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"It's Not the Destination, It's the Journey": 2011 Society of Surgical Oncology Presidential Address

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I want to thank Jim Economou for his kind and wonderful introduction. Jim and I come from vastly different, one might say diametrically opposite, backgrounds. Jim is an impressive intellectual; I am not. Jim is an outstanding, funded scientist–investigator; I am not. Jim comes from a surgical pedigree, the product of a surgeon leader, a former chief of surgery at Rush University Medical Center; I do not. Jim studies ancient cultures and languages such as Akkadin, Sumerian, and Ugaritic. I struggle with English. When you hear Jim speak, it is a mix of William F. Buckley, George Will, and Richard Dawkins. When I speak, you hear a mix of Yogi Berra, Ralph Kramden, and Jerry Seinfeld. Suffice it to say we are different. But the one thing we share, the one common thread, is an unbridled passion for and unwavering commitment to the SSO—to its mission and its values, what it has been, what it is today, and what it will be in the future.

The SSO is my professional family. My professional brothers and sisters live with me here. Friends and colleagues, this is my professional home. It has truly been a singular honor for me to serve as your president this past year. It is the crowning achievement, the pinnacle of my academic and professional life. I am still not sure how this has all transpired. I am simply a blue-collar, rank-and-file, hardworking surgeon like everyone else in this room. I thank you for the privilege of working with you and for you, and I will never be able to adequately convey how meaningful this year has been. It is humbling for me to look around and see the many past presidents, true surgical leaders and visionaries who have made our Society such a great organization, the landing zone for surgeons committed to the care of the cancer patient. It is because of them and all of you in this room that I can emphatically state that we are a strong, vibrant, and growing society. Look around and you will notice that the very foundation of this Society is the youth of our membership. There is no other meeting I attend where the number of surgical residents, fellows, and young faculty are so readily abundant and engaged, and participants in the events that define an organization, especially its annual scientific meeting. We must take advantage of and continue to exploit that youthful exuberance since that is the currency for our future success. Equally important is the inherent and growing diversity of our Society. The ranks of our approved fellowship-trained surgical oncologists are growing. Increasing numbers of surgeons trained in affiliated oncologic disciplines such as endocrine surgery, foregut surgery, hepatobiliary surgery, and colorectal surgery, to name a few, have joined the SSO. Our international membership is steadily increasing and an intellectual force in advancing the science of oncology and surgery. Likewise, we have peeled away the outer layers of our Society, and at its core is the community-based general surgeon who performs the overwhelming majority of cancer surgery in North America. We must understand and embrace the blend of needs of this broad constituency, including nursing and other midlevel providers, if the SSO is going to be a beacon for all those participating in surgically oriented oncology care, not because it is SSO's birthright but because we accept the challenge and readily recognize the opportunity to lead and deliver to this heterogeneous group of stakeholders.

In order to fulfill our destiny and accept this responsibility, the current leadership of the SSO, with a forceful

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nudge from Dr. Economou, began in the summer of 2009 to take on the task of shaping our Society's future over the next 5–10 years. First it was necessary to take stock of our current situation and the new environment we now inhabit. The SSO under the leadership of past president Raphael Pollock last underwent a thorough inventory of the organization and devised a strategic plan in 2006. This was an extraordinary effort that brought the SSO to a level of prosperity from a scientific, educational, and financial standpoint that heretofore was unmatched. So why the need for a new accounting of our Society? Frankly, the landscape has been irrevocably altered, and therefore the Society's defining moment has arrived. The new landscape is punctuated by an explosion of knowledge in molecular biology and oncology that has affected and will continue to affect how we deliver care to our cancer patients. In addition, surgical oncology has become fragmented. That fragmentation is evident on two critical fronts. One is our own SSO-approved fellowship training programs. The products of these training programs are a talented group of academically inclined young surgeons who are subspecializing in a particular disease site, not in general surgical oncology. This is fact, and it is driven by what they desire and what academic institutions are offering in the marketplace. We, of course, have SSO-approved breast fellowships that again are designed to place surgical oncologists on an appropriate, yet narrow, trajectory. The second front is that other specialty societies that are either disease- or organ site-based (for example, hepatopancreatobiliary, endocrine, and foregut) or those that are technique or skill based, minimally invasive surgery fellowships, are heavily invested in malignant disease as a component of their training mission or actual practice. Finally, and arguably, the most compelling and significant factor in prompting a reassessment of our Society is the relentless progress toward a formal subspecialty certificate in surgical oncology.

