commission on Cancer, which will ultimately be segued into the National Accreditation Program for Rectal Cancer.

The Young Surgeons committee under Jason Mizell and Heather Yeo developed the successful Saturday mock orals session. Young surgeons will also be moderating the 400+ e-posters throughout the meeting. The committee has also just completed a young surgeons first job survey. This is the most popular committee; we have also had a number of very senior members trying to get on the committee!

Our research foundation, under the leadership of our president Michael Stamos, has awarded a total of 26 grants in 2017. Over \$5.7 million (5,750,110) in grants have been awarded since 1990. I hope you have all supported the Research Foundation with the Meet the Challenge last night at the Welcome Reception. If not, there is still time to contribute.

We have also been developing a number of new collaborative initiatives with other organizations, including an IBD surgery research alliance with CCFA, and initiatives with SAGES for development of clinical practice guidelines especially focusing on endoscopy.

I would like to address you today on the joys of a surgical career and will frame this in the stages of a career from becoming a colon and rectal surgeon, early career, mid-career and late career, and mesh this with the development of our specialty. At every stage of my career, I have been told by many that I missed “the golden age” of medicine. I never quite saw it that way, but perhaps they were right, as I believe we are in the “golden age of colon and rectal surgery.” Our specialty is popular and we continue to have more applicants for colon and rectal fellowship than we have positions; we have a number of new procedures and new technology. Most of the procedures many of us perform today were not in existence when we trained. We have an incredible depth and breadth to our specialty and our influence far exceeds our relative small size.

I would suggest that there is a special joy which comes from the practice of surgery, and that a career in surgery creates an identity and a defining sense of purpose in life. It has a number of planned and unexpected challenges and limitless unique opportunities.

Initial Education and Training

So, let’s examine the stages of a surgical career-- first initial education and training. In this country, colorectal training is one year and follows five years of general surgery residency. We currently have a total of 99 training positions in 57 programs in the U.S. and three in Canada. The number of programs has increased by about one-third over the last decade. But despite this, our specialty has become so popular that about 30% of those who apply do not match. Our board, working with the American Board of Surgery, is exploring several 4 + 2 training programs with four years of general surgery followed by two years of colon and rectal surgery.

We know, however, from a survey performed by the American Board of Colon and Rectal Surgery, that most trainees don’t start medical school with an interest in the specialty. A survey of 189 colon and rectal residents noted that most identified colorectal surgery as an interest in their third or fourth year. Seventy percent had rotated on a colorectal rotation by the end of their second year. The top factors in deciding on colorectal as a career choice were influence of colorectal mentors and teachers and a positive exposure to colorectal surgery as a PGY 3, 4 or 5. So genuine passion for the field and effective role modeling are the most important factors. Or, as our Past President Curtis Mechling stated in 1933 “nothing is so contagious as enthusiasm. It moves stones and charms brutes. It is the genius of sincerity and truth accomplishes no victories without it.” The interest in the third and fourth year has implications

for training as we talk of early specialization, and we must find ways to expose medical students and early trainees, especially junior residents in general surgery, to our specialty.

As colorectal surgeons, many of us have an integral role in the training of general surgery residents. General surgery is the pipeline to our specialty and I believe that we need to continue to commit to and be involved in the training of general surgery residents. While many of us trained in the “see one, do one, and teach one” era, we now recognize and value the role of simulation, but I would suggest that most of our sim centers are underutilized for teaching and training. And although we have concerns about the impact of duty hours restrictions, consider this-- an 80 hour work week over a five year general surgery residency is 19,200 hours (or 3,840 hours for a one year colorectal residency). We have a lot of hours to train residents!! Anders Ericsson, a cognitive psychologist at Florida state university has told us that it takes 10,000 hours of practice to become an expert. But it is, of course, not just 10,000 hours, but deliberate and purposeful practice with ongoing timely feedback combined with the grit and determination of the individual.

