



SSAT Presidential Address: Whereof What's Past Is Prologue

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Abstract

In preparation for an upcoming SSAT strategic planning process, the rich history, current demographics, and financial outlook of the Society are reviewed. Building on a strong tradition of innovative leadership, the SSAT remains a vibrant and financially sound organization that continues to attract new members from across the spectrum of GI surgery. However, several trends—subspecialization, an increasing focus on clinical research, the size of DDW, among others—challenge the society to better to define its identity as we plan for and prioritize for the future.

Keywords SSAT · History · Demographics · Finances · Strategic planning

I am more than humbled to be up here today as the 59th president of the SSAT—it really is the biggest honor of my career. Any success I have had has been the result of being in the right place at the right time, but even more the result of being with the right people. I wish there were time this morning to recognize all the residents, colleagues, and patients at the 3 institutions where I have worked—Washington University in St. Louis, University of California at Los Angeles (UCLA), and Brigham and Women's Hospital; I am here because of them. I would like to specifically acknowledge a few individuals that have played a critical role in my professional development and who continue to serve as role models.

First, my dad, Charles A. Ashley, MD. He was a pathologist and scientist who spent his career at Bassett Hospital in Cooperstown, NY. Bassett has always been about providing the best medical care, teaching, and research in a rural community; my dad served as the director of that hospital for the last nearly two decades of his career—for me, my father and Bassett continue to be what the best of medicine is all about—he's here today.

Samuel A Wells, Jr., MD—the consummate surgical scientist. After all that he had done at Duke, Washington



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University, and then for the college, he retired to become an investigator at the National Cancer Institute where I believe he is still facilitating trials. Sam was committed to the highest standards for his residents, and he had more impact on the direction of my career than any other individual. I thought I was going to be a community surgeon but, in the spring of my PGY2 year, Dr. Wells told me that I was going into the lab with Laurence Y. Cheung, MD.

Larry grew up in mainland China, went to medical school in Taiwan, and then did an internship at a private hospital in Salt Lake where he caught the attention of Frank G. Moody, MD. Frank brought him to the University of Utah where he finished training and worked in the lab with Frank before joining the faculty at Washington University. Larry is a gifted surgical investigator but he is also a man of incredible wisdom. He had a set of rules for success in academic surgery and for life in general, some of which he had learned from

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Frank and some of his own. I left his laboratory with a terrific foundation for an academic career.

My first real job was at UCLA with Michael J. Zinner, and I worked for Mike for nearly the next 20 years. He has been my boss, my mentor, my friend, my advisor, and my surgeon (we have both operated on each other—I think they call that surgical incest). There is nobody better to work for—he is a chair who both inspires you to do more but is always also your biggest supporter. I think we would both say it was a partnership—he let me do anything I have wanted with the department and, maybe, some of the things he did not want to do as well, gave me as much slack as I asked for but was always willing to pull me back when I got into trouble. I always felt like I had the best surgical job in America.

The SSAT has also had an incredible impact on my career—unbelievable mentors, colleagues, and friends who have made all the difference—I wish there were time to acknowledge all of you individually. My first national presentation was at the SSAT in New Orleans in 1984.¹ If I remember correctly, Barbara L. Bass, MD—who has consistently done nice things for my career, David W. McFadden, MD, and F. Charles Brunicaudi, MD were all residents presenting as well—this was before the Resident Research Conference, but I think we met and have been life-long friends since. At the time SSAT meetings were still just a single track, it felt like an enormous audience; after the presentation, the comments/questions were all made up front, and then, the presenter closed. I got through the talk fine and then five or six surgical giants that I had heard about and read their papers all got up and made comments. I was shaking so much that I could not write and I kind of fell apart closing, but everybody came up and encouraged me afterwards. Sam Wells actually came to the meeting just to hear my talk, which he missed because his plane was delayed, but he took me out to lunch with his former residents, Dana K. Anderson, MD and John B. Hanks, MD. I do not think we can overestimate the impact of that kind of experience on young surgeons. I went home excited about research, and ever since, the SSAT has felt like home. (SLIDE)

The SSAT board has decided to begin a new strategic planning process over the next year, and as background for this, I thought it might be an appropriate time and place—Washington, D.C.—for a state of the union address—the organization's history and where we are today as a starting point for planning. The title is a line from the *Tempest*—again Washington-appropriate—it is on a statue at the National Archives, a few blocks away on the mall. The full quotation is, “Whereof what's past is prologue, what to come in yours and my discharge.”² Antonio makes this statement to Sebastian, suggesting that all that has happened previously provides a context for what is about to occur; they were about to commit murder and hopefully that not be the result of our strategic planning process.

This history is based on presidential addresses on our history by Tom R. DeMeester, MD in 1998³ and Carlos A. Pellegrini, MD in 2000.⁴ In addition, I reviewed board minutes since the late 1990s and got a lot of help from Jon Blackstone, the SSAT's Executive Director. I asked Bernard M. Jaffe, MD if he had led one initiative and he responded, “Well I was involved but it was likely a cabal of many of us”; the SSAT has been a cabal and there are undoubtedly omissions. Reading through the minutes, there were many more initiatives that failed than were successful and many that did so three or four times before they succeeded. The SSAT has been about friends doing the good work and committed to innovation in pursuit of its mission. Our willingness to think outside-the-box and take some risk has resulted in some remarkable successes, but we have also been resilient when our efforts fail.

Our History

The SSAT was founded as the Association for Colon Surgery in 1960 by Robert Turell, MD from Mt. Sinai; John M. Waugh, MD from the Mayo Clinic; and Warren H. Cole from the University of Illinois. The initial members were authors of a series of volumes of the *Surgical Clinics of North America* on gastrointestinal surgery and of Turell's textbook, *Diseases of the Colon and Anorectum*. The society's origin was not without controversy; many questioned whether another surgical organization was needed, but this group agreed that the surgical treatment of GI disease was not getting enough attention at other national meetings. By the time of the first meeting in 1961, Turell was appointed secretary-treasurer and Cole was the first president. Cole had already served as President of the American College of Surgeons and of the American Surgical Association, and he convinced the membership that the need was broader than just the colon—they changed the name to the Society for Surgery of the Alimentary Tract. Turell was to later comment, “We started out as anal pruritus and ended up as generalized dermatitis.”⁵ They articulated a vision for, “a new surgical organization oriented to the problems of the alimentary tract and of creating a supporting research or education foundation.”⁵

The third presidential address given by Robert Zollinger in 1963 became known as the Society's Declaration of Independence. He suggested that, “If we have encouraged and brought into focus, at a national level, the clinical and experimental solutions to the many problems of the alimentary tract, we will have justified our existence.”⁶ The SSAT pretty rapidly became the place for American GI surgeons to present their best work. In parallel with the scientific program, the Society continued to mature through a series of member-led initiatives.