Some of you, in fact maybe many of you, see some, if not all, of these factors in this evolving environment as controversial, if not downright threatening. However, I see it through a different lens, as does the current leadership, who strongly believe that this is a once-in-a-generation opportunity to redefine our mission, embrace our values, facilitate partnership development, and challenge ourselves to take charge of our own future by enhancing our programs, services, activities, and visibility. If we are not bold as a Society—not ready to lead—then we are, at a minimum, at risk for further marginalization and, worse, becoming progressively irrelevant.

Let me take you back to where this journey began 14 months ago and bring you up to date. The first of two preplanning retreats to begin to craft a strategic plan was held in Chicago in January 2010, and the second was held immediately before the 2010 Annual Meeting in St. Louis. One of the defining characteristics of an exceptional organization is that strategic decisions are driven by data. In our case, the leadership felt it was critical to survey our membership and to use the gleaned data as a launching pad for the strategic planning process. Therefore, in June 2010, two surveys were sent to our membership: one to our North American members and one to our international members. Those data were collated and analyzed with expert assistance from Sandra Wong. The overall response rate was approximately 30%, with 28% response in North American and 39% international colleagues. I will first focus on the North American results and also mention when results from the survey of our international colleagues were congruent. Two-thirds of those surveyed were in an academic practice and one-third in private practice. Thirty-six percent fell into a group considered young in that they were either in practice less than 5 years or candidate members in training. Of those who responded, there was an even split between those considered high-attendance (4 or 5 meetings), medium-attendance (2 or 3 meetings), and low-attendance (1 meeting) members based on how many meetings they attended during the past 5 years.

Overall, 68% felt that the annual meeting met all or most of their expectations. Interestingly, those with low attendance at SSO meetings have preferentially attended non-SSO disease site or subspecialty meetings. Similarly, when we examined meeting content, the most popular education sessions were subspecialty symposia. This would lead one to conclude that there could be great benefit derived from partnering with other subspecialty societies at our meeting to enhance meeting content to meet our members' needs. Eighty-one percent felt that there was a good balance between basic, translational, and clinical science. Ninety percent felt that we should not introduce more basic science into our annual meeting, and two-thirds of our members wanted more clinical science. This suggests to me that part of our job moving forward with our annual meeting is not to diminish basic science offerings per se; instead, we must be able to link discovery to what people are actually doing in clinical practice. These results were similar to those from the international survey. Three-quarters of those responding felt that short oral presentations of the best posters would enhance the poster sessions, and again, there was a similar result when we surveyed the international members. Eighty-nine percent of respondents, both international and national, felt that speakers from other disciplines added value to educational sessions, but a two-thirds majority did not want an increase in registration fees to support these speakers.

A gap analysis was then performed to assess members' expectations against the SSO's performance (Table 1). The annual meeting was deemed the most important service

TABLE 1 Gap analysis of North American member expectations versus SSO performance

Topic	Expectation	Performance	Gap
Annual meeting	4.65	4.26	−0.39
Annals of Surgical Oncology	4.06	4.27	+0.21
Advocacy and public policy issues	4.28	3.56	−0.72
Providing important resources to members (e.g., Web site, newsletters, research grants)	3.9	3.56	−0.34
Training of surgical oncology and breast oncology fellows	4.5	4.28	−0.22

Likert scale, highest score = 5; positive gap indicates SSO is exceeding expectations; negative gap of >0.3 or 0.4 indicates areas needing attention

that the SSO provides. However, it only ranked third in how well the SSO meets its members' needs. The largest gap was in how the SSO provided representation for surgical oncology, including areas of advocacy and public policy. Furthermore, three-quarters supported the SSO developing expert consensus statements (an even larger percentage of international members wanted the same). Our best performer was our bible: *Annals of Surgical Oncology*.

