PRESIDENTIAL ADDRESS

The Impact of Professionalism

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Honor is a perception that is bestowed and received. Serving as your president this year has been an honor, which I humbly receive, knowing the stature of the individuals who have preceded me. I thank God daily for safe passage through this year, as I look forward to achieving that most desired status of Past President. I cannot take sole credit for this honor and, in fact, never imagined this to be possible in my youth. I have served with many of you in many areas of our society and it has been through those combined efforts that I have come to serve you as your president. Thank all of you for your friendship and hard work and thank you for this honor.

As I read through the speeches of 100 Past Presidents, I too became aware of the fact that everything that really needs to be said has previously been said. I refer you to this extremely interesting living history of our society which, thanks to Stella Zedalis, will soon be available through a link on our website. The struggle to identify a meaningful topic and a title for this speech has plagued every past president since A. B. Cooke first published his talk in 1910. As you can see from this table, I also struggled, until I settled on the "*Impact of Professionalism.*" Looking into the past has helped me understand our responsibility for today and given me hope for the future of our society. Our expressed goals will become the future (hopefully) and our actions will be seen as the past in a few short years. One can only hope that *our* "past" reflects our purity of heart, our soundness of mind, and our selfless pursuit of what is right today. Even though the issues in our 1st century of societal life are different from those in 2010, the methods by which we overcome those hurdles have not changed. Our ethical, moral and professional compass continues to find the truth, as hard work drives the expedition toward our goal of improved care for patients. The 13 founding members of the American Proctologic Society claimed professionalism as the basis of their affiliation and the source of their ideals for the scientific treatment of colorectal disease.

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Webster has defined a profession as "a calling; vocation or employment requiring specialized knowledge and often long and intensive academic preparation."[1] Funk and Wagnall states "a profession is an occupation that properly involves a liberal, scientific or artistic education."[2]

Professionalism according to Webster describes a person who adheres to: 1) "characteristics of or conforming to the standards of a profession – technical and ethical; 2) following a line of conduct as although it were a profession; 3) conduct, aims, qualities etc, characteristic of a profession."[1] However the best definition that I have found is from Peter Volpe's address to our society in 1991.[3]

> Professionalism is a social contract between a group or organization and the overall populace that it serves. This social contract carries with it responsibilities and corresponding privileges. Professionalism always

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> implies a specialized body of knowledge, a code of ethics, and an overall responsibility to society to serve the public trust. The specialized body of knowledge, such as held by this audience, must be continually advanced, shared freely, and maintained at an excellent level, with deficiencies corrected on a voluntary and continuing basis.
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> An ethical code of behavior must be established and followed. The professional group or individual, places service as a fundamental ethic, putting the interests of those being served ahead of self interest. Professionalism demands a societal responsibility, a contribution beyond the practice of the profession per se, by involvement with the community at large.

Professionalism requires that I acknowledge the numerous (too numerous to name) influential teachers, staff, mentors, partners in practice, coworkers, and friends in my life who have started, shaped, supported, stretched, and stabilized my career. Likewise, it dictates that I acknowledge the love, support, counsel, and joy that have been my pleasure to experience with my wife, Linda, and my 3 children, Brett, Cindy, and Angie, over the past 33 years. Some have given more advice than others. I must also acknowledge the grace of a loving, generous God. I must tell you the reputation that Stella Zedallis bears as the most helpful person in our organization is an understatement. Without Stella nothing happens. The same can be said for my home-based staff, led by Liz Nordike, who guides my outstanding group of partners Ira Kodner, Elisa Birnbaum, Matt Mutch, Steve Hunt, Anne Lin, and Bashar Safar as they build a great program. I must also acknowledge my friends and former partners Drs. Robert Fry, Tom Read, David Dietz, and Jennifer Lowney, all of whom have contributed to my success in many ways.