Perhaps the most significant event in our history was the formation of Digestive Disease Week. The SSAT initially met in conjunction with the American Medical Association. In

1966, the board asked Lloyd M. Nyhus, MD to lead a liaison committee to the American Gastroenterologic Association (AGA) to explore areas for collaboration. It apparently took several years before we were able to get their attention when the AGA, under Morton I. Grossman, MD, PhD's leadership, started urging the NIH to consider an institute devoted to digestive disease, what was to become the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)—it apparently helped the argument for an institute devoted to digestive disease to have surgeons at the table. Drs. Robert Zeppa and Ward O. Griffin were also very involved in the discussions. The SSAT membership was apparently concerned that we would be swallowed up by the AGA, which was likened to an octopus, but Frank G. Moody, MD and William Silen MD, among others, made convincing arguments in favor of the association, and in 1973, we were part of the first DDW. In his presidential address, several years later, Dr. Zeppa concluded that joining DDW had increased attendance at the SSAT, improved the quality of our science, enhanced collaborations, and provided a continuing source of dollars that would permit the society to fund other initiatives.⁷ Dr. Pellegrini, in his history, suggested that this was the event that moved us from a society based primarily on surgical technique to one focused on the science of surgical digestive disease.⁴

DDW was also the beginning of what has been an ongoing theme for the SSAT, collaboration with other societies. In addition to our three partners in DDW, we have developed strong connections with other American surgical organizations—the Society of American Gastrointestinal Endoscopic Surgeons, the Americas Hepato-Pancreato-Biliary Association, the American Society of Colon and Rectal Surgery. Internationally, we have a combined symposium with the International Society for Digestive Surgery and currently are pursuing associations with the Brazilian, Indian, and Japanese GI surgical societies, to name a few. This convening function has been one of the SSAT's real strengths.

In 1986, we had the first Resident Research Conference. Initially sponsored by Ross Laboratories, Inc., R. Scott Jones, MD; Hiram C. Polk, MD; and Ronald K. Tompkins, MD were the society leaders who attended a day-long event in the Napa Valley. Yesterday was our 33rd Resident and Fellow Research Conference, and it continues to offer a unique opportunity for presenting residents and fellows to interact directly with the leadership and establish a meaningful relationship with the society. Ross Laboratories, Inc. eventually stopped being able to sponsor the event, and it is now largely funded by the SSAT Foundation.

The next landmark was the establishment of the Career Development Award in 1987. Research sponsorship was part of Turell's original vision; our share of the excess from DDW finally permitted this. Bernard Jaffe played a significant role in advocating for this, and he, with David L. Nahrwold, MD, developed the application process. The first awardee was Barbara Bass. There was concern at the time that this would not be sustainable but the society again took some risk, and the

track record has been pretty remarkable. Many would suggest that supporting young academic surgeons is our most important work—we have now had some impact on the early careers of 33 recipients. Three of these have now served as president of the society and 2 as editors of the *Journal of Gastrointestinal Surgery*. At least 8 by my count have gone on to become chairs of surgery, and many others are division chiefs and/or are serving in leadership roles for the SSAT and elsewhere.

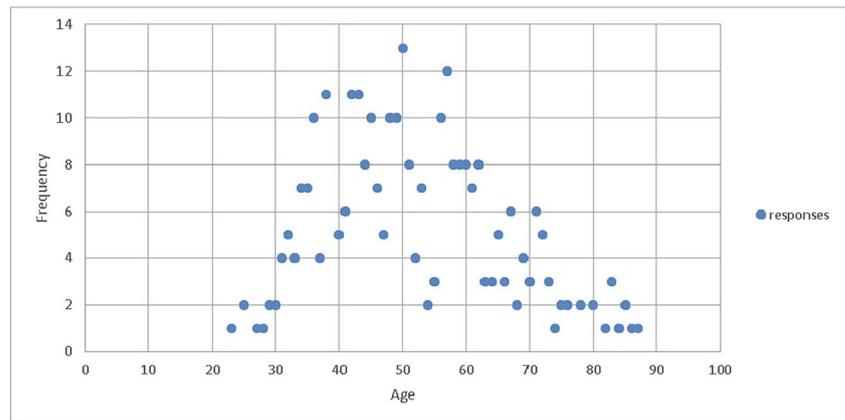
Another major advance was the expansion of the membership that occurred in the early 1990s. By the 1980s, the membership committee had adopted a requirement for at least 10 publications, and active membership numbers were stagnant at about 1000 academic surgeons. During his presidency in 1993, Bernard Langer recommended that we eliminate all publication requirements and allow applicants to initiate the application themselves. With help from Lawrence W. Way, MD and an active campaign by the chair of the membership committee, Robert W. Beart, MD, membership increased by nearly 50%; the assumption was that many of the new members were community surgeons.

Another not so simple endeavor was the start of our journal. Since nearly its inception, the Society's papers had been published in the *American Journal of Surgery* and two of its editors, Robert Zollinger and Hiram Polk had also been SSAT presidents. Bernard Langer again made this a priority and, with the help from Larry Way, in 1997, the journal was launched under the leadership of John L. Cameron, MD and Keith Kelly, MD. It has been a remarkable success—a steady rise in impact factor and readership. John and Keith were followed by 2 equally strong stewards—Charles J. Yeo, MD and Jeffrey B. Matthews, MD—and then recently by the third generation, Timothy M. Pawlik, MD and Richard A. Hodin, MD.