Now let me highlight some of the distinctive results of the survey returned by our international members. The geographic locations of our international members are listed in Table 2. When asked why they joined the SSO, 72% identified their subscription to the *Annals*; 99% felt the SSO was a valuable organization, and 92% thought that the annual meeting provided a valuable educational experience. Low attendance at the SSO annual meeting was attributed to financial reasons in almost half of the respondents, pinpointing an area where, if we are thoughtful and proactive, we can greatly extend our reach beyond our borders. To further emphasize this issue, 62% of those who travel to the meeting use personal funds, while only 17% were supported by industry—a far cry from what happens with our medical oncology colleagues. I therefore propose that the Executive Council, Membership, and International Committee quickly develop a sound financial strategy to foster membership for international surgeons and facilitate their attendance at our meeting. Eighty percent of international respondents felt that the annual meeting met all or most expectations. Both skills-based and subspecialty courses were quite popular with the international community—another area for us to focus on and partner with our international colleagues both for those surgeons in practice as well as, and maybe more importantly, those in training. The gap analysis (Table 3) revealed that, again, the annual meeting was the most important service provided by the SSO, followed by the *Annals of Surgical Oncology*. The largest gap margin was again professional society representation for surgical oncology, including advocacy and public policy issues. As mentioned earlier, 86% were supportive of expert consensus statements from our Society.

What can we conclude from the survey data (Table 4)? The annual meeting is the backbone of the SSO and, while incredibly good, can be improved. Emphasis on disease-site and subspecialty symposia can enhance the meeting and is fertile ground for partnering with other societies, both inside and outside North America. We have to provide a sensible and financially responsible way to allow more of our

TABLE 2 International SSO member demographics

Site	%
Western Europe	35
Latin/South America	30
Asia	22
Middle East/Africa	8
Eastern Europe	5

TABLE 3 Gap analysis of international member expectations versus SSO performance

Topic	Expectation	Performance	Gap
Annual meeting	4.55	4.37	−0.18
Annals of Surgical Oncology	4.40	4.52	+0.12
Advocacy and public policy issues	4.05	3.80	−0.25
Providing important resources to members (e.g., Web site, newsletters, research grants)	3.95	3.79	−0.16
Training of surgical oncology and breast oncology fellows	4.16	4.05	−0.11

Likert scale, highest score = 5; positive gap indicates SSO is exceeding expectations; negative gap of >0.3 or 0.4 indicates areas needing attention

TABLE 4 SSO member survey summary

The SSO annual meeting is the most important service the SSO provides.
Disease site and subspecialty symposia improve the quality of the annual meeting and can serve as a mechanism to partner with other cancer-related societies.
The SSO should continue its efforts to enhance international participation in the Society.
Emphasis should be focused on clinically relevant science at the annual meeting that is applicable to the SSO members' practice.
The SSO should increase its efforts in the areas of advocacy, public policy, consensus statements, and cancer management guidelines.

international colleagues to join us and participate in our Society. The science of the meeting must be clinically relevant and applicable, and we can and should package this science so that it is germane to our members' needs. The Society must step up to the plate in representing our constituents, especially with regard to advocacy and public policy issues. Likewise, our membership is expecting us to define the optimal care of cancer patients with expert consensus statements and guidelines. In taking a first step toward this, the SSO has decided to proceed with the development of a self-evaluation program for surgical oncology, similar to what ASCO has produced for its members.

The strategic planning retreat was held in Chicago in late July 2010 over one and a half days and was attended by 26 members, 7 SSO staff, and 2 facilitators. Three work groups, Education, Research/Policy and Practice, and Administrative, produced a draft strategic plan that will serve as the framework for how the Society moves forward, and I would like to briefly summarize that for you. Our mission statement is concise and bold: "*Improve patient care by advancing the science and practice of surgical oncology worldwide.*" We also confirmed our values as both a society and for our individual members, which include professionalism, quality of care, lifelong learning, leadership, and discovery.

