Ann Surg Oncol (2011) 18:3027–3035
DOI 10.1245/s10434-011-1964-0

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ORIGINAL ARTICLE – AMERICAN SOCIETY OF BREAST SURGEONS

American Society of Breast Surgeons Presidential Address: Three Simple Ideas

Eric B. Whitacre, MD

Breast Center of Southern Arizona, Tucson, AZ

As we came up to the podium, I asked Dr. Snider if I should sit up at the table with him and he said, "Oh, it's as you prefer." Certainly my advice to next year's president would be to sit in the audience. Some of those pictures I had forgotten and a couple I thought I had burned. I promised that during Dr. Zannis' introduction last year. Your presentation was very kind, but overstated. Thank you very much.

It would be inappropriate for me to address this group about any specific aspect of breast surgery. Whatever the topic, inevitably there would be someone, if not many people, more skilled or more knowledgeable than I. But there is an area where I have some expertise: Having been on the ASBS Board since 2004 and been involved with many committees, I have some sense of ideas that can be brought forward and turned into successful projects by this society. So today, instead of talking about breast surgery per se, I thought I would talk about several things that I think we as a society will need to address in the near future.

1) Increase Member Participation in Clinical Research

The first idea is simple and is nothing new: to increase member participation in clinical research. We have focused on this for a long time as a society, because we all know it is the foundation of future clinical activity. We have had multiple pre-meeting courses on clinical research in the community setting, including one at this meeting. In addition, the Society hosts several registries: The Mammosite Registry, really a gem and the ASBS crown of achievements, which has generated multiple scientific publications. It is still the largest cohort of prospectively followed breast cancer patients who have received accelerated partial breast irradiation. The Society has recently launched a nipple-sparing mastectomy registry, which is well underway under the direction of Dr. Sunny Mitchell. In this registry, for the first time, the data collection is built on top of the Mastery of Breast Surgery program. Other registries are in development, including one for lymphedema, which would be novel because it would allow patients to enroll themselves electronically and then request information from the physician. This might alleviate some of the additional paperwork that is clearly a hurdle to clinical research in a busy community practice. If, in addition, we could submit information to the registry from data already entered in the Mastery program, it could be something very exciting.

Yet, this is different from some other achievements. Who does not know of our member Dr. Gary Unzeitig and what he has done enrolling patients in phase III clinical trials, personally generating enrollment numbers larger than many major cancer institutions? There is clearly a gap here that we need to help members bridge; I know, because I experience it personally. Dr. Unzeitig outlined during a recent presentation the necessary steps to become involved in clinical research (Fig. 1). These are the seemingly simple steps to become involved in a clinical research program: obtain institutional review board (IRB) approval, an FDA 1572 investigator number, an NCI investigator agreement, etc. As I reviewed this, I realized that for several years I have been stuck at step 2, at the FDA investigator number. In fact, that is not entirely true because I have not really solved step 1: the IRB approval process. I work almost exclusively at a surgery center, where it is difficult to get IRB coverage, because it is just not part of the institutional structure. I expect there are other members who have the same problem or other similar obstacles. If there is any group that can help breast

© Society of Surgical Oncology 2011

First Received: 5 July 2011;
Published Online: 9 September 2011

E. B. Whitacre, MD
e-mail: ewhitacre@gmail.com



FIG. 1 Necessary steps to become involved in clinical research. *Source*: Dr. Unzeitig

surgeons overcome these obstacles, it is our Society. Once again, this is not a new idea, but something that I think needs increased focus. We have been very successful with promoting image-guided biopsy and with our educational and certification programs, but there is still a huge opportunity with clinical research in the community setting.