The addition of the royalties from JoGS to the overage from DDW has made the SSAT even more than financially sound. In the late 1990s, there was a sense that we would be better off with a different mechanism for investment and fundraising than the society itself. The result was the establishment of the SSAT Foundation in 2000 which, with able leadership by past presidents David Fromm, MD; Michael G. Sarr, MD; Keith D. Lillemoe, MD; Barbara Bass; and, currently, David W. Rattner, MD, has flourished. We now fund, between the foundation and the society, 15 grants and awards, including our named awards, which honor several of our past presidents, and several traveling fellowships.

Another significant change since the 1990s has been the evolution of our program. Responding in part to the increasing subspecialization of GI surgery and, beginning with Mike Sarr as program committee chair followed by Barbara Bass; David Mahvi, MD; Mark P. Callery, MD; Jean-Nicolas Vauthey, MD; and, now, Vic Velanovich, we have gone from a single plenary format consisting mainly of scientific presentations, through the addition of multiple parallel sessions—panels, combined symposia, and quick shots. During Nic's tenure,

Fig. 1 Age distribution of SSAT membership completing the survey ($n = 307$)



we transitioned to the current 3 parallel tracts of foregut, Hepato-Pancreato-Biliary (HPB) and small bowel/colorectal. The program has gotten better and better—this year we reviewed over 350 abstracts. Perhaps not consciously, it has also become more clinical—a reflection of our members needs but also a change in the focus of GI surgical research.

David Rattner, during his presidency in 2010, initiated a formal strategic planning process that he led with Dave Mahvi and John G. Hunter, MD. This was meant to be a 10-year plan so we are at the right time to begin a new process. The group reframed our vision statement to suggest that, “The SSAT will provide leadership in setting the standards for gastrointestinal surgery and interdisciplinary management of digestive disease, in North America and around the world.”⁸ Perhaps the major initiative was an effort to more fully engage our membership by revitalizing our committee structure, allowing members to self-nominate, and developing a formal process for committees to recommend initiatives and request funding. Committee participation has increased dramatically, and output has risen significantly in response.

Looking back at Turell’s original goals for the Society, the only area where we had missed the mark was in developing an SSAT-sponsored training model. Advanced GI surgical training has been a consistent theme in many presidential addresses—Drs. Moody, Cameron, Kelly, Way, Pellegrini, Lillemoie, among others—and we have had several task forces focused on this, but for a host of reasons, this has been a difficult row to hoe. With his presidency in 2015, Fabrizio

Michelassi resurrected the effort and we sponsored an SSAT Task Force on Advanced GI Surgical Training with representatives from all the relevant GI sub-specialty societies and the board. The Task Force developed a curriculum and case requirements—the white paper they produced describes a training paradigm that focuses on more complex GI surgery across multiple subspecialties than what is usually performed by the general surgeon in practice, but excludes the very high-end procedures done by the subspecialists.⁹ Matthew M. Hutter, MD and Aurora D. Pryor, MD are leading an effort with some pilots this year with the hope to expand this in the future. This might be most appealing to the surgeon headed for community practice, not traditionally our biggest audience, and it is a little bit of a “If we build it, they will come” effort; admittedly, there is some risk but this is again the kind of innovation that has defined the SSAT, and, if it succeeds, we will be a stronger organization as a consequence.

The SSAT Today

So where are we today? We number 2756 with 1932 active, 434 senior, 19 honorary, 348 candidate, and 23 medical student members. We have not historically collected demographic data, but in 2016, the Diversity and Inclusion Group did the first such survey; 307 members completed the survey, and 280 elected not to self-identify. Figure 1 shows the age distribution of our members. The largest concentration is in the 40–50-

Fig. 2 Gender identification of SSAT membership completing the survey ($n = 307$)

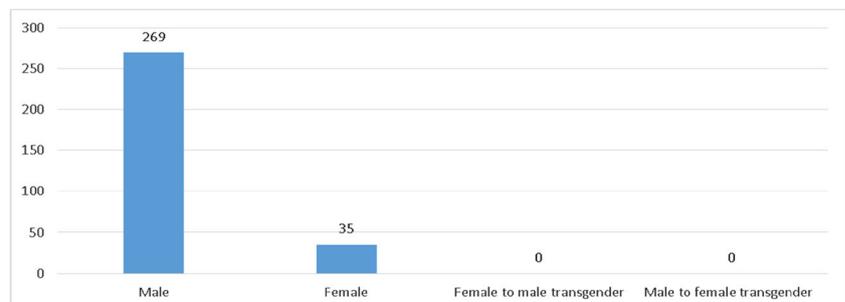


Fig. 3 Race/ethnicity of SSAT membership completing the survey ($n = 307$)

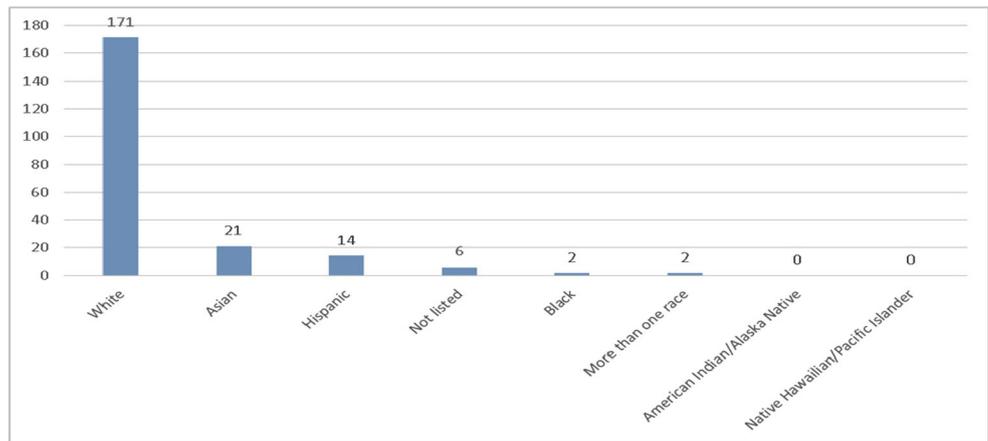


Fig. 4 Practice type of SSAT membership completing the survey ($n = 307$)