Professionalism requires that we as colon and rectal surgeons adhere to a high standard of care and practice, maintain our skills under a tough, fair certification and recertification process that responds to the changing climate and science of colorectal surgery. As part of this effort the American Society of Colon and Rectal Surgeons (ASCRS) continues to support the American Board of Colon and Rectal Surgery (guided by Dr. David Schoetz) in its ongoing efforts to develop a Maintenance of Certification process and hold high the criteria for entry into our specialty. We have moved from being a small elitist group of 70 fellows in 1936 when entry to our society was selective and restricted owing to a lack of certification. Our American Board of Colon and Rectal Surgery, founded in 1935 as an independent board under the American Board of Medical Specialties, is our most precious of possessions and the ultimate expression of our professionalism. It alone allows us to be self-governing and self-directed, unlike other surgical subspecialities. We are now a merit-based society based on inclusion of all who have achieved 2 board certifications and practice colon and rectal surgery. Our membership is larger and our potential is greater. Our impact as a society is much greater than our proportional size compared with other surgical societies. The pride that I have in this society is in proportion to the joy that I experience working with you, my colleagues, and the amount of effort that I am willing to expend on behalf of our collaborative agendas.

Our Board, with members from within our society, has influenced other Boards much larger and stronger. Once again, with the influence of our liaison (Dr. Senagore) from the American Board of Colon and Rectal Surgery (ABCRS) to the American Board of Surgery (ABS) pushing the agenda, the ABS is considering a change in the way general surgeons are trained to provide better candidates for training in our fellowships. Our specialty is more complex and has assimilated new technology, which makes it very difficult to train our residents in 1 year. General surgery training has been affected adversely by the 80-hour work week and the lack of independent operating experience in their programs. The Board of Surgery is once again considering the 4 + 1 + 1 format to increase the abdominal surgery exposure for general surgery residents interested in Colon and Rectal Surgery as a specialty (Fig. 1). This may go a long way to counter the loss of independent operating experience and shortened work hours in residency. The last year of general surgery can be tailored to achieve prerequisite training for colorectal residency. The final year of the 4 + 1 + 1 will be controlled by our training programs. Finishing trainees would receive board certificates from both the ABCRS and ABS. We support this effort by the ABS to accommodate our need for more focused trainees to enter our training programs.

The Residency Review Committee for colorectal surgery under Dr. Eric Weiss' leadership, recently revised the program requirements and the application forms for colorectal training. The Program Directors Association for Colorectal Surgery is working to define a standardized training program, educate program directors, develop simulator methods of training, refine the Core Curriculum, and work with the Colon and Rectal Education System project to build an online educational system. The ASCRS continues to support the Program Directors Association with funds, member participation, and oversight. Since Dr. Goldberg established the Program Directors Association, it has continued to evolve and has begun the new process of influencing colorectal education under the leadership of Dr. Gerry Isenberg. Our colorectal residents have never been better trained. Even with the limits on work hours, our trainees have remarkable experience in a broad area including advanced new techniques.

This year a new committee for the ASCRS under the leadership of Dr. Pat Roberts started the arduous task of developing a method for evaluating operative skills during

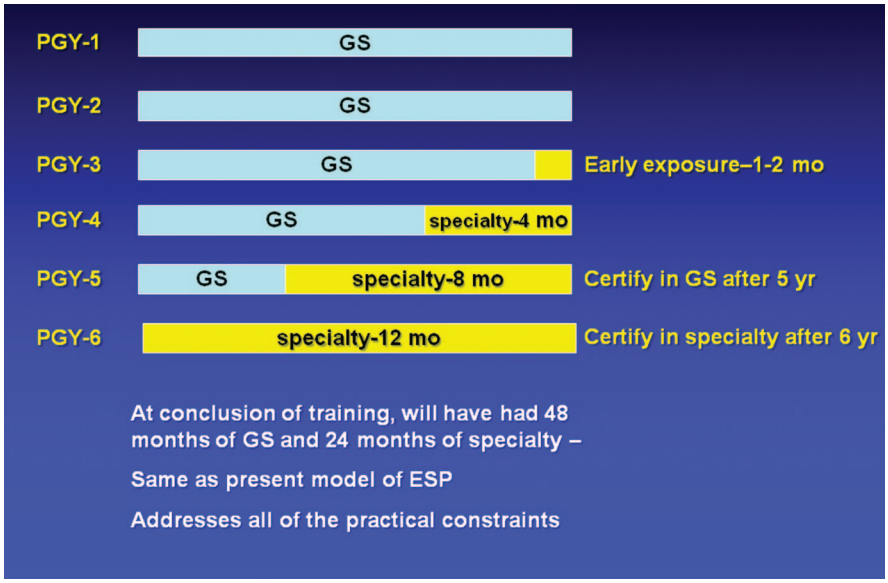

FIGURE 1. "Straw man" model to consider for surgical training. GS = General Surgery; PGY = postgraduate year; ESP = Early Specialization Program. Courtesy of Dr Frank Lewis, MD, Executive Director of ABS.