We then developed initiatives in all three work groups and prioritized them. The SSO leadership believes that all these initiatives are important, and we are committed to see all come to fruition, but we made decisions regarding what to tackle first, understanding that we are still a relatively small society and must match our mission with sensible resource allocation of both monetary and human capital.

Under the Education rubric, the high priorities are to develop a plan that continuously gathers member data from all SSO members to drive programs and services and to define disease-site task forces to be the fuel of the SSO engine. Intermediate priority items include: (1) modular programming with integration of a core curriculum, skills training, and workshops, lunch tumor boards, and expansion of premeeting seminars; (2) identification of opportunities to develop and implement symposia and premeeting courses in cooperation with other national and international societies; (3) integration of all committees associated with the annual symposium; and (4) international initiatives such as a funded observership program, utilization of Web-based emerging technology to enhance international participation, and an international ambassador program. Finally, under the Education heading, it is understood that the work relating to specialty certification is ongoing and an undeniable top priority for the SSO in the next 2–5 years.

The Research/Policy and Procedure Work Group identified as high-priority items the optimization of a fund-raising organization to enhance the SSO's mission and to promote and enhance member/trainee education and participation in prospective clinical trials and specifically support the American College of Surgeons Oncology Group in its research efforts. Intermediate-priority items included to focus on comparative effectiveness research and to develop comprehensive education and training programs to enhance practice management.

The Administrative Work Group identified as high-priority initiatives the updating of the SSO bylaws and at the same time creating a compendium of policies and procedures to optimize the functionality of the SSO and to develop a comprehensive 3-year financial plan. Intermediate-priority initiatives included updating the committee and executive council process and composition by: (1) creating a detailed committee handbook that provides charges for the committees and the responsibilities and expectations of the committee members; (2) reviewing all committees for relevance and necessity; (3) developing a transparent and open process that engages more member participation in the SSO and allows those interested in serving on committees to do so; (4) developing an overarching education committee; and (5) reviewing the current process for selecting executive council members and officers that results in greater transparency. Finally, other initiatives that will be tackled are to develop a comprehensive membership recruitment and retention program and to establish a leadership development program focusing on our young members. The 2010 strategic plan as outlined above was unanimously approved by the SSO executive council in October 2010.

That was the easy leg of the journey. The grueling portion of this journey involves implementing the initiatives by a sound operational plan that is linked to a responsible financial plan to ensure the necessary resources to complete the tasks at hand. As you might imagine, this is no simple feat; it requires that we set our priorities, remain rational, and—because much is at risk here—be bold. This reminds me of a quote from America's greatest mountaineer, Ed Viesturs, the only American to climb all 8,000-m peaks, that should help guide us: "To summit is optional; to get back down is mandatory."

What has been accomplished to date since the plan was approved in October and what will be in progress over the next 6–12 months? First of all, we have thematically reorganized the SSO committee structure into five councils, each of which will be overseen and under the leadership of an SSO executive officer or executive council member. Without going into great detail, the five councils include the Executive Council, the Administrative Council, the Educational Council, the Research Policy and Practice Council, and the Disease Site Council. The Disease Site Council will serve as the home of the Disease Site Task

Forces, one of the identified high-priority education initiatives. These task forces are critical since they will perform the basic blocking and tackling of the SSO: review abstracts, develop education topics, define maintenance of certification tools, and develop position papers and consensus statements that our membership demands as an important service for the SSO to provide.