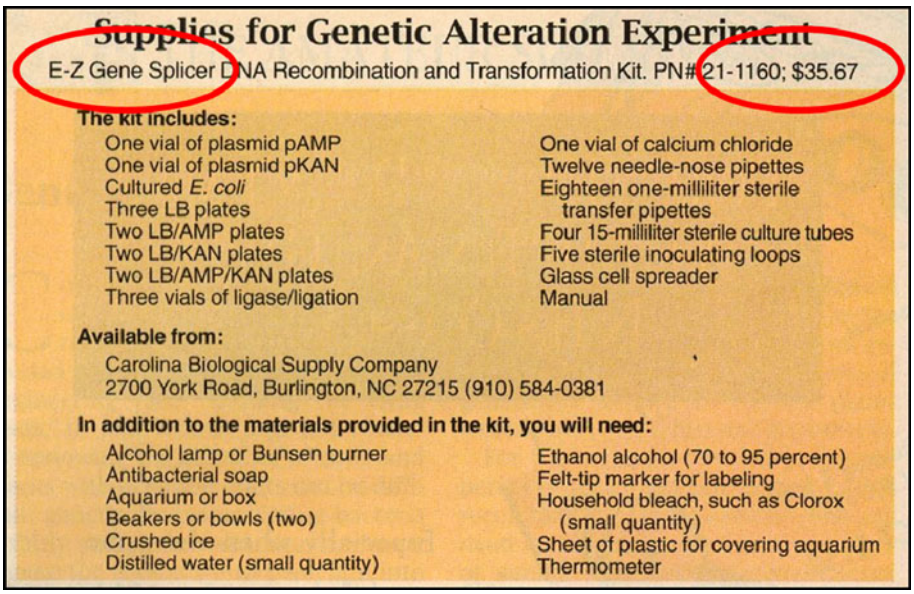
2) Refresher Courses in Molecular Biology and Genetics

Now what Dr. Snider may not have told you in his introduction is that I enjoy cartoons. I do; I think they are entertaining and liberate the mind. I have used many of these pictures for presentations at previous ASBS meetings (Fig. 2). But what Dr. Snider may not have known is that I also like science fiction. One of my favorite stories is a short story by William Tenn called "Child's Play." This is the story of a young man who quite unexpectedly receives a biochemistry set from the future. It comes with a tag, "Merry Christmas 2353." The kit is called "Bild-a-Man" and has the rather cheesy logo: "Only with Bild-a-Man can you build a man." It is a kit for cloning, because we all know that 300 years from now cloning will be a simple high school experiment. The story is about a young man who is having some romantic problems and decides he needs to clone his girlfriend before she leaves him for someone else. He works his way through the different chapters of the manual, cloning first viruses and bacteria, then small birds and mammals, and then an infant. When it comes to cloning an adult, he decides he needs to practice on himself. However, as soon as he finishes, a census keeper from the future—because if you now allow cloning, you need to keep track of these things—a census keeper from the future arrives and destroys the wrong clone! Just the kind of thing that would keep Dolly the sheep awake at night.

Imagine my surprise when I was reading an article on genetic transformation and bacterial resistance to



FIG. 2 Pictures used by Dr. Whitacre for presentations at previous ASBS meetings


Supplies for Genetic Alteration Experiment

E-Z Gene Splicer DNA Recombination and Transformation Kit. PN# 21-1160; $35.67

The kit includes:

- One vial of plasmid pAMP
- One vial of plasmid pKAN
- Cultured *E. coli*
- Three LB plates
- Two LB/AMP plates
- Two LB/KAN plates
- Two LB/AMP/KAN plates
- Three vials of ligase/ligation
- One vial of calcium chloride
- Twelve needle-nose pipettes
- Eighteen one-milliliter sterile transfer pipettes
- Four 15-milliliter sterile culture tubes
- Five sterile inoculating loops
- Glass cell spreader
- Manual

Available from:

Carolina Biological Supply Company
2700 York Road, Burlington, NC 27215 (910) 584-0381

In addition to the materials provided in the kit, you will need:

- Alcohol lamp or Bunsen burner
- Antibacterial soap
- Aquarium or box
- Beakers or bowls (two)
- Crushed ice
- Distilled water (small quantity)
- Ethanol alcohol (70 to 95 percent)
- Felt-tip marker for labeling
- Household bleach, such as Clorox (small quantity)
- Sheet of plastic for covering aquarium
- Thermometer