colon and rectal residency. Standardization of procedural-based assessment tools and a simulated summative skills test may help us shorten and improve our training simultaneously. This is a cutting-edge experiment that the ASCRS is funding. If successful, it will propel us to the forefront of competency-based certification and provide the ABCRS with a modernized method of certifying new colon and rectal surgeons. Our society is fortunate to have as members experts in the area of education and testing and we will rely heavily on their advice and expertise. Thanks to Drs. Reznik and McRae, to name a few.

Professionalism requires submission to recertification and a conscientious effort to maintain continuing education. It also requires that members of ASCRS volunteer their efforts to the process of education and examination. The maintenance of our status as professionals and as a professional society is directly linked to our efforts in continuing medical education (CME). The difficult tasks of managing the CME of our society and developing online education through the Colon and Rectal Education System Committee has fallen to Dr. Elisa Birnbaum. Our members will contribute educational modules according to the core curriculum established by the Program Directors Association, to standardize training of residents and provide materials for CME. The leadership of the Self-Assessment Committee has been passed to Dr. Matt Mutch from Jose Cintron to begin the next series of Colon And Rectal Self Assessment Educational Program. This publication continues to be central to the Maintenance of Certification (MOC) efforts of the ABCRS and the ASCRS, and is updated every 3 years. Dr. Pat Roberts (President of ABCRS) and Dr. Tom Read (Examination Committee Chair of ABCRS) are currently collaborating to develop a central question bank to be housed at the ABCRS for use on all of the MOC instruments.

In 1898, the retiring President of the American Medical Association, Dr. Joseph Matthews, called together the 13 founding members of the American Proctologic Society to their first official meeting June 7, 1898 in the Chittendon Hotel (the Great Southern later) in Columbus, Ohio. Dr. Matthews brought professionalism to proctology and the impact has been profound. Their agenda was simple: to establish proctology as a specialty and wrestle the treatment of proctologic disease from quackery and snake oil salesmen. They replaced carbolic acid injection with skillful hemorrhoidectomy; taught pelvic, rectal, and anal anatomy in medical colleges; expanded their membership to committed science-based proctologists who focused on proctologic and intestinal disease; recorded their proceedings, published their data, and wrote textbooks on proctologic practice. They pledged to themselves to bring coloproctology to academic institutions.

This same professionalism challenges us to make progress beyond our beginnings and our current state. We must continue to standardize and improve our training programs. Dr. Stanley Goldberg challenged us in 1984 (my first ASCRS meeting) with the call to action. "Additional training programs must be created and existing ones expanded so that a broad colorectal surgical experience can be obtained by increasing numbers of young surgeons. Ideally these programs should be affiliated with university departments of surgery so that maximum interaction with basic scientists can take place."[4] At that time 27 programs trained 50 residents. We have listened and now have 50 programs training 87 residents. Eight are affiliated with universities (Table 1); 20 are truly university based (Table

TABLE 1. University affiliated colon and rectal residency programs

1. Grand Rapids MERC/MSU Colon & Rectal Surgery Residency
2. Henry Ford Hospital/Wayne State University
3. Indiana University School of Medicine Colon & Rectal Residency
4. Presbyterian Hospital/Parkland Memorial Hospital - Dallas
5. St. Francis Hospital and Medical Center
6. UMDNJ–Robert Wood Johnson Medical School
7. University of Minnesota Hospitals
8. University of Texas Affiliated Hospitals

2); 6 are at major clinics (Table 3); and 16 are private hospital based (Table 4). Colon and rectal surgery continues to grow and applications continue to increase (134 last year). This gives us a greater ability to be selective in our matching process and tells us that more programs and more training positions can be filled by trainees. The issue becomes the funding and quality control of our programs. We are making progress. At the same time, the finishing residents are often choosing university-based appointments. In a recent survey of the membership (594 responded), 213 members are employed full time in an academic institution and another 87 are employed part time. The majority of us are in a multispecialty practice or colorectal group. Colorectal surgeons are now employed at 93 universities in the United States and Canada (Table 5). We have answered our founding fathers' challenge to bring colorectal surgery to academic institutions (Fig. 2). We now have colorectal surgeons in every state. We can do more.