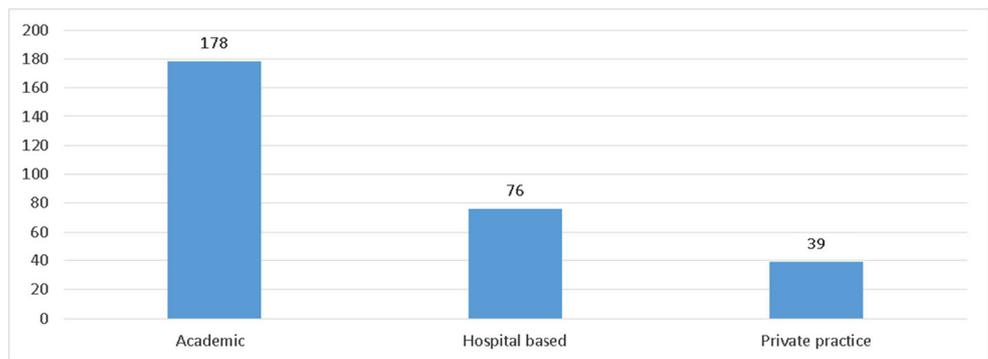


Fig. 5 Practice location of SSAT membership completing the survey ($n = 307$)

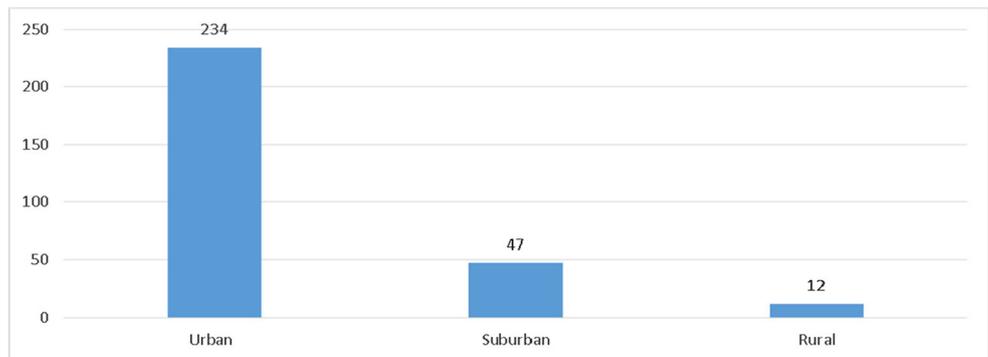
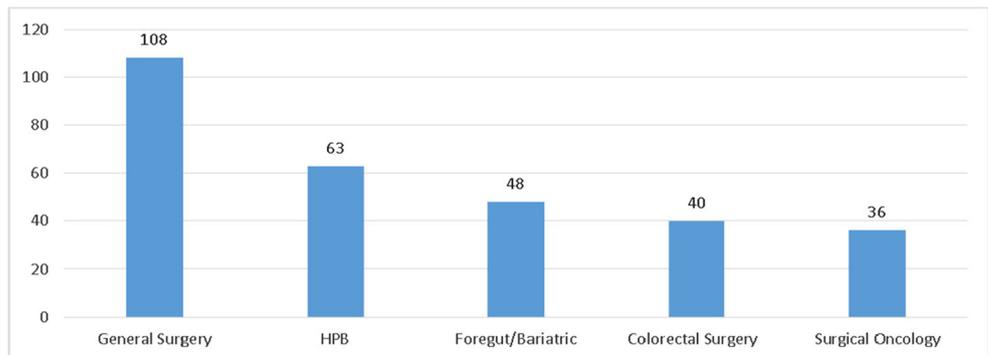


Fig. 6 Practice focus of SSAT membership completing the survey ($n = 307$)