FIG. 3 Genetic alteration experiment supplies advertisement

antibiotics, and I saw this small inset at the top corner of one of the pages (Fig. 3). It said "Supplies for Genetic Alteration Experiment." That sounded pretty intriguing, and I admit I was quite excited as I looked through the list, until I saw the name: "E-Z Gene Splicer." I remember rolling my eyes and thinking, "Oh, I can see this now. I'll order this kit and the first thing it'll say in the manual is "Only with E-Z Gene Splicer is it easy to splice genes." I was about to turn the page when I looked at the price: $35.67. It occurred to me that only aliens could come up with this kind of pricing strategy, and I ordered one right away!

The kit arrived almost the next day and had everything you needed to get started: Petri dishes, culture media, and a loop to plate the bacteria. Biologicals came separately on dry ice—very cool. Unfortunately, as soon as I had all the materials, I realized that I had somehow managed to purchase a house without a sterile hood to conduct such experiments. Not a problem, since "they" had thought of it; you simply buy an aquarium, put it on its side, cover it with cellophane and that prevents any ambient bacteria from falling on the Petri dishes, just in case you happen to have some multidrug-resistant *E. coli* just floating around the house (which was the point of the experiment.) Well, I also didn't have a Bunsen burner, and what "they" didn't tell me, and something I found out years later on Wikipedia, was that the small propylene torch, which I had purchased to heat the loop, burns a little hotter than a standard Bunsen burner—about 2000 degrees hotter. So I had a really sterile loop, but I was never able to plate the bacteria. I would put the loop in the bacteria and it would go "snap, crackle, and pop," and I was right back to cartoons! It was a wonderful closure, but I could never really grow the *E. coli*. I did, however, keep the plasmids, because for me they were the essence of genetic transformation. I kept the plasmids in the freezer next to the Eggo waffles for years (Fig. 4), until one day my wife eventually threw them out. It was a dark day for science in the Whitacre household.

The point of all this, obviously, is that this *is* child's play. This kit was commercially available in 1994. The geometrical advances that have occurred in the basic sciences since then have created an exponential divide between at least my understanding of basic science and how we implement it clinically. And don't think that this is not important, because we use this all the time. Everyone knows about optimal handling of breast biopsy specimens, whether it is for ER/PR or HER2 analysis. We need to know some basic genetics for BRCA counseling, but what exactly is a "polymorphism?" We frequently discuss the merits of different microarray profiling techniques, and



FIG. 4 Stored plasmids in the Whitacre freezer

here I can have a quasi-intelligent discussion and hide what I don't know (which is a lot), but when we get to reports of more sophisticated microarrays and genetic profiling I frankly have trouble understanding the reports.

This is important clinically. Let me give an example. I recently treated a 29-year-old woman with 3.6-cm infiltrating ductal carcinoma, nuclear grade 3, triple negative, Ki-67 50%, with multiple positive lymph nodes on FNA and PET. She received neoadjuvant chemotherapy, and as expected did very well with a complete clinical response at the time of mastectomy, which was her choice because of a strong family history, although she was BRCA negative. The final pathology showed that she had had a complete pathologic response in the breast, but still had 9 of 11 positive axillary lymph nodes. At surgery, I knew there was a problem because there was a fibrotic area in the axilla consistent with chemotherapy effect and around it were multiple small, 2- to 3-mm, firm, glistening lymph nodes, which I suspected were grossly positive at the time. I dutifully completed the axillary dissection, knowing that she would need radiation and possibly additional systemic therapy. Postoperatively, the tissue was sent for more sophisticated microarray analysis, the "Caris Target Now™" analysis from Caris Diagnostics. Agents with a similar microarray profile useful in this setting were nab-paclitaxel and 5-FU; methotrexate, doxorubicin, lapatinib, and trastuzumab would not likely work. As I studied the report, I found the following disclaimer:

"Due to the degradation of RNA obtained from formalin-fixed paraffin samples, it is not possible to determine whether the reduced relative fluorescent units for a gene in the patient sample is due to the reduced presence of that RNA or if the RNA is highly degraded and impeding its detection." My first thought when I read that was "Did I do that?" And I did, because I submitted the tissue in formalin for permanent sectioning, which is what I normally would have done, not considering the impact of future mRNA analysis.