As a member of Washington University's Medical School Admissions Committee, I am exposed to a number of enthusiastic, intelligent, motivated, well-educated young people

TABLE 2. University-based colon and rectal residency programs

1. Brigham and Women's Hospital/Harvard
2. Brown University
3. Creighton University
4. Mount Sinai School of Medicine
5. New York Presbyterian Hospital/Cornell and Columbia Campuses
6. Penn State University
7. Schumpert Medical Center/LA State University Health Sciences Center
8. Southern Illinois University School of Medicine
9. Stony Brook University
10. Stroger Hospital of Cook County/University of Illinois
11. Thomas Jefferson University Hospital
12. University at Buffalo, The State of New York
13. University of Chicago
14. University Hospitals Case Medical Center
15. University of Louisville
16. University of Miami/Jackson Memorial Hospital
17. University of Pennsylvania
18. University of Southern California
19. University of Toronto
20. Washington University/Barnes Jewish Hospital/St Louis Children's Hospital

TABLE 3. Clinic foundation colon and rectal residency programs

1. Cleveland Clinic Foundation
2. Cleveland Clinic Florida
3. Grant Medical Center Colon/Rectal Surgery Residency Program
4. Lahey Clinic
5. Mayo Clinic
6. Ochsner Clinic Foundation

who have incredible potential for making an impact on medicine as a whole. I can see a brighter future for colon and rectal surgery if only a few of these candidates were to choose our specialty. As the number of applications for positions in colon and rectal surgery residency increase on a yearly basis, I am encouraged for the continued advancement of colon and rectal surgery and the enrollment of dedicated, focused, and world-changing professionals. We must continue to influence students and residents early in their careers to replenish our ranks over time. Volunteering to teach students may be the most meaningful expression of professionalism because the reward is always in the distant future and affects an ever widening circle as the students become practicing physicians.

Professionalism requires that we undertake our research in an ethical, controlled, and reproducible manner whether funded by individual institutions such as a university or our society, industry, or the government. This year the ASCRS began an ongoing partnership with the National Institutes of Health (NIH) to fund a worthy ASCRS member in their research. The ASCRS will match salary support for an approved K08 or K23 "New Investigator Grants" application by an ASCRS researcher. This basic science (K08) or clinical research (K23) grant must be relevant to Colon and Rectal Surgery as determined by our Executive Council. This will allow the funded individual to focus 75% effort on research. The grant requires a 5-year commitment of $75,000/year from the ASCRS to combine with the $100,000 salary support of the NIH. All direct funds for the project will be funded by the NIH. Dr. Jose

TABLE 4. Private colon and rectal residency programs

1. Baylor Medical Center
2. Cedars –Sinai Medical Center
3. Christus Santa Rosa Colon & Rectal Surgery Program
4. Florida Hospital Colon & Rectal Surgery Residency
5. Georgia Colon & Rectal Surgical Clinic
6. Greater Baltimore Medical Center
7. Lehigh Valley Hospital Colon & Rectal Residency Program
8. North Shore Long Island Jewish Medical Center
9. Orlando Health/Colon & Rectal Surgery Program
10. Rhode Island Colorectal Clinic Program
11. Saint Vincent Health Center
12. St. Luke's/Roosevelt Hospital Center
13. St. Mark's Healthcare Foundation CRS Program
14. Swedish Colon & Rectal Clinic Program
15. Washington Hospital Center
16. William Beaumont Hospital

