

# PRESIDENTIAL ADDRESS

From the American Venous Forum

## The American Venous Forum and the lessons learned from the battle of Thermopolae

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For 18 of the past 20 years, I have sat in the audience and listened to every American Venous Forum (AVF) Presidential Address. The majority of the addresses were well written, thoughtful, inspiring, and captivating. As a member sitting in the audience, I listened intently, hoping to glean some pearls of wisdom from the men and women who had the privilege of being president of this great organization. I asked myself if given the opportunity, what would I say when standing at this podium? I have asked myself this question countless times this year and had difficulty deciding on a topic. A presidential address is the one time in an academician's or practitioner's career where a presentation is not based on one's personal research. No data were gathered, no statistical analysis occurred, and the validity of my conclusions cannot be debated based on the flaws of my scientific design. A presidential address is the one time where you can share your life's experiences and openly discuss personal perspectives. I therefore spoke to previous past presidents and asked them how they chose their topics. One past president from the Society for Vascular Surgery (SVS) told me to write my conclusions first and work backward. The AVF past presidents told me to discuss my passions in life and share this with the audience. I therefore asked myself what are my passions in life? The answer I gave myself was that I am passionate about my wife and children, I love resident education, I love golf and the NY Giants despite their poor performance this year, I love my cultural heritage, and I love the American Venous Forum.

I did not think an exposition on my family, resident education, golf, or football would make a good presenta-

tion, so I decided to focus on my heritage and the AVF. Specifically, I wanted to explore why I loved this organization so much. I have been a member of almost every local, regional, and national general and vascular surgery society in America, yet the AVF is the only group that I have dedicated a significant amount of my personal and professional time to. Tom Wakefield, one of our past presidents, once said to me "Peter, the AVF is where my heart is" and on an emotional level, I knew exactly how he felt and what he meant. I think it is important to expand on why I feel the same way. What is it about the culture of this group that inspires me, motivates me, and makes me want to continue to contribute? Major corporations ask themselves this very same question because they know that corporate values define their company, how they are viewed by the rest of the world, and the degree to which they are successful organizations. I therefore thought it would be valuable to define the AVF's corporate/societal values for the next generation of leaders and AVF members sitting in the audience today. These values are the foundation and perspectives we draw upon to guide us through changing and often difficult times. After defining these values, I will suggest how we can apply our guiding principles and draw upon the lessons learned by the ancient Greeks to address today's future challenges.

So what are our corporate values? I think the values that best define the AVF are mentorship, tolerance, passion, innovation and integrity, and vision and leadership.

### MENTORSHIP

My first exposure with the AVF was in 1991. I was a fourth-year general surgery resident and I was presenting at my first national meeting. That meeting was memorable for several reasons. First, the invited reviewer of my paper, Dr Ralph DePalma, left the questions he was going to ask me at the hotel registration desk so that I would not be nervous and overwhelmed at the podium. I never forgot this gesture and always made it a practice of mine to do the same when asked to review a paper. Second, at that meeting, an announcement was made that the North American Symptomatic Carotid Endarterectomy Trial (NASCET) was terminated by the Data Safety Monitoring Board due to the overwhelming advantage of carotid endarterectomy for symptomatic carotid disease compared with medical ther-

From the Department of Surgery, The Brooklyn Hospital Center.  
Competition of interest: none.

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apy. A great cheer erupted from the audience and the energy in the meeting hall was palpable. Third, I met my future vascular surgery mentor, Dr Robert W. Hobson, II. He was the Recorder that year and in those days, you had to hand your manuscript in at the meeting. I was struck by his charisma, charm, and grace, and I remember the impression he made on me that day. Finally, I met Dr Michael Hume, the president elect of the AVF that year. He was the moderator of the session where my paper was presented, and he took the time to personally seek me out and complement me on my research. I was overwhelmed at the collegiality of the membership, the enthusiasm of the presenters, and the approachability of the organization's leadership. The fact that the reviewer of my paper and the president-elect of the AVF sought me out made me feel valuable. Without realizing it, the bar for my future national meeting experiences and expectations was set very high. The comfortable size of the organization, the intense effort to elevate the field of venous disease research, and the desire to encourage young people to choose venous disease as an academic career opportunity, fostered a mentorship environment that exists to this day. Registrants to this meeting, regardless of status, age, or position, can stop an AVF leader in the corridor and discuss a patient care problem or a research question without fear of being ignored or demeaned. The leadership's approachability, sincerity, and desire to impassion physicians who care for venous disease patients supersedes any desire for personal gain or career advancement.