The reason that this is important is because of my different level of understanding of these two diagrams: one depicting the gross anatomy of the breast and the other outlining molecular impact of DNA damaging agents (Fig. 5). I understand both diagrams, but I have a much greater depth of understanding of the anatomy that I see every week at surgery. If I have a patient with a large, fixed, axillary mass, I know to obtain the appropriate imaging to define its relationship to the vessels and nerves before I arrive in the operating room. When I look at the other diagram, however, although I can trace through the different pathways, I do not understand it to the same degree. If I did, I might have thought ahead with my 29-year-old patient and said, "If she has residual gross

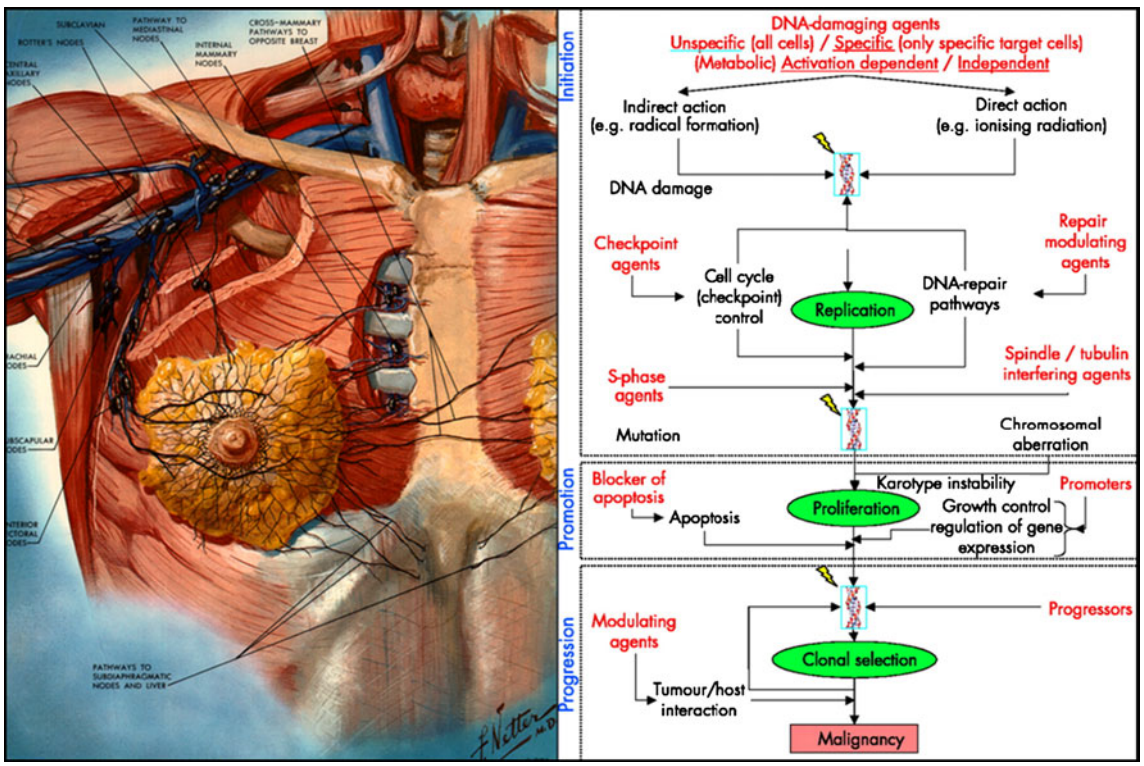


FIG. 5 Images of gross anatomy of the breast and an outline of the molecular impact of DNA damaging agents (reprinted with permission)

disease, I may need either dry ice or an mRNA fixative in the operating room." This would not have been hard to do. I knew to prepare for one eventuality, but not the other. The solution I think, at least for me, would be to have some formal basic science courses—say "refresher" courses—at a meeting such as this.