The other high-priority item from the Education Work Group was to develop a plan to have a member-data-driven SSO. The survey was the first step in that direction, and a plan has been composed to collect and analyze relevant data on a continual basis. I am certain you all have noticed the substantial changes that have been initiated in this year's meeting program, and Tom Weber and his Program committee team should be congratulated. In addition, we have already expanded our premeeting seminars with two, breast and hepatopancreatobiliary, now being offered at this year's meeting. We have also instituted for the first time a "Best of SSO" at three international sites this year—Mexico, India, and Egypt/North Africa—and a task force has been formed to formalize and standardize this exciting new SSO offering. Under the Education Council's umbrella, I will circle back to the ongoing work related to subspecialty certification in a few minutes. Finally, as mentioned earlier, the SSO plans to develop and implement a self-evaluation program in surgical oncology. Of the two high-priority initiatives that were identified by the Research, Policy and Practice Work Groups, one has already been achieved and is in the process of being optimized. The James Ewing Foundation is now the sole centralized fund-raising arm of the SSO. The SSO will now set the priorities to prepare for the future, and the JEF will raise the necessary funds. All collaborations with industry will be funneled through the JEF, which is essential in a new environment where industry's role in supporting the educational mission of societies like ours is under increasing scrutiny and requires the utmost transparency. We have therefore contracted with an experienced development firm in an attempt to substantially enhance our fund-raising efforts to fund the work of the SSO, which you will agree has significantly increased. The Administrative Work Group identified two high-priority initiatives; however, I am certain it has not been lost on anyone that having a solid and highly functional infrastructure is mandatory if we are going to achieve all of our goals. Therefore, all of the identified strategic items in this arena are, in my opinion, high priority, and we have appropriately moved forward on many fronts and must continue to invest in our operations center to be positioned to succeed in the future.

The SSO bylaws are in the process of being updated and streamlined, and the companion piece, a compilation of policies and procedures, has been proposed and is in the initial stages of preparation. This will allow us to nimbly move forward with the operational aspect of the SSO. We have also begun to overhaul the committee structure and function as mentioned earlier, and we are in the process of developing a detailed committee handbook outlining tenure policy, appointment processes, goals and objectives, committee chair and member roles, responsibilities, and expectations, and evaluation of member performance to hold members in these critical positions accountable. This will also include a transparent and open process to take advantage of our extraordinary human capital—all of our members—thereby allowing all those interested and motivated members to actively participate in SSO committees, helping us to achieve our collective goals. Finally, we are in the process of developing a comprehensive 3-year financial plan to complement our operational plan and match resources to the planned tasks. The Finance Committee has already met with a number of investment advisors to determine how to best manage and diversify our investment portfolio and proposed that a new money manager be responsible for our investments with careful and consistent oversight by the Finance Committee.

Let me now try to bring this full circle. What justifies this monumental effort and expenditure of resources? Why overhaul the bylaws? Why reconfigure, realign, and recharge our working committees? Why should we reinvigorate an already successful annual meeting? Why should we establish a centralized fund-raising foundation and reassess our financial portfolio? Why consider partnering with other surgical societies? Why continue to expand our membership beyond our close-knit circle, especially in the community and international surgical fronts? Why should we establish our own self-evaluation program, develop consensus statements, and be more highly visible with regard to public policy issues? I have only briefly and tangentially mentioned the white elephant in the room: subspecialty certification in surgical oncology. Fabrizio Michelassi dedicated his entire presidential address to this issue just a year ago in St. Louis. Let me address it now head on, from a different vantage point and with a perspective I am hopeful you will embrace. But first I will briefly digress and take you back in time almost 3,500 years. Past president Al Cohen once admonished me for introducing religion and politics into a talk I gave at this meeting. His advice was sound, but I will ignore it this one time. If you remember biblical history, Moses led the exodus of the Hebrew people out of Egypt on a journey across the Red Sea to Mount Sinai, where he received the Ten Commandments—God's bylaws, if you will. This journey continued for 40 years. Many events occurred that we do not have time to reflect on, but during that journey, the laws that would govern the Hebrews, now referred to as the Old Testament or the Compendium of Policies and Procedures, was received. To make a long story short,

Moses was not permitted to enter the land of Canaan; he brought his people to the banks of the Jordan River, to the brink of the final destination, but he did not cross—arguably, compelling evidence confirming that it is not the destination but the journey.