TABLE 5. Universities with colon and rectal surgeons

Brown University	University of California - Irvine
Case Western Reserve University	University of California - San Francisco
Cleveland Clinic	University of California–LA
Cleveland Clinic Florida	University of Central Florida
Commonwealth Medical College of Pennsylvania	University of Chicago
Creighton University	University of Cincinnati
Dartmouth Hitchcock	University of Colorado
Drexel University	University of Connecticut
Emory University	University of Florida
Florida International University	University of Hawaii
Hackensack University	University of Illinois
Harvard University	University of Iowa
Indiana University	University of Kansas
Johns Hopkins University	University of Kentucky
Lahey Clinic	University of Louisville
Loma Linda University	University of Massachusetts
Louisiana State University	University of Medicine and Dentistry of New Jersey
Loyola University	University of Miami
Marshfield Clinic	University of Michigan
Mayo Clinic	University of Minnesota
McGill University	University of Missouri
Medical College of Georgia	University of Montreal
Medical College of Virginia	University of Nebraska
Medical College of Wisconsin	University of Nevada
Memorial Sloan Kettering	University of North Carolina
Michigan State University	University of North Dakota
Mt Sinai School of Medicine	University of Pennsylvania
New York University	University of Pittsburgh
Northwestern University	University of Rochester
Nova Southeastern University	University of San Antonio
Ochsner Clinic	University of South Alabama
Ohio State University	University of South Florida
Oregon Health Science University	University of Southern California
Owen's University, Canada	University of Tennessee
Penn State University	University of Texas - Houston
Rush University	University of Toledo
Southern Illinois University - Carbondale	University of Toronto
Stanford University	University of Utah
State University of New York, Buffalo	University of Washington
Stonybrook University	University of Wisconsin - Madison
Texas A & M University	UT MD Anderson Cancer Center
Texas Tech University	UT Southwest - Dallas
Thomas Jefferson Medical University	Vanderbilt University
Tufts University	Virginia Commonwealth University
Tulane University	Walter Reed Army Medical Center
University of British Columbia	Washington University in St. Louis
University of Calgary	Wayne State University
University of California - Fresno	Weill Cornell Medical College
	Wright State University
	Yale University

Guillem has led this effort, which should open doors for the ASCRS to have members on study sections in the NIH and direct the research toward our members. The Executive Council is seeking industry support for these grants. Only as we develop young basic scientists dedicated to basic research in colorectal disease will we be able to claim our position as "*the*" authority in colorectal disease. These members or fellows, who are devoting their lives to the process of basic discovery, represent the future for our position in the fore front of patient care.

In an effort to guide the ASCRS to develop trials which will lead to evidence-based colon and rectal surgery practice, Dr. Walter Koltun has agreed to lead the newly established Research Development Committee. This committee is charged to work alongside the Research Foundation to generate multicenter, randomized clinical trials that will guide our practice in the future. By working together we will be able to answer questions that have been only partially answered in the past by individual researchers. Comparative trials will become the basis of our practice in the future and help us to develop appropriate practice parameters for colorectal diseases. Our society must lead by establishing research priorities and cooperate to produce multicenter data which reliably changes practice.

In an ever-changing backdrop of technology, we are confronted with new instruments, pharmaceuticals, and technique platforms. Professionalism dictates that we evaluate all new technology critically before recommending use by our members. This evaluation process within the confines of conflict of interest, informed consent, and the institutional review process must be complete before members endorse the new technology as experts. The ASCRS has established a New Technology Committee headed by Dr. Peter Marcello to guide this process. I hope that we can all bring our questions to this group to help us find the right method to evaluate the new technology in an ethical, yet efficient way. I anticipate the use of prospective comparative trials to evaluate new technology as we go forward. Only this nonpartisan pathway can protect our patients from unintended injury as new technology floods our specialty.

Professionalism will guide our relationship with industry, the government, and the public. Disclosure of relationships with industry does not eliminate conflict of interest nor does it necessarily indicate conflict of interest. As our society enters the new era of Pharma and Advamed, which restricts industry sponsorship of societal research and educational efforts, we hope to maintain adequate funding for all of our events and projects that define our society. Our policies of complete control of educational content in all of our meetings will be maintained. Separation of research funding from sponsorship pressure has previously been established by the Research Foundation. The ASCRS Education Foundation continues to grow and is currently sitting at $5 million with a goal of $25 million as envisioned by Dr. Bruce Wolff. The resulting independence of the society from industry sponsorship at our yearly meetings can only be good for both the society and industry. The members of the ASCRS are the only group

FIGURE 2. Full-time university colorectal surgeons.

that can ultimately make this happen with directed gifts from members themselves and grateful patients. I challenge you to make this independence possible.