Here again, it is not as though we as a Society have been remiss. The Annual Meeting includes scientific oral presentations, an abstract poster session, specific general sessions addressing genetics, and molecular analysis. This year's keynote speaker—for many reasons our first choice—will talk to us about translational research and a successful research paradigm for development of targeted therapies for breast cancer.

As an alternative to refresher courses, I suppose we could all try to educate ourselves. I have tried. I recently ordered a copy of *Molecular Cell Biology, 6th Edition*, by Lodish et al. (W. H. Freeman and Company, 2008, New York), and I can tell you, it is a great read, and very easy to approach. It has 1,150 pages, and after 6 months I am still on page 32. It is not that I like Chapter 1, which I do, it is just hard to do at the end of a busy day, and my comprehension would benefit from a more interactive environment where I could ask questions. So here again, a simple idea: development of formal basic science refresher courses. Now, I hear a faint murmur from some the younger members who are saying, "Boy, I'm glad I'm not as old as he is." The bad news for the younger folks is that in the future the rate of change will be even faster, so over a similar length of time you will be even farther behind. We all need this.

3) Tools for Shared Decision-Making

For my last topic, I would like to go back to last year's Annual Meeting. This is a video clip from the first general session on the Regional Management of Breast Cancer (Fig. 6). This is a question from an audience member addressed to the moderator Dr. Armando Giuliano; he rephrases the question and turns to Dr. Kim Van Zee for a detailed response:



FIG. 6 2010 ASBS first general session on the Regional Management of Breast Cancer

Dr. Giuliano: "…ER-positive tumor, HER2-negative, and micrometastasis. How old was the patient?"

Attendee: "Fifty-four."

Dr. Giuliano: "Fifty-four. Dr. Van Zee can you plug that into the nomogram in your head?"

Dr. Van Zee: "There are some other variables also in the nomogram but, so I'll say plug it in, and I'll go through and I'll tell her the standard care is to do an axillary dissection. I'll tell her that axillary dissection probably will not show any additional nodal disease, and that if she doesn't do an axillary dissection her risk of axillary recurrence down the line is relatively low. We'll talk about the pros and cons—it's a conversation. I have some women in that exact situation who do have an axillary dissection, and I have some that don't. Each individual woman often feels very strongly about it when I present the same data, but they feel strongly about it in opposite directions. So, again I would argue that it's an individual conversation."

What a concise and elegant description of the process that goes on between the patient and her physician: "A conversation." It is just an extraordinary metaphor, but there is a formal term for this: Shared Decision-Making. Wikipedia provides a much more expansive definition:

"Shared decision-making is an approach where clinicians and patients communicate together using the best available evidence when faced with the task of making decisions, where patients are supported to deliberate about the possible attributes and consequences of options, to arrive at informed preferences in making a determination about the best action and which respects patient autonomy, where this is desired, ethical and legal." (http://en.wikipedia.org/wiki/Shared_decision_making)

This is nothing new for breast surgeons. We do this from the moment we see patients, from the very moment we help them to decide about breast conservation versus mastectomy, or about prophylactic surgery versus other risk reducing options. We do this all the time, and we should, because unlike other fields, we have the data. Figure 7 shows three classic NSABP trials, and it takes only takes three to show the depth of information we have compared to some other clinical specialties. Here are prospective trials with 20- and 25-year follow-up data on the surgical management of breast cancer, and a double-blinded, prospective, randomized trial on prevention with a P value that goes out five decimal places. Not every specialty has this, so we enjoy a depth of information and understanding that helps us to counsel our patients better. Spending time helping our patients with these difficult decisions is something that we enjoy and take pride in. How many times have we heard at the Coding and Reimbursement Symposium at this meeting a member ask, "How can I get