And I would suggest that we are training the best and the brightest, a group of highly motivated individuals. And if we cannot train residents to proficiency in this time period, then perhaps we have a problem with our training programs and not our trainees. While we may need to have a total “disruptive innovation” in our training paradigms in the future, I believe there are a number of positive changes we could make immediately.

We can improve our teaching, especially in the operating room. As we do this we need to be focused on the competence of our trainees, the degree of autonomy we give them in performing a procedure and the degree of complexity of the procedure. There are several effective methods we could easily implement. These include the following techniques:

The BID technique-- briefing or the 2-3 minutes interaction at the scrub sink, followed by intraoperative teaching and then debriefing. The Zwisch model devised by Jay Zwischenberger at the University of Kentucky, which consists of four stages to assist in the training and assessment of residents to achieve operative competence. We need to take advantage of every teachable moment in the OR and also give better feedback.

We can also improve assessing the competence of our trainees not just during training but during the certification process. Surgical competence includes knowledge, judgment and technical skills.

We assess knowledge through written boards and judgment through our oral boards, but we have not rigorously assessed technical skills at the time of board certification. Our society has been on the forefront of developing technical skills assessment tools and developed COSATS, the colorectal objective structured assessment of technical skills. The COSATS was developed by our Operative Competency committee. Following two successful pilots in 2011 and 2012, COSATS was administered to 70 first time test takers at the oral board examination in 2014. There were eight technical skills stations representative of colorectal surgical practice, and candidates went from station to station, and were evaluated on their technical skills by a global rating scale and checklist. Individuals who failed the COSATS were different from those who failed the written or oral exam, thus demonstrating we are evaluating a different construct. We are currently working closely with the board and other organizations to further COSATS and incorporate it into the certification process. We have been the first specialty to formally assess technical skills at the time of certification.

We also need to look at our curriculum and figure out what our trainees need to learn in one year (or two years). Consider this-- in 1950, medical knowledge took 50 years to double, in 1980 it was seven years, in 2010 it was 3.5 years and in 2020 it is projected to be 73 days-- so a student graduating from medical school in 2020 will experience four doublings of knowledge. It is clearly impossible to absorb and certainly impossible to memorize, so we need to focus on how to access timely relevant information and how to process and integrate BIG data. What we previously wrote on index cards can now easily be accessed by a smartphone.

Furthermore, many of the procedures we do today, we were never trained to do in our residency. For instance, when I started training, there was colectomy. There was no open colectomy because there was no laparoscopic colectomy. Now we have open, straight lap, hand assist, single port, robotic, etc. When I trained, there was fistulotomy or seton placement. Now we have plugs, glue, flaps, and LIFT procedures.

How will we assimilate this knowledge and how will we become proficient and learn new procedures? How will we navigate through BIG data? Will every physician be querying Watson for clinical conundrums? I don't have all the answers but I would suggest that procedures and knowledge change rapidly. Simply adding more material and time to the curriculum simply won't do it. We need to develop the framework for lifelong learning and lifelong training. How will we do this? One way may be to develop the growth mindset. What do I mean by this? Carol Dweck is a professor at Stanford University who studies motivation, personality and development. In her book, "Mindset-the New Psychology of Success," she believes that there are two mindsets: the growth and the fixed mindset. Fixed mindset students believe that success is based on innate ability. Growth mindset students understand that talents and

abilities can be developed through effort, good teaching and persistence. Now, certainly not everyone is the same and can be an Einstein but they believe everyone can get smarter if they work at it. This is important since growth mindset individuals continue to work and thrive despite having setbacks. We need to work to develop the growth mindset in our trainees and ourselves.