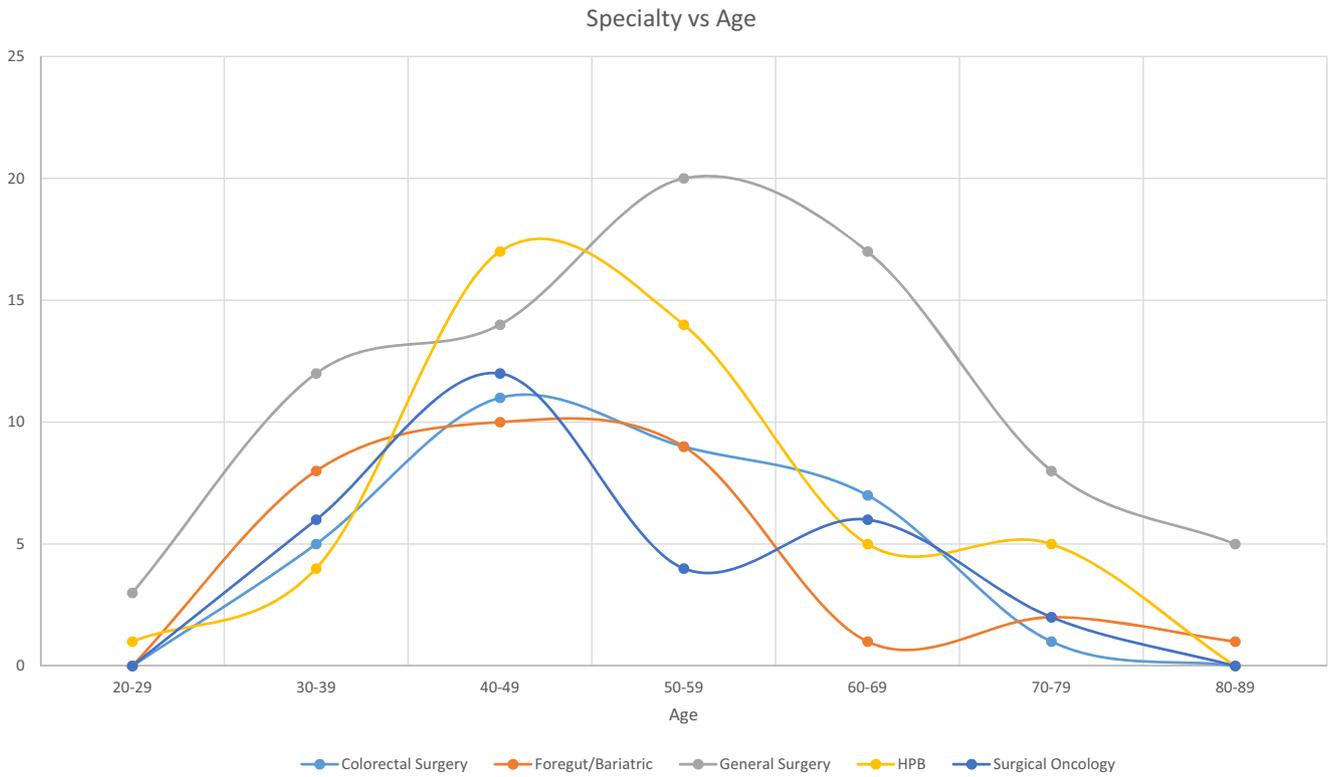


Fig. 7 Practice focus versus age of membership completing the survey (n = 307)