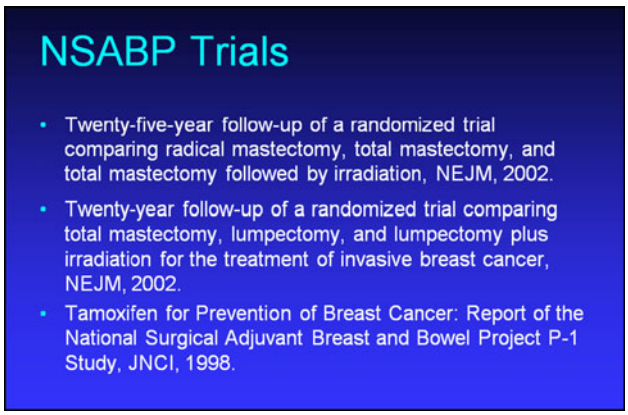


FIG. 7 Three classic National Surgical Adjuvant Breast and Bowel Project (NSABP) trials

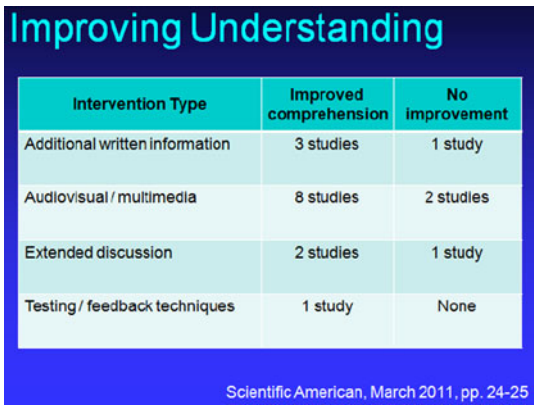


FIG. 8 Summary from March 2011 Scientific American article demonstrating the efficacy of decision making tools in improving understanding in medical decision-making (reprinted from *Scientific American* magazine)

paid for the time I spend with my patients?" Indeed, who among us has not given the near-perfect "cancer talk?" We all know what that is; it is an informed patient who is not so frightened that she will not hear what we are going to say. A patient who comes with a support group, not someone with 30 questions off the internet, but a true support group: someone who will be there to listen and discuss and to help her in her deliberations later when she leaves. As you go over the subtleties of treatment and management, you can see her understanding; she nods knowingly at the appropriate times and you can read comprehension in her eyes. You walk out of the room and think, "This is a patient who will make an informed decision," only to find out that 5 minutes later, as soon as you left the room, the patient turned to your assistant and said, "So what should I do?" We all know that this happens, and it has happened to all of us.

The problem is that we actually have tools to address this and it is not clear to me that we have incorporated them into our formal decision-making process. There are multiple venues—paper, multimedia, and web-based—that include different decision-making algorithms. There are even testing mechanisms that patients can utilize to assess their understanding. In the situation above, maybe the patient needed to see your assistant first, and then sit down and talk with you. These also are culturally sensitive issues. Anybody treating a large Hispanic population, such as myself, knows that Hispanic women make decisions to get mammograms or have genetic testing differently from other racial and ethnic groups. So the question is, given all these tools, where do we stand in incorporating them in to our practice? This information is now being reported in the lay press. Figure 8 shows a summary from an article in Scientific American entitled "Uninformed Consent" by Deborah Franklin, March 2011, which reports the efficacy of decision-making tools in improving understanding in medical decision-making. Who is to say whether someday use of these techniques could not actually be a quality measure? In the future, we may not only discuss with patients whether they are candidates for lumpectomy and radiation or mastectomy but also document the specific decision-making tools that were used to arrive at that decision.

In summary, here are three simple ideas which I think we can all agree have some potential value. Still, whatever their intrinsic value, we should all realize that if we leave them where they are today, they will go exactly nowhere. This is really not surprising, because we are a volunteer organization. The fact that the people who are in leadership positions are busy in the full-time practice of surgery is one of the strengths of our society. It is very easy for us to consider an idea and determine quickly that it will never succeed, because we know it conflicts with the exigencies of daily practice. In contrast, and this is the potential pitfall of the system, good ideas may be left stranded because there is limited time and energy to make them successful projects.