EARLY CAREER

Switching to the first 10 years in practice-- the early years in practice are some of the maximal times for professional growth and development. Upon entry into practice, many will feel that there is a time "that you just can't train another day," but there is still trepidation about independent practice and operating. But first, some guiding principles with respect to the practice of surgery. Treat your patients as you would wish to be treated yourself or have a member of your family treated. If you cannot cure, you can provide comfort and empathy. Be positive. It has been said that perpetual optimism is a force multiplier. Be humble. Take your position seriously but not yourself. If you make a mistake, admit it and say you are sorry. Winston Churchill said, "in the course of my life, I have often had to eat my words and I have always found it to be a wholesome diet." Be consistent, truthful and honest. If you are honest, you never have to remember what you said. Take care of yourself. If you have not taken care of yourself you don't have any gas in the tank to take care of patients. Have self-awareness/self-knowledge, treat yourself, take time off and spend time with family and friends, have your own primary doctor. Build resiliency or mental toughness, since it is not what happens to us, but how we react to it. The ability to recover from a setback, adapt well to change and keep going in the face of adversity is key. In a recent review of physician burnout and well-being in the June issue of *DC&R*, David Rothenberger contends that two effective strategies for well-being and avoiding burnout are aligning personal and organizational values and enabling physicians to devote 20% of their work to medical practice that is particularly meaningful to them. (Good advice for returning to what motivates us-- the sense of autonomy, mastery and purpose which Daniel Pink talks about in book, "Drive"). Pay it forward-- we have all had spectacular teachers and mentors-- pass it on-- you do not need to be in an academic environment to do this. You can pass it on to a nursing student, a scrub tech, a medical assistant or a high school student potentially interested in a medical career. Never stop asking why. When you ask questions, you get answers. Be inquisitive. You don't need to have an RO-1 grant to do this-- keep an open mind-- challenge the dogma, ask the difficult questions, examine the literature and seek the evidence.

Pursue innovation-- today's facts are tomorrow's fallacies. Be grateful (not entitled). Be grateful to your patients, your teachers, your mentors, your office staff, friends, family and all those who have supported you. Remember that "from those to whom much has been given,

much will be expected” (Luke 12:48). Be involved in and understand health care policy reform. We have enormous challenges throughout the world to deliver health care to the entire population. My personal believe is that basic health care is a fundamental human right.

In the first few years of practice, regardless of whether you will have an education or research focus or pure clinical focus, it is important to establish yourself clinically and to have the respect of others as a sound clinician and surgeon. So focus on building a robust practice and pass your boards. Don't try to get overly involved in other activities until you have done this.

And as you develop and start your practice I would like to encourage all of you to develop your niche or develop your colorectal surgery identity. It is increasingly difficult to be a utility player who can do everything. And having said that, we all have favorite operations. I love reoperative surgery. Sometimes I question this when I am in the third hour of adhesiolysis, but nevertheless... I love perineal rectosigmoidectomy, total abdominal colectomy and ileostomy and those rare mucosectomies for an ileoanal pouch procedure.

Become an expert in a specific disease or condition and follow the literature. I have had a long interest in diverticulitis. And recognize that although you may like a specific operation, the operations change although the diseases generally do not.

In the early career, there are a number of competing priorities, including starting to establish yourself as a surgeon, potentially starting a family and having young children, starting to establish your educational or research interests. Throughout your career and even in your early career, there are times when you have too many opportunities-- too many manuscripts to review, too many research projects, and too many invited speaking engagements-- it is difficult to say no at this point because you feel like you will never be asked again. I can recall a time that my husband once picked me up at the airport and dubbed me the Visiting Wife instead of the Visiting Professor because I had been away so much. It is okay to say “no” from time to time. They will ask you again. You can do a lot and potentially do it all, but not all at once.

As you hit your stride from a clinical standpoint, I would encourage you to get involved further in ASCRS, your regional colorectal society and the ACS. Continue to teach medical students and residents or simply be an ambassador for our specialty.

MID-CAREER

Looking at mid-career, after the first ten years, you have established yourself clinically, found your niche and become involved in other organizations.