Let me fast-forward to our present journey. At the core of our mission statement—"*Improve patient care by advancing the science and practice of surgical oncology worldwide*"—is education. The certificate of subspecialty in surgical oncology in and of itself is a piece of paper signifying an achievement, a destination. Likely none of us sitting here today will hold this certificate. The certificate for every person in this room at this moment does not validate or ensure the competent surgical oncologist that our Society has committed to in the past, at the present time, and in the future and that you arguably represent. However, the process to achieve this goal of certification, which has taken two decades to realize, and the framework that will now be created to sustain it does. It has provided the necessary spark to ignite our Society to live up to its inherent responsibility and to be accountable, something we have not confronted for some time. As John Wooden said: "When you are through learning, you are through."

We have a collective responsibility to raise the bar with regard to training fellows in a comprehensive manner to prepare them to be not just surgeons, but card-carrying, identifiable oncologists. We should delineate the aggregate fund of knowledge that defines the cognitive requirements of surgical oncology. This is not only true for our trainees but for every one of us in this room, as well as others who are surgeons providing care for cancer patients. Russell Berman and the Training Committee have spent countless hours creating a core curriculum that is competency and SCORE based, as well as refining and updating requirements for operative case type and number that would serve as the minimum necessary to certify individuals in training as competent. Our past and present requirements do not adequately represent either the depth and breadth of surgical cases necessary to practice surgical oncology or the fundamental ingredients of modern surgical oncology. Likewise, we need to develop a core curriculum for our broad membership that reflects the current oncologic, biologic, and genetic underpinnings of current-day cancer care, in addition to and in parallel with defining appropriate surgical techniques and approaches. We must meet the challenge to develop a sensible surgical oncology self-evaluation program and skills verification that keeps our members on the cutting edge of care for our cancer patients.

Who should be pushing surgical innovation in cancer care? I recently participated in a Gastric Cancer Processes of Care expert panel in Toronto, where we argued and struggled over who should be performing minimally invasive resections for gastric cancer. It was lamented by some that these procedures were being performed in increasing numbers by individuals who were trained in minimally invasive fellowships and are not practicing surgical oncologists. Well, I offer that we should take a long, hard look in the mirror. Have we as a group been quick to embrace MIS technology and thoughtfully apply it in the care of our patients? The answer for some of us is yes, but for many of us, it is no. Even more worrisome, how many of our SSO-approved fellowship programs have systematically incorporated emerging technologies, robotic or otherwise, into our curriculum? The answer is not many. If we have been complacent and dropped the ball, why should we be critical of those who have picked it up and run with it? Instead, should not we be the ones conducting groundbreaking clinical trials of innovative surgical techniques? Why have we not made clinical trial research part of our DNA, as our colleagues have in medical oncology, and embraced clinical trials as a routine practice? Why should a paradigm-shifting trial (ACOSOG Z5041) exploring neoadjuvant therapy for resectable pancreatic cancer take 3 years to accrue 90 patients? Is someone in this audience curing so many more pancreatic cancer patients than the rest of us that he/she does not feel that any question in pancreatic cancer is not compelling enough to pose and try to answer?

Why are we not emphasizing and promoting clinical trials research in our training programs and, most importantly, ingraining the need to participate in clinical trials? Regardless of the consequences of the IOM report and the configuration of future cooperative group cancer trial research in this country, surgeons must band together to alter and improve clinical trial research and be leaders again in defining optimal care for our cancer patients. I would offer that this is a once-in-a-lifetime opportunity to nudge our culture and regain our clinical primacy in the management of cancer patients. My heart sinks every time a patient comes to see me in the clinic, and after spending time with them explaining their disease and designing a treatment plan, they invariably ask me "Do I need to see the oncologist?" We have to return to the disease. As a wise person once said, "It's the cancer, stupid."

Let's not focus on the certificate per se but instead on the opportunity it has provided to identify what has to be done and understand why it has to be done, and let us commit as a community of cancer surgeons to just do it. This is our journey! Remember, joy is not found in finishing an activity, but in doing it.