CHAMPIONS TURN IDEAS INTO PROJECTS

What these ideas need is a champion. A champion is someone who is passionate about an idea, and who is tenacious and persistent. A successful champion is willing to say after a minor rebuff, "Let's try again, and introduce this idea one more time," but also is someone who is realistic, understanding that theirs may not be the only good idea, and that there are limited resources all around. Let me illustrate this with a very poignant recent example, because this happens with the ASBS Board all the time. A number of executive committee members recently attended the Society for Surgical Oncology Annual Meeting and heard a presentation from Dr. Hiram Cody updating us on

management of axilla based on published results of three large sentinel lymph node trials. This was all very exciting—practice changing information—which we knew that we would be discussing again at this meeting only weeks later. Nonetheless, when I arrived home, I received an email from Dr. Victor Zannis encouraging the ASBS leadership to alert our membership of these findings:

"…Second, after hearing Chip Cody's presentation yesterday on axillary dissection, the axillary node dissection issue is extremely important, very dynamic, and needs some immediate attention. I believe that the ASBS should be the front-runner to lead any standard-of-care changes in this arena with an official statement that will obviously be modified over time, similar to how impactful our brachytherapy statement was and still is. I would suggest to Ed Clifford and Eric that we do this immediately…" [Excerpt from an email March 3, 2011.]

When I saw this I could not have agreed more, and went click, next email. We are all busy, so when we see something like this we may agree with the idea, but may not have the energy or time to take the next step. Dozens of emails later—I thought it was days later, but looking back, it was the next day—the Executive Committee received another email from Dr. Zannis:

"Eric, Executive Committee, and Ed Clifford: I'm still here at the SSO meeting, and at the risk of being a pain in the butt, overpersistent, controlling, or whatever else you want to call it, I feel obligated and a lot of passion…" [Dr. Zannis wears 'champion' on his sleeve] "…to once more discuss the issue of a position statement on the axillary dissection issue.…" [Excerpt from an email March 4, 2011.]

I finally realized "Okay, this is important, let's get it done" and you all hopefully received the email alerting you to the changes in the management of the axilla and encouraging you to come to this meeting for additional information.

This is an example of a fairly simple process of an ASBS board member following up on a simple email suggestion. In contrast, a project like the Mastery, which was a new idea of uncertain value and costing who knows how much money, took dozens of emails, many of them pages in length. We actually had created at one point a four-part structured logical framework supporting the program. The logic was not difficult; it was basically that breast surgeons need to be involved in quality measurement in breast surgery, and therefore we had better get our act together. That apparently simple idea generated a protracted discussion that evolved over months. Of course, there were the same impassioned follow-up emails when things were not happening quite as quickly as some of us wanted:

"Dear all, Well it's been more than 48 hours without a biting, sarcastic email, and I am sure that you can all feel my pain. Attached is a more complete version of the "Mastery of Breast Surgery Program," which includes Alison [Laidley's] comments and some changes. I cannot emphasize strongly enough that if this is all we have when we arrive Saturday, we are sunk. Sinking in the titanic is spectacular, but sinking in the lifeboat is just pitiful." [Excerpt from an email January 9, 2008.]

Oh, what can I say? It's just a different style, but it reflects the same urgency and the same passion, and was meant to urge the leadership into action.

Why is it important for everyone here to know this? It is because this is just the way the Society leadership functions, and I do not foresee it changing any time soon given the pressures of practice and the fact we will remain a volunteer organization. It is important because it strikes at how we accomplish our mission (Fig. 9). Specifically, the mission "is accomplished by providing a forum for the exchange of ideas." Effective exchange of ideas is not just sending one email, but rather becoming a champion for an idea. That is important because we have so many people with so many good ideas. How do I know? They come up to me at meetings such as this and they hand me articles they have written, or even books—we have such talented members—or someone may tell me about a computer program they have written, or about how they run their multidisciplinary conference, and on and on. I know it happens to other board members as well, and if these ideas go no further, it will be a loss for us all.