It is also time to develop leadership. Now, some say not everyone can be a leader, but I would suggest that while we do not all aspire to be a department chair in surgery or president of the society, in the field of surgery, we are all leaders. We lead the team in the OR, we lead our office staff, we lead the team on rounds. A recent ACS bulletin said that leadership is a choice not a rank.

The word leader actually comes from the word ledare. It appeared in the English language in 1300 and is derived from the words for path, road or course of a ship at sea. There are many definitions of a leader. I love fortune cookies and a few years ago, I got a fortune cookie that said, "a leader is someone who takes you to a place you would not go by yourself." I think this is a great definition. Leaders may be defined as directing the activities of a group toward a shared goal. In every organization, good leadership is essential for sustained success.

There are a number of reasons that I think that surgeons in particular make good leaders.

These are:

- The ability to remain calm in stressful situations.
- The ability to make decisions based on incomplete information and make decisions quickly.
- The ability to communicate with a wide variety of people.
- The ability to show compassion and empathy.

While our surgical leaders in the past were often chosen based on the triple threat-- the excellent clinician, researcher and teacher-- additional competences are needed to be successful today. These include self-awareness and emotional intelligence, communication skills, the ability to work in teams, to identify, recruit and develop talent, and build alignment and some knowledge of the business side of healthcare.

As we look at leadership, mid-career may also be the time where you may feel that you have maxed out and do not see future opportunities at your own institution. In colorectal surgery, there is enormous movement in the market. Academic centers previously had one colorectal surgeon and now a number of centers, especially in the Boston market, are trying to build up divisions and are looking for young mid-career talent. When we look at career advancement, we can divide it into: Stay at your institution or "dig your heels in." or Leave you institution or "Move on to move up."

Every move is really a calculated risk. We need to recognize that the grass is not always greener. Career moves are rarely made in isolation and to be successful need to involve spouses /partners and family.

And for those of us in more senior positions, it is somewhat bittersweet-- but if one of your junior or mid-career faculty leaves for a spectacular position, I would suggest that it is (after the initial stages of shock and disbelief), a time to celebrate that their talents and potential have been recognized by others.

After 10-plus years in practice, we have perfected our surgical technique and feel confident performing most procedures, but it is not the time to be complacent, rather, it is the time to continuously learn and to adopt new procedures. This bell-shaped curve outlines the diffusion of innovation and while we are not all early adopters, I would suggest that if you are the laggard and the last to adopt change, you may define your irrelevance. Some have called this additional training, retooling. Barbara Bass has been instrumental in building a prototype facility in Houston called MITIE, the Methodist Institute for Technology Innovation and Education, where over 30,000 health care providers in practice, mainly surgeons, have come through to retool or experience new procedure or technology in a safe environment. This is a promising model for training in new procedures.

I would also suggest that it is optimal to reassess your career at least every five years. You need to do this purposefully because in the swirl of the day-to-day events, it simply does not happen. It does not matter if you are a baby boomer, gen x, gen y or millennial, you need to constantly reassess and redefine your sense of passion and purpose to prevent your surgical career from just being a job.

I believe that teamwork and collaboration are the key to ongoing success of our specialty. We need to be the thought leaders and to continue to elevate the care for colorectal conditions by working collaboratively with other organizations and with our surgical and medical colleagues to optimize treatment of colorectal cancer, inflammatory bowel disease, and other conditions. If we look at the colorectal procedures performed in the country, we have an increasing number performed by colorectal surgeons. However, with a total of 2,310 board certified colorectal surgeons and a population of 326 million (or 1 colorectal surgeon for every 140,000 people in this country) it is unlikely that we will be doing all of the colorectal surgery.