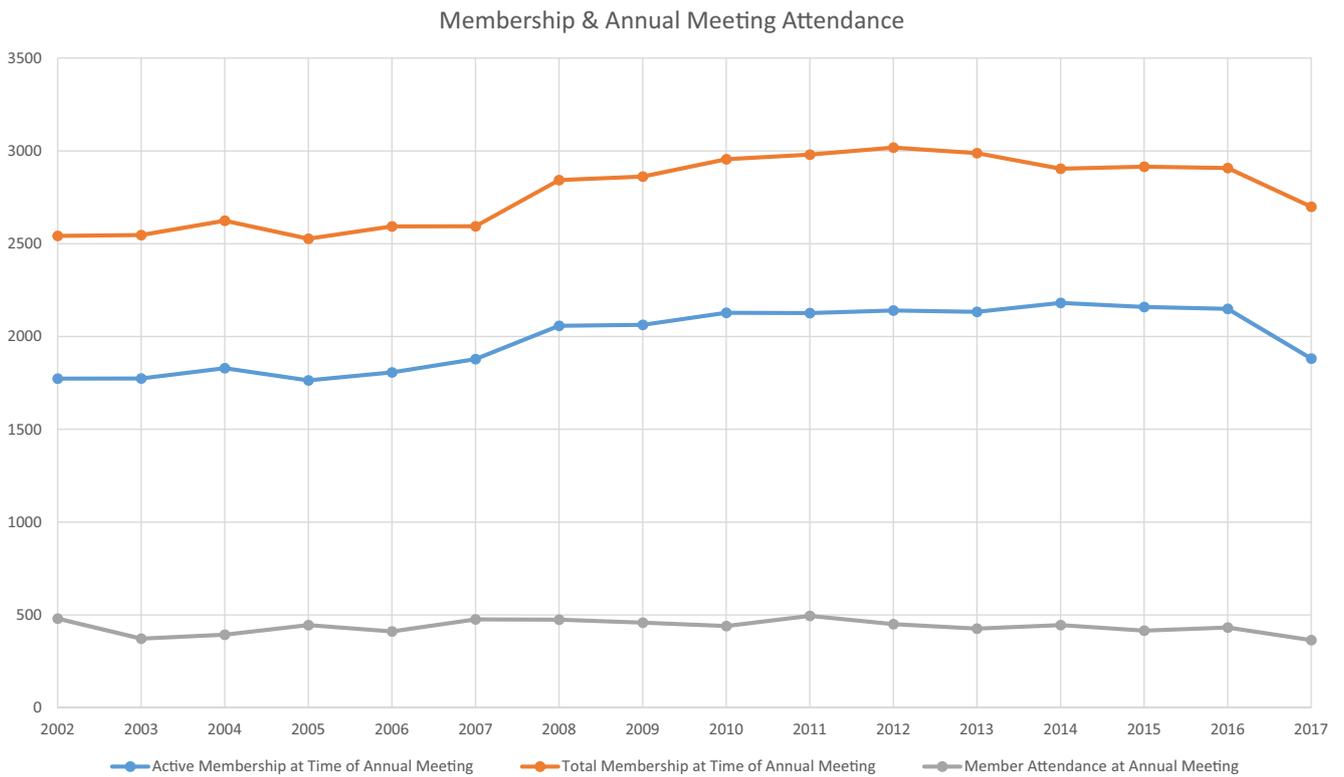


Fig. 8 Membership and annual meeting attendance since 2002

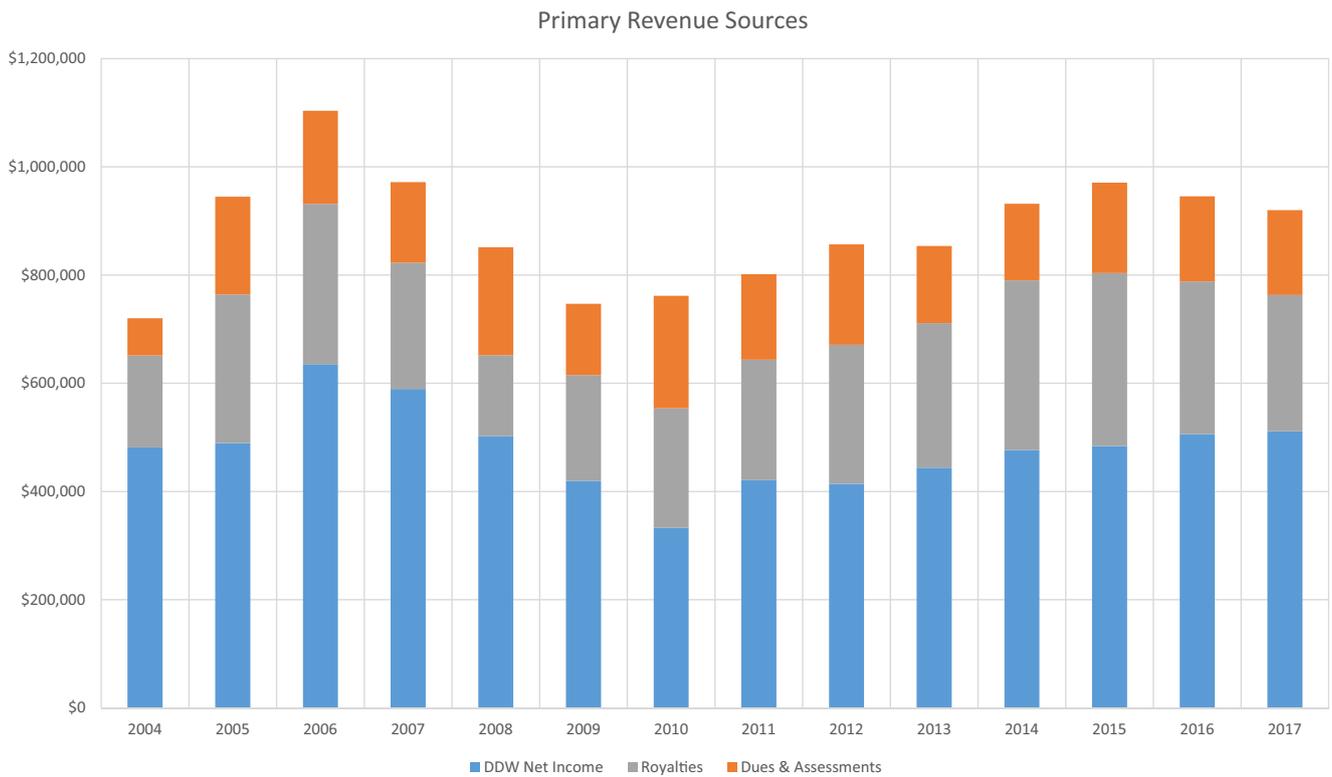


Fig. 9 Annual primary revenue sources since 2004 separated into DDW income, *Journal of Gastrointestinal Surgery* (JoGS) royalties and dues and assessments

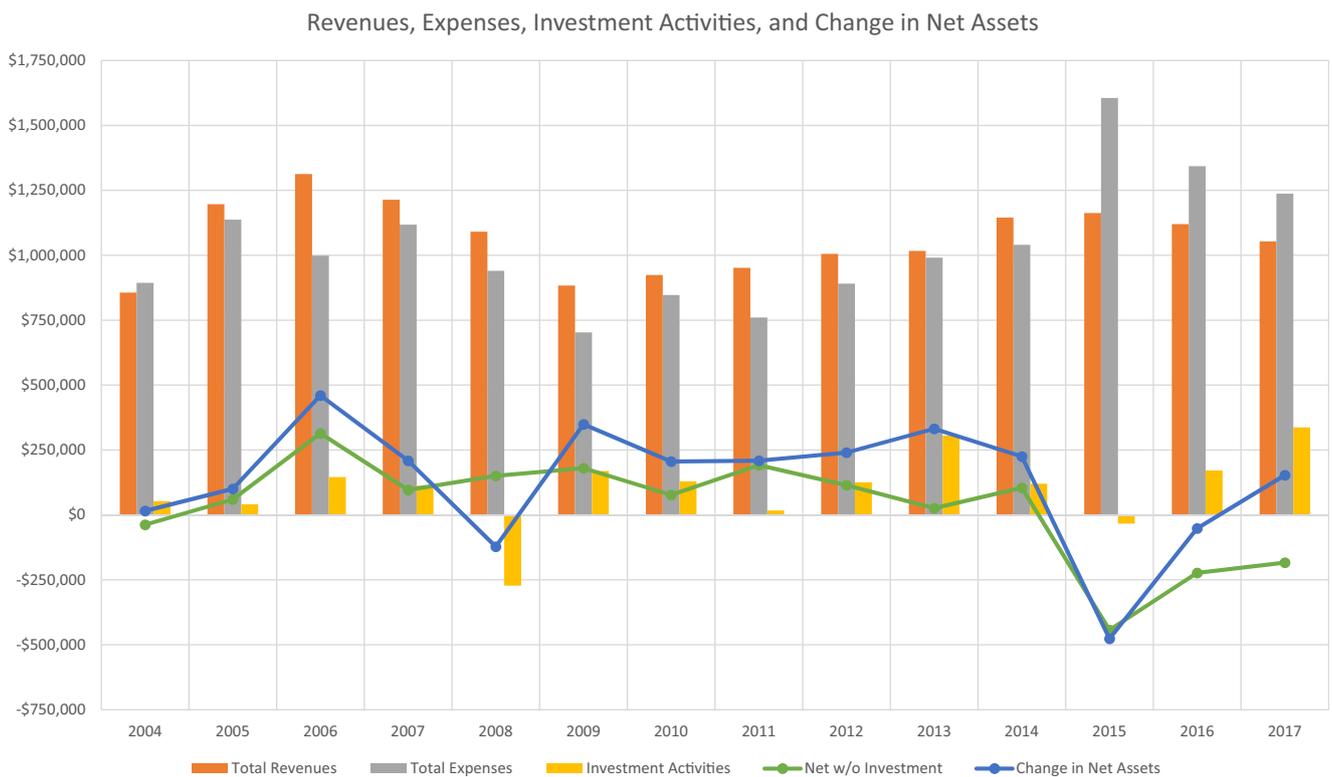


Fig. 10 Revenues, expenses, investment activities, and change in net assets since 2004

year-old range, and we do have a pipeline. Perhaps not unexpectedly, we are not a very diverse society either in gender (Fig. 2) or race/ethnicity (Fig. 3). We have very small numbers of Under Represented Minorities.

Most of us are in academic practice, although there were significant numbers in hospital-based and private practice (Fig. 4). Most of us practice in an urban setting (Fig. 5). We have few rural surgery members. For Fig. 6, members were asked to identify their primary area of practice focus. They were only allowed to choose one, and I was surprised to see that we had so many identifying primarily as general surgeons. However, if you look at practice focus vs. age (Fig. 7), the peak for general surgery is in the 50–59-year-old age group, while the subspecialties were more represented at younger ages. In a decade, general surgeons will not predominate.