### **TOLERANCE**

The intense desire to improve the care of a patient's suffering from venous disorders is further exemplified by the organization's valuation of tolerance. When the organization was first founded in 1988, the active membership was limited to 300 people with academic backgrounds. The goal of the organization at that time was to establish a forum for the exchange of scientific data, elevate the quality of venous disease research, and develop the next generation of venous disease leaders. Over the past 20 years, I think it is safe to say the organization has achieved its original goals. Venous disease practitioners are no longer viewed as second class citizens in the vascular surgery or medical community. Our national meeting is the pre-eminent national and international forum for the presentation of cutting-edge research and a new generation of venous disease leaders has stepped forward. As part of the natural maturation and growth of any society, the goals of the organization have changed. The AVF is no longer an elitist group of academicians, and the society no longer has an exclusive membership policy. Changes to the organization's mission, operational structure, and national meeting format have all occurred with little to no resistance from the leadership. The willingness and tolerance of the leadership to listen to the ideas of younger leaders and allow them to implement their suggestions for change is a phenomenon I have yet to witness in other academic societies. I am a clear example of the organization's tolerance. I was allowed to change the

AVF's membership policy and experiment with the annual meeting format when I was program director. Most importantly, the leadership tolerated my youthful indiscretions and valued my desire to have the organization achieve its potential. The AVF's tolerance of people from various professional, cultural, and ethnic backgrounds, fosters inclusiveness and an environment conducive to experimentation and change.

### **PASSION**

Our founding fathers created the American Venous Forum based on their passion for venous disorders and their intense desire to improve the well-being of patients suffering from venous diseases. Just look at the person sitting next to you. If you all were not passionate about venous disease, none of you would have taken time away from your busy practices and paid money to attend this meeting. Look at our past and present leaders. You cannot mention coagulation disorders and not think about Joseph Caprini. Evidence based medicine and not think of Mark Meissner. Venous thromboembolism pathophysiology and not think of Tom Wakefield. Venous stenting and not think of Seshandri Raju and Peter Neglen. The passion of these men and others gave venous physicians the respect and honor they deserve. To me, passion and the AVF are synonymous and unseverable terms.

### **INNOVATION AND INTEGRITY**

Improving the care of patients suffering from venous disease and validating the cognitive and technical skill sets of venous disease practitioners has been accelerated by the advent of new technologies. The AVF has thoughtfully and intentionally created a national and international environment that stimulates innovation via its many initiatives. The Pacific Vascular Symposia, the CEAP classification, physician-validated outcomes tools like the Venous Clinical Severity Scoring (VCSS) score, evidenced-based practice guidelines, the American Venous Registry, venous valvular repairs, and the Greenfield Filter are a few examples of innovations that were developed by the AVF and AVF leaders. The annual meeting provides a forum for cutting-edge research presentations and an opportunity to evaluate the effectiveness of newer technologies. For example, I distinctly remember the very first presentations on radiofrequency ablations that were presented at this meeting. The technology was met with great skepticism by the members of this organization. Our members demanded better clinical trials and hard data that could withstand AVF scrutiny. I firmly believe that endothermal ablation techniques gained national acceptance in part due to the vigilance of the AVF and the demand by our leadership for clinical effectiveness data. Once an analysis of the clinical data we demanded was available, the AVF adopted this technology and actively promoted it.

As I stated previously, endothermal ablative techniques were not universally accepted by this organization when first introduced. The AVF was criticized by the endothermal enthusiasts who stated that any and all new techniques

should be accepted. The enthusiasts felt that lack of acceptance would hinder innovation and technological advancement. The AVF resisted such criticism and relied on its core values for guidance during those tumultuous days. The AVF has always balanced the need to move the field forward with an intense desire to protect patients from the newest fad of the day. As a result of this balancing act, the AVF has developed a reputation for integrity and honesty that is highly valued. Integrity and honesty are key components of the AVF brand that must be jealously guarded. As a result of this vigilance, our relationships with industry have been beyond reproach. My mother often reminded me as a child that it takes a lifetime to develop a reputation and 5 minutes to lose it. Therefore, our leaders must perpetually remain vigilant and never jeopardize the organization's reputation for any temporary or short-lived gain.

### VISION AND LEADERSHIP

Leadership has many forms and definitions. A facet of leadership is the ability to provide structure and guidance for an organization and prepare people for future challenges. Identifying future challenges, assessing environmental circumstances, and convincing people to accept a shared path is vision. Therefore, leadership and vision are inseparable components and the lack of one component diminishes the effectiveness of the other. Leadership and vision are hallmarks of the AVF. Our founders established the AVF due to a recognition that the field would not progress without establishing an organization dedicated to the entire spectrum of venous diseases. They created an environment for mentorship, developed future venous disease advocates, and established the pre-eminent forum for the exchange of scientific ideas. Twenty-three years later, the AVF faces new challenges. Varicose vein therapies, venous stenting, pharmacomechanical thrombectomy devices, improved venous imaging techniques, and diminishing healthcare dollars in nonvenous specialties have increased interest in caring for venous disease patients. It has been estimated that 80 million people in the United States have some form of venous disease. Our government and third-party payers understand the enormity of this patient population and are beginning to place barriers to venous healthcare access. For example, Blue Cross and Blue Shield of Massachusetts recently implemented a coverage policy stating that only general surgeons, vascular surgeons, and interventional radiologists will be reimbursed for performing endothermal ablations due to concerns over patient safety and the skill set of physicians outside these specialties performing venous procedures. For example, cardiologists, dermatologists, internists, gynecologists, family medicine doctors, wound care centers, and plastic surgeons are all now interested in performing venous procedures due to decreasing reimbursement pressures within their own specialties. The AVF and the American College of Phlebology (ACP) unsuccessfully fought this coverage policy because we do not believe insurance companies should determine local credentialing policies. However, this issue emphasizes the fact that specialties with little to no formal graduate

medical training in venous disease are caring for venous disease patients and how ineffectual the AVF and ACP were in our initial attempts to influence the policies of a third party payer.