Professionalism assumes that we, as physicians, will display compassion, provide free care when needed, put others first, and treat all individuals with whom we come in contact with behavior that reflects our concern for humanity. By definition we must strive to be mentors both in practice and in life. In some ways this can be called emotional intelligence. The components of emotional intelligence are self-awareness and social awareness and the ability to manage self and relationships (Fig. 3). The

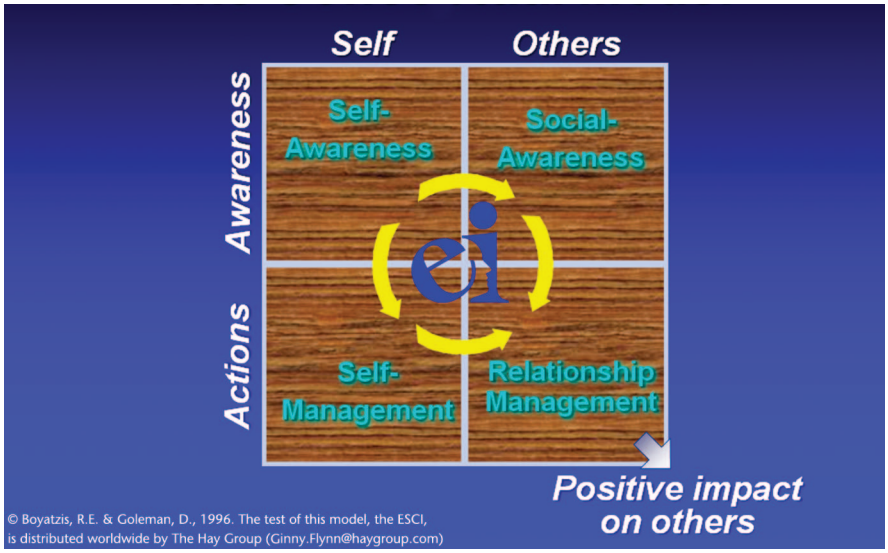

FIGURE 3. Emotional intelligence: the conceptual model.[5]

goal of developing emotional intelligence is to manage response to feelings and change a negative response to a positive behavior. This begins with a 360° evaluation from 9 people who interact with you on a regular basis. The competencies that are evaluated in this audit can be categorized under 4 main headings. Emotional self-awareness, accurate self-assessment, and self-confidence can be learned with accurate feedback. Emotional self-control, transparency, adaptability, achievement, initiative, and optimism are products of self-awareness. Empathy, organizational awareness, and service orientation are measures of social awareness. Mentorship, leadership, influence, conflict management, and teamwork are the results of social awareness. Self-awareness and self-management greatly influence behavior. Social awareness and relationship management are the basis for successful sections of colorectal surgery and professionalism. In today's world, adherence to the "code of behavior" in the workplace has become mandatory. Learning or developing emotional intelligence can help us as professionals become better physicians, mentors, and colleagues even as pressures increase to be more productive and remove our independence. Professionalism requires us to consider every means possible to continually improve our practice and ability to teach, lead and innovate. I urge you to consider your own level of emotional intelligence through such a process. Kathy Cramer will be speaking on this subject during this meeting.

Never before has there been a time with a greater need for professionalism in medicine. As we struggle with healthcare reform it is easy to lose focus on the true reason for our very existence as physicians – the patient. The ASCRS has opposed the legislative branch of our government as they focus on the money, control, distribution of medical services, money, cost, and, did I mention, money? In conjunction with other surgical societies we have asked Congress to focus on quality patient care and the establishment of a healthcare system based on quality initiatives and improving patient care. We have supported broadened coverage and removal of the sustainable growth rate mechanism of Medicare funding. We have opposed the establishment of an independent medical advisory council responsible only to the President and the taxation of selected specialties based on their performance of nonessential procedures. Professionalism demands that we begin healthcare reform via a quality improvement basis unrelated to efforts to save money, but with the ultimate outcome of more efficient, cost-effective, improved patient care. We are grateful to Dr. Frank Opelka for his efforts through the American College of Surgeons; Drs. Baxter, Senagore, Morris, and Temple through our Quality Assessment Committee and their participation at the table with National Quality agendas; and Dr. Orangio as he takes his seat at the American Medical Association Specialty Society Relative Value Scale Update Committee. Dr. Senagore has assumed leadership of a new committee for Healthcare Reform at the ASCRS. This committee is charged to keep us apprised of legislative and regulatory changes, guide us through the needed changes within our society such as public engagement and public reporting of quality data, and help us to respond to the government's healthcare reform plan. The Quality Assessment Committee is currently working to develop quality measures that truly reflect the patient outcomes that are relevant to colorectal surgery and monitoring those groups that would usurp that prerogative.