Figure 8 shows trends for total membership, active membership, and meeting attendance at our annual meeting since 2002. Membership has been very stable except for the addition of about 150 members from the Australia-New Zealand Gastroesophageal Surgery Society in 2008; that relationship ended in 2016. This stability does not mean that we are not recruiting new members—in addition to retirements; we currently lose more than 100 each year who have not paid their dues—so we are actively adding new members but they are replacing those that we have lost. We believe we have a significant number that get a paper on, join for registration benefits, and then choose not to pay their dues again—we may

have as much to gain by thinking about retention as new membership initiatives.

Figure 9 is our annual revenue since 2004 broken down by source. Most significant is that from DDW—we receive a percentage of the DDW overage based on our active membership compared with the active membership of the other DDW societies. The remainder of our revenue is from royalties from JoGS and from dues and assessments. We have been able to keep our dues low because of DDW and JoGs and are in a considerably better place than many other organizations our size.

We have also been able to spend our revenues. Figure 10 shows profits and losses since 2004, demonstrating revenues, expenses which includes regular significant transfers to the foundation, our investment returns, and the nets with and without investments, respectively. The last 3 years we have been in the red without investments, a combination of a big transfer to the foundation in 2015, several new initiatives from our committees, and the SSAT Winter Course. Overall, in the red in 2015 and 2016, our investment returns kept us in the black in 2017; it may be fiscally irresponsible for an organization to depend on investment dollars.

The foundation's assets have grown steadily since its inception to just over 3 million dollars (Fig. 11). Figure 12 shows revenue without investment returns. The largest source of growth has been through transfers from the Society; although we have had reasonably steady annual members giving of between \$50,000 and 75,000, we would love to see this grow.