Let me begin to close by reemphasizing the theme of my address here today and providing another illustrative example. Martin Luther King Jr., the champion of civil rights in this country, began his journey in 1955 with the Montgomery bus boycott, and it sadly ended on April 4,

1968, in Memphis. The night before his death, he delivered his now famous "I've been to the mountain top" speech. Almost prescient in his impending death, he said, and I paraphrase: "I have seen the Promised Land, and I might not get there with you, but we as a people will get there." Dr. King clearly understood the inherent value of the journey. I am not delusional enough to think that our journey takes on the importance of the illustrated journeys of both Moses and Dr. King, but for us, this is our time to ensure our future viability. I urge you to get involved with and shape our wonderful Society.

In the few remaining moments, I would beg your indulgence and allow me to briefly reflect on my own personal journey. I am very lucky! I have been extremely fortunate to have been and continue to be associated with, guided by, and supported by so many people who have dramatically influenced my career and cleared a path for me. Unfortunately, I do not have the time to recognize all of those individuals, many of whom are in this room, but I would remiss not to mention a few who have definitively shaped me as a professional and as a person (Fig. 1). The one individual who sparked my interest in surgical oncology when I was a resident was a Memorial-trained surgical oncologist, Nathan Pearlman, whose extraordinary dedication to our veterans by providing compassionate and expert care while allowing the surgical residents to mature into competent surgeons inspired me and a generation of University of Colorado trainees. I was lucky to have the privilege of working with Norman Wolmark at the University of Pittsburgh, who helped shape my approach to patients by insisting that patient care should be directed by sound evidence, not anecdotes. There are two people during my time at the University of Chicago whom I must acknowledge (Fig. 2). I would like to thank Fabrizio Michelassi for having the confidence in me to bring me to U of C and allowing me to blossom as an academic surgical oncologist. The chairman of the Department of Surgery during my first 10 years, Bruce Gewertz, taught me the value of emotional intelligence and the true meaning of leadership: treating each individual as if they were critical to the institution's mission, whether they were maintenance

FIG. 1 **a** Nathan Pearlman, MD. **b** Norman Wolmark, MD

FIG. 2 **a** Fabrizio Michelassi, MD. **b** Bruce L. Gewertz, MD

FIG. 3 Murray F. Brennan, MD

people, the security guards, or beginning or highly renowned faculty—not because it was expected, but because you really believe it. He has countless times kept me on the right path, and even when pointing out my deficiencies, he did it in a way that was constructive and uplifting. Finally, how do you recognize the person who single-handedly served as a human blueprint for how you wanted to craft your professional life and be perceived as a surgeon and oncologist (Fig. 3)? The individual who when you are confronted with any clinical scenario, simple or complex, automatically comes to mind, and you ask yourself, "How would Dr. Brennan handle this?" Well, I know that I never did it as well as he would have, but it was special to have that extraordinary example. To the residents and fellows who chose the path of surgical oncology and whom I have had the privilege of working with, thank you for educating and stimulating me to continue to learn. You represent, along with all the other residents and fellows in this room, our future, and it is bright.

Finally, this personal journey would be meaningless if it was not for my family. Their guidance, love, and support were constant, and their personal sacrifice was essential to my standing here today. My parents, like others of the greatest generation, were unwavering in assuring that their children would be able to pursue the American dream. Although they are not physically with me, they remain a constant presence in guiding me. My two amazing daughters, Sara and Alexa, are both very different and gifted in their own way and serve as a constant source of pride. They provide perspective to me on a daily basis of what is truly important in life. Finally, there is Janice. Everyone who truly knows us understands what a remarkable person she is, and without a doubt she is the better three-quarters. She still is the most beautiful person, both externally and internally, whom I have ever met. She defines for me the lyrics of the eternal Bob Dylan classic "If Not for You."

Let me close by again thanking you for allowing me the privilege to serve in this position. It has been a true labor of love. But again I am no different than anyone else sitting in this room because at our very core, what we have dedicated our lives to is service to our patients. This quote from one of my heroes, Jackie Robinson, says it best: "A life is not important except in the impact it has on other lives." If we always keep that as our message, our journey together in the future will always be as rewarding as it is today.