The state of our society is excellent. The debate on healthcare reform has overshadowed national and international disasters, celebrity scandal, sport success stories, and the deaths of great contributors to our national way of life. We must remain involved and consider our professional responsibility to be part of the solution as we go forward. The society, through its relationship with the American College of Surgeons, will remain involved and support the combined surgical specialties as we try to shape healthcare reform.

Professionalism according to Peter Volpe, is a "social contract between a group and the overall populace that it serves."[3] This can only be accomplished if the populace is fully aware of the group, its members, and its goals. In that vein, efforts are underway to improve our visibility in the eyes of the public and organized medicine. This branding effort was initiated at this meeting by Drs. Harry Papaconstantino, Debra Nagel, and Tom Cataldo. Our relationship with CBS Healthwatch, the local CBS station WCCO, and the Family Practice Physician CME program have all started this year as we seek to raise our level of visibility at each successive venue for this meeting. The ASCRS is promoting colon and rectal cancer awareness for the nation *and* Minneapolis, as well as the definition of a colon and rectal surgeon.

The ASCRS is continuing to support the International Council of Coloproctology, led by Dr. Graham Newstead, in its efforts to standardize the training of colorectal surgeons around the world. We welcome the President of the newly established European Society of Coloproctology (Dr. Giovanni Romano) to our meeting this year. We thank the members and leadership of our longtime partners, the Section of Coloproctology of The Royal Society of Medicine, the Association of Coloproctology of Great Britain and Ireland, and the Australian Society of Colorectal Surgeons for their continued support and efforts to improve the care of patients with colorectal disease. We must realize that medicine is global and our thoughts and efforts must be considered in a global setting. Please welcome our international guests and make them feel part of our society as members of our profession. I would urge you to consider attending the European Society of Coloproctology meeting in Sorrento, Italy, in September 2010 and the Tripartite Meeting next year in Cairns, Australia.

Medicine has been under attack for many years. As far back as 1938, where Dr. Harry Hibshman, as President of the ASCRS, responded to President Roosevelt's suggestion of socialized medicine, medicine has fought to

control itself as a profession. There is no such thing as the "Golden Era of Medicine" in my opinion. There have always been struggles within medicine and with outside agencies. Medicine has been forced to react to change and conflict to survive. The history of colon and rectal surgery is no different. We have survived. In the words of Victor Fazio in his 1995 presidential address, "We must stay the course over the universal truths. These universal truths include the patient and a caring physician, a physician dedicated to advancing and promoting science and practice of treating patients with disease of the colon and rectum."[6] And as Dr. David Rothenberger said in 1997, "We must individually pledge that we will take the high road and maintain the high standards that should characterize our activities. By staying patient focused, I believe that we can maintain professionalism at this time."[7]

My advice to our young members, the future of medicine and the ASCRS, is to get to know our past presidents. I have worked in some way with almost all of the last 30 who still wander the halls of our meeting and continue to serve our society in meaningful ways. I consider them all to be friends and know them to be mentors, willing to give of themselves even to this day. For those of you who have not had the privilege to work with one of them, please take the time to engage them and feel the strength of professionalism they all embody.

"What is the impact of professionalism?" – The impact of professionalism is the legacy that each of us leaves behind – selfless contribution that makes a difference, in the form of friends, grateful trainees, grateful patients, and an altogether better practice of colorectal surgery, community, society, and world. It is the standard by which we measure our successes and the foundation on which we base our decisions. We must *never* sacrifice our professionalism, rather we must hold up our professionalism as our battle flag to motivate others to follow us as we move to a better world for our patients. May God bless our society and each one of you and keep on living the dream.

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