We are an increasingly diverse society. Charles Littlejohn spoke of diversity in his presidential address last year. I would like to speak specifically about women and colorectal surgery. I remember when I started in the field, there were very few women. We had all heard of

Ernestine Hambrick, the first board certified woman in colon and rectal surgery, for whom we have a yearly invited lectureship. Mary Spears was the first woman member in 1933. Ann Lowry was our first female president in 2006. In my early years, Ann Lowry started a lunch for women colorectal surgeons. I was at the first lunch in 1988 in Anaheim, California and we had one table with four attendees and lots of extra room at the table. We currently have over 280 attendees signed up for our annual women colorectal surgeons luncheon which is increasingly valued for mentorship and networking opportunities. Our society is now 21% women and we have increasing numbers of women in our training programs. Our Executive Council is 25% women and 24% of our committee chairs are women. We have had two female presidents, five vice presidents, two treasurers, one secretary, 11 female executive council members at large and one female research foundation president. Of the 162 invited lecturers from 1990-2015, we have only had 19 women and 11 have been for the Hambrick lecture. I think we have some opportunity here! Nineteen percent of the diplomates of the American Board of Colon and Rectal Surgery are now women. Last year, 42 out of 99 total who took the boards were women. Our training programs in colon and rectal surgery are over 40% women.

I acknowledge that we have made enormous strides. I would anticipate increasing numbers with the increase in our pipeline. When I joined this society, our women membership was under 2%. I have always felt welcomed and well treated. We have certainly come a long way in with respect to women in surgery in this country but we still have a journey. Explicit discrimination and sexual harassment are much less common. The current gender issues often get framed in terms of parenting and work-life balance, but I would submit that these are issues for all, and especially issues for dual career couples. I particularly think we should do away with the term work-life balance because there really is no balance (if your patient needs to go back to the OR for an anastomotic leak right when you are supposed to be at a parent teacher conference) and substitute it with work-life integration.

Many of the current issues in surgery in this country relate to disparities in salary and career advancement. In terms of career advancement, despite nearly equal numbers of male and female graduates of U.S. medical schools, the proportion of female representation decreases proportionally at the height of the academic ladder. In U.S. academic medicine, 17% of full professors are women and in surgery the number is under 10% (9.8%). The sex differences in full professorship persist after accounting for age, experience, specialty and measures of research productivity. If we continue on this pace, it will be 121 years for there to be 50% women professors of surgery; this is just too long. In colorectal surgery, I would like to believe that things are a bit better. If we look specifically at our trainees from 1994-2014 and the current trends, it will take eight years for us to have 50% female trainees. With respect to salary, according to the last survey, women still make 80 cents on the dollar for what men

make. This is not just surgery, but all professions from the U.S. women's soccer team, to law, to engineering and to medicine. I don't have all the answers but we can and should do better. We need to examine our implicit biases and gender schemas. I commend the incoming president of the American Surgical Association for starting a task force to examine implicit bias in academic surgery. And when will we reach equity and how will we know it? Perhaps only when we become nouns and not adjectives-- when we are surgeons and not female surgeons or women surgeons.

LATE CAREER

Let's look at the final career years. After 30+ years in the field of colorectal surgery the senior surgeon has tremendous experience and expertise. He or she may feel like they have "seen it all," including the changing pendulum from bowel prep to no bowel prep to bowel prep, from more aggressive to less aggressive surgical treatment of diverticulitis, to changes in treatment of rectal cancer.

There is enormous value in this expertise and I would suggest that the later part of a career is about giving back. How do we give back? Giving back can occur in many ways, but I would like to speak specifically about mentorship.

The word mentor comes from Greek mythology and from Homer's "Odyssey." Mentor guided the development of Odysseus's son Telemachus from adolescence to adulthood while Odysseus was away. A mentor has been termed a "developer of talent, a teacher of skills and knowledge of the discipline, an assistant in defining goals and one who shares social and professional values." Or as aptly noted, a mentor is someone whose hindsight can become your foresight. A mentor is different from a coach. I think a coach is very tactical-- someone who helps you win the game-- not necessarily someone who is with you for your career. Or one might say a mentor is like a tattoo that stays with you forever. The ideal mentor motivates, empowers and encourages, teaches by example, offers wise counsel, raises the performance bar and is able to shine in reflected light. I think the word mentorship is overused but it is a very special relationship between the mentor and the mentee. I have had two great mentors in my career. I would like to recognize my two mentors, Erwin Hirsch, who was chief of surgery at Boston City Hospital, a master of conferring graded responsibility and independent operating, or as he called it, "spiritual maturation," and David Schoetz, who has been a wonderful friend, partner, colleague and mentor for 35 plus years.