The other reason that this is important is because of the growing stature of the Society. Based on the vision and leadership of previous leaders, based on the continued growth of the Society and the prominence of our individual members, and based on the value of our educational programs and other projects, I think we can all agree that the future of breast surgery is in this room. Not as an individual, of course, but as a group. This is not just about blowing smoke about the Society—you can tell from those



FIG. 9 Mission statement of the American Society of Breast Surgeons

emails this is not a simple "mutual admiration" society—it is just a fact. The people in this room have the skill and the talent, the energy and the expertise, and importantly, they have the practices to implement new techniques efficiently and to do it well. In the end, that goes beyond our mission because it directly benefits our individual patients.

Being a champion is not all bad. There are some perks, because if you are a successful champion, you will get to do a lot of extra work. Very simply, if you pester enough people for long enough, you will get stuck with the job, which is not a bad thing because you will be passionate about it. Also, if your project is successfully incorporated into the Society, you may not get much formal credit. The project will benefit from the additional strength and value of the Society name, but in the end the credit will go to those four initials "ASBS."

Well, if we go back to these three topics you can say, "Eric, as a past president you will be on the Board for another year. Why don't you just take what you know and make one of these happen?" And I would, but I am going to be busy with some other things, or at least I hope to. You know I would really like to make the Mastery work for more of our membership. It has evolved from a simple program to report quality measures, into something people now use to track cases, generate reports, and in some cases even get MRI clearance from insurance companies. It really has had unexpected benefits. One of the things I have been interested in is using it to suggest clinical trials. This should not be hard; we simply compare the clinical data set in the Mastery with clinical trial eligibility criteria. Imagine that once you complete all the data on the Mastery cancer screen, you hit a "Suggest Clinical Trials" button and it lists the eligible trials for that patient. You could even begin the suggestion process before all of the data have been entered. Based on only limited data—say tumor type and ER/PR status—you press update, and the computer can project ahead and say, "You know if this patient's cancer is HER2 amplified, she would be a candidate for the following trials.…" We could even use this for molecular profiling, and because this promises in the future to become more important and potentially more complex, this may actually become very important in day-to-day care of patients (that is unless, of course, you have just taken one of the basic science refresher courses we discussed earlier.)

As I considered this and thought about all the basic science involved, it sort of reminded me of the plasmids; you know, the ones next to the waffles. Did you know that you can still get E-Z Gene Splicer online? It's new and improved and is advertised now as "Beyond transformation." Oh, "they" have learned quite a lot about marketing since it was first introduced. Granted, the kit is still called "E-Z," but they have changed some things. It is actually now a six-station kit as though they intend it to be used in schools or institutions, and in fact, they only sell to "schools and businesses." (I actually think they may have heard about me.) Today, they openly promote it as an "Introduction to cloning," which frankly is just creepy. And they have increased the price: It's now $177.00 even. Not $177.95. Not $179.99. It's $177.00. Twenty years of the Internet, eBay, Amazon, "Transformers" the movie, and this is the best that group can do? To me, this is an opportunity. We need to get our Corporate Relations Committee together, have a little close encounter meet-and-greet, and get these people on the Mastery! I have already got the home webpage designed. It looks something like this, with "More than just plasmids" next to their



FIG. 10 Mastery of Breast Surgery, American Society of Breast Surgeons

corporate logo (Fig. 10). All kidding aside, who knows what the face of breast surgery will look like in the future? But I do know that if we can take all of the good ideas that are in this room today and turn them into projects that benefit our members and their patients, then we will have done something of tremendous value. I believe this is the group to do that, but it is important that we all know how that is done within the Society framework.

In the minutes that remain, I can only say "Thank you." Thank you to the membership for allowing me to stay in the leadership position on the board for so long. Thank you to the staff—we have great staff—they are the backbone of the day-to-day operations of this Society. Jane Schuster has put together a wonderful team. Also, I am proud to say that I was on the Board when we had the vision to create the position of Executive Vice President, and the wisdom to select Dr. Arthur Lerner to fill that post. Finally, I would like to thank the other board members, who for so many years put up with the impassioned arguments and the follow-up email antics, because they understood that it reflected caring and concern for the particular project under discussion and for the overall welfare of the Society. It has been a tremendous honor to serve. Thank you all very much.