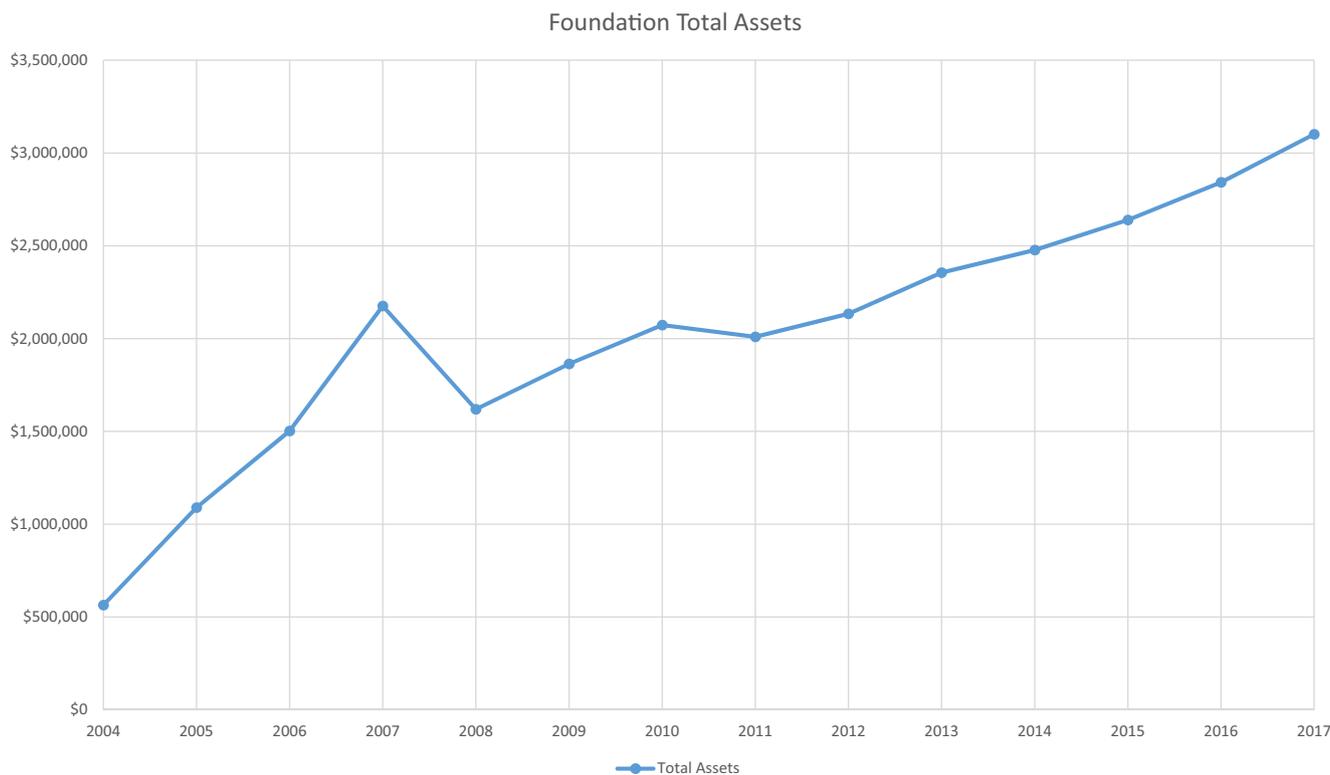


Fig. 11 Foundation assets since 2004

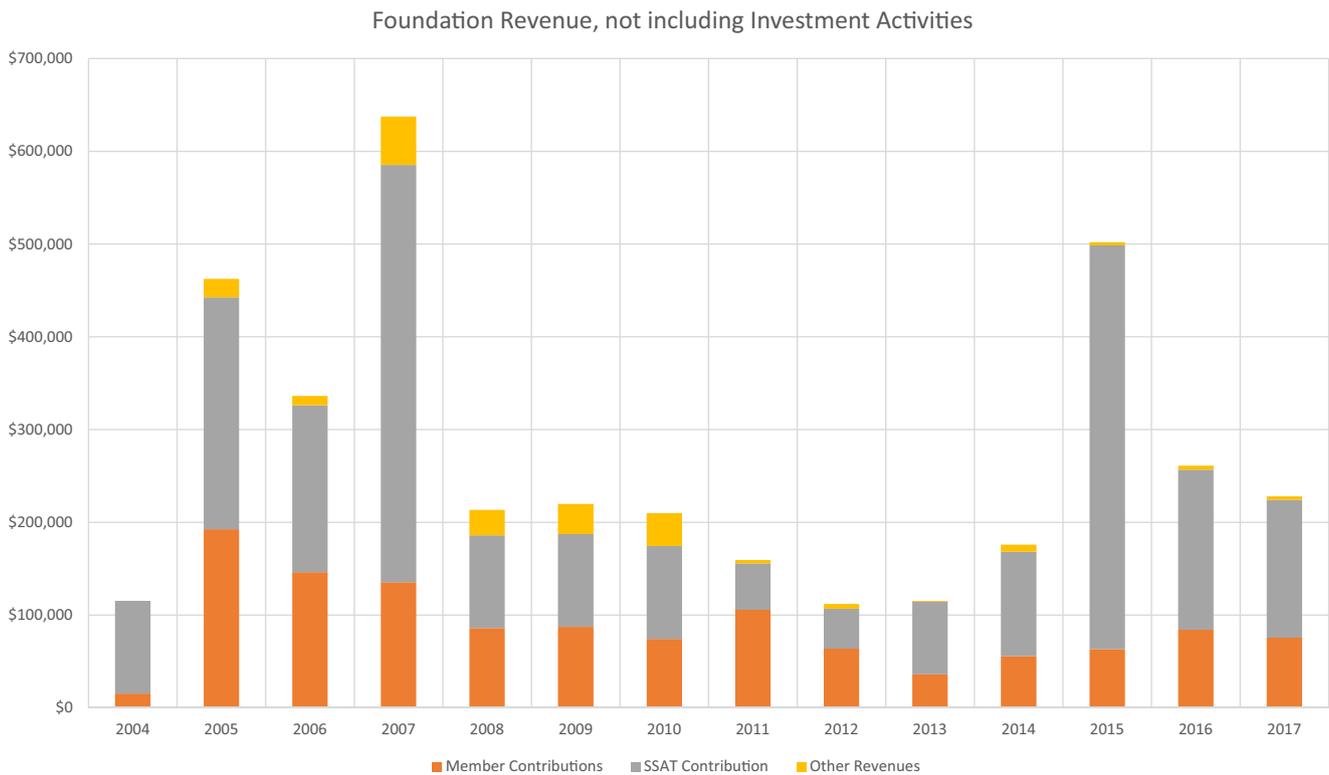


Fig. 12 Foundation revenue without investment activities, separated into sources from member contributions, SSAT contributions, and other sources

The Future

So, as prologue for our strategic planning process, where are we? We have a rich history and have matured into a society that has more than justified its existence, fulfilling our founders' vision through a series of innovative initiatives. We have advanced the science of GI surgery, supported the research and early careers of our members, and are in the midst of sponsoring a new model of advanced GI surgical training that may appeal to community surgeons that have not historically been a big part of our membership. We have a diverse program responsive to our members' needs, a robust foundation, and a vibrant journal. Our membership is stable and we are largely fiscally sound. If you are a glass half-full person, the SSAT is in a great place and should just keep doing what it's doing.

Alternatively, a half-empty take might be that, in our efforts to be an umbrella organization for all of GI surgery, to satisfy our multiple stakeholders—subspecialists and generalists, academic and community surgeons, researchers, and clinicians—we have diluted our impact. This argument would suggest that we cannot be all things to all people—the “jack of all trades, master of none” concept—and that trying to be so has prevented us from articulating a vision based on the uniqueness and added value of the SSAT. I think the reality is probably somewhere in between. And we are not alone as a surgical organization facing these issues—the Society for Surgical Oncology

and even the American College of Surgeons, both organizations with multiple stakeholders, struggle with mission-focus as well. The challenge for all of us is that addressing this would necessarily mean emphasizing some areas and downplaying others based on our strengths as a society but also on our predictions about the future. And to quote Yogi Berra, “It's tough to make predictions, and especially about the future.”¹⁰

Up until now, I think we have successfully avoided the issue. Steven Sample¹¹ who writes about what he calls the contrarian approach to leadership has suggested that the best leaders do not tackle a difficult issue today that can reasonably be put off to tomorrow—I think this does make some sense in some circumstances—sometimes, they solve themselves. However, I believe we are getting to a point that it may no longer be reasonable to put this off—we need an elevator speech for the SSAT that is about our future and not just our nostalgia for what the SSAT has been. We should start with small steps and not plan to get there overnight—this I hope will be the charge for our strategic planning.

For example, one approach might be transitioning from our current all-encompassing vision to a specific focus on providing leadership for efforts that truly are cross-cutting and span GI surgery, perhaps even explicitly saying that one of our missions is to facilitate the efforts of the subspecialty societies. And/or we have the history

and the resources to support innovation, research, and career development, and we could help others with that as well. Or we could say our major focus is professional development—with a new MOC coming, you could see us trying to lead the development of new approaches to the assessment of GI surgeons. And we should think about our relationship with DDW, which has to be framed in terms of its current benefits but also whether the financial upside is likely to continue. We could do any of these and continue with our current diverse program because we still want to attract all groups to be at the table, and we still could be the primary home for surgeons who do a range of less complex GI procedures; the group that might find an advanced GI training program of interest.

So as we think about strategic planning—we are going to discuss this at the board meeting Tuesday—I would like to suggest that we make at least part of it about defining our identity, a vision for what the society will be in the future and what will be our add to what other organizations offer. To simplify, there are really two types of strategic planning and we should be doing some of both. The first is what we most often do—start with a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and then come up with initiatives for the next few years to capitalize on the opportunities and minimize threats, really extended annual planning. And we need to do some of that kind—address the issues with our finances, decide whether we should continue our winter course and our efforts in international recruitment, etc. But I also would like to advocate that we do some of the second type of planning, focusing on a more aspirational vision for where we want to be in the future, what it is that really

distinguishes the SSAT and then work backwards to develop a set of strategies that will help us get there. The hope would then be that every proposal for a new initiative would be considered in the context of this vision and strategies.

Thank you. It has been an incredible honor and privilege to serve as your president.

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