The latter part of a career consists of transitions. Transitions are difficult-- they begin with an ending-- an ending is associated with loss, a period of feeling unsettled, and finally a new beginning. We spend a lot of time training to become a colorectal surgeon and very little time

on planning transitions, either to retire or to have another role. We need to do better at this. The best advice I have ever received about transition and/or retirement is from Sam Labow, one of our past presidents, who stated that he could retire if he was Sam, but not if he was Dr. Labow. In other words, to successfully transition we need to define ourselves by something other than our profession.

Many of us will have a “second career.” The average career is about 30 years. Life expectancy is close to 80 years old and has increased by three decades in the past century, and the narrative of the traditional journey of education, work and retirement has changed.

The average age of the practicing surgeon is rising along with the American population and one-third of all practicing surgeons are over 55. As surgeons, we are not immune to age related decline in physical and cognitive skills, and it is inevitable that we will all have career transitions. Peter Drucker, a transformative figure in American business has stated that “the purpose of the work on making the future is not to decide what should be done tomorrow, but what should be done today to have a tomorrow.” We need to do better at preparing for “the tomorrow” and defining new paths which will continue to deliver value and meaning for the second phase of a surgical career.

I stand here today on the shoulders of giants and recognize the enormous support and encouragement from friends, family, mentors and colleagues.

My thanks and sincere gratitude to:

Our Past presidents—for their encouragement, support and advice particularly in the early stages of my career (Herand Abcarian, David Rothenberger, Phil Gordon, Bruce Wolff, and Bob Fry).

To my good friends and our more recent presidents Michael Stamos, Charles Littlejohn, my designated dinner partner Terry Hicks, and Jim Fleshman.

To the Executive Council and particularly the Executive Committee Guy Orangio, David Margolin, Tracy Hull and Neil Hyman, for their support and hard work over the last year and the many emails, texts, and phone calls. The ASCRS is in excellent hands with our next president, Guy Orangio.

To the EAI staff—Carla, Rick, Gina, Kristi and the entire team.

Thanks to my partners at Lahey throughout the years, who have been a second family. We have worked hard and had a lot of fun.

Thanks to the 65 colon and rectal fellows at Lahey who I have had the privilege of working with throughout the years. I think I have learned more from you than you from me.

Thanks to the incredible OR nursing staff and office staff at Lahey, many who are here today.

Thanks to my parents, and especially my mother, who instilled in me a belief that anything was possible with hard work, that no goal was unachievable, and 99.9% was simply not good enough.

Finally, thanks to my children Hailey, Andy and Hannah who are all here today and to my husband Mike. I love you more than you will ever know.

Thank you.

My career in colorectal surgery began at Lahey and I have continued at Lahey throughout my career. My association with ASCRS began around the same time and has continued. I have had wonderful mentors, superb colleagues and have been privileged to work with you and to care for thousands of patients. I have witnessed each day that what we do as colorectal surgeons serves as a source of hope for thousands of patients, whether they have a rectal cancer, ulcerative colitis, fecal incontinence or anal problems, and is a source of inspiration for medical students and residents contemplating a career in our field. And I have recognized that the best hope for the future of our specialty, for our health care system and for the ethical practice of medicine, rests not with the economists, the administrators and the politicians, but with us and particularly with the upcoming generation, who are our greatest asset and whose attitudes, values and vision will guide us to a successful and bright future in colon and rectal surgery.

Thank you and thank you for the honor of being your president over the last year.