### BATTLE OF THERMOPOLAE

In response to insurance companies and government agencies placing restrictions on venous disease healthcare access and as part of the maturation of our organization, the AVF leadership decided in 2007 to add patient and physician advocacy to our mission. I have thought long and hard on how to achieve this goal. In searching for an answer, I realized that our current situation was not unique and that the lessons of history can help guide us in our current journey. I will therefore take a few moments to share with you my vision for the future, how the values I have articulated above and the battle of Thermopolae can show us how to proceed.

In the 4th century BC, Greece was a conglomeration of feuding city states with colonies in Asia Minor (today's Turkey) and Sicily. In 490 BC, Ionia, an Athenian colony in Asia Minor, revolted against the Persian Empire. During the revolt, Athens assisted Ionia in a losing cause. In retaliation for the Athenian's assistance, King Darius of Persia massed an armada of 600 ships, 20,000 infantry and cavalry, and landed 26 miles north of Athens at Marathon. Outnumbered two to one, the Athenian General Miltiades used the Greek terrain to eliminate the Persian's ability to use their cavalry and boldly ordered a frontal attack on the Persian front lines. In the counterattack, the Persians thought they were pushing the Athenians back against the mountains. However, the Athenians faked a retreat and outflanked the Persians. The Persians suffered heavy casualties and retreated to their ships. Although the battle at Marathon was won, the Persian navy was not destroyed. Miltiades ordered a forced march and met the Persians at Athens preventing the destruction of the city. The prevailing wisdom of the day was that Miltiades was a military genius and the savior of Athens. However, one of Miltiades's generals at Marathon came away with a different lesson. Themistocles realized that the Persian navy almost caused the destruction of Athens. He realized that infantry were only as powerful as their naval support. Themistocles also deduced that the Persians would not suffer two defeats at the hands of the lowly Greeks and that a counterattack would eventually come. Themistocles therefore convinced the Athenian parliament to delegate a portion of the proceeds from a recent silver mine discovery towards building a navy by creating a fake threat from the nearby island of Aegina.

Over the next 10 years, Darius directed his efforts at quashing revolts throughout the empire. To remind him of the damage the Greeks did to his reputation, he ordered a servant to whisper in his ear, every night before dinner, "Sire, remember the Greeks." Despite quelling the revolts in his empire, Darius died before he could enact his revenge on the Greeks. Darius' son, Xerxes, rose to power and vowed to complete his father's task. Xerxes amassed the

largest military force known to man at that time. Xerxes's engineers constructed a 1-mile bridge across the Bosphorus Strait rather than travel around the Black Sea and gathered an army estimated to be as large as 150 to 300,000 strong. He also gathered 1000 ships to support the infantry and cavalry. The Athenians learned of the Persian's plans and realized they could not stand alone against this enemy. The Persians meant to destroy Athens and make Greece part of the Persian Empire. For the first time in Greek history, the feuding city states put aside their differences, forged an alliance, and banded together as Greeks. This alliance was the beginning of Hellenism and set the stage for the eventual rise of Alexander the Great many years later. The Athenians asked King Leonidas of Sparta, the traditional enemies of the Athenians, to lead the united Greek army due to their well-known fighting abilities. In return, the Athenians, under the leadership of Themistocles, provided 200 naval ships for the upcoming battle. History tells us that once again, the Greeks used Greece's terrain to bottleneck the Persian infantry at Thermopylae's narrow pass and severely damaged the Persian navy in the narrow Artemesian Straits. The Greeks eventually defeated the Persians at Platea and drove them out of Greece. The second Persian invasion helped Phillip of Macedon unite Greece and stimulated Alexander the Great to conquer Persia and prevent them from ever invading Greece again.

#### THE FUTURE OF THE AVF

How is any of this relevant to venous disease and the current healthcare environment we live in today? For most of my career, I thought the AVF, ACP, SIR, ACCP, and ASH were the primary organizations that cared about venous disorders. That notion changed several years ago when the AVF was asked to join an effort sponsored by the Vascular Disease Foundation (VDF). The VDF wanted to create a group called the Venous Disease Coalition (VDC). The goal of the VDC would be to increase public and health professional awareness of venous disease. The VDC was able to get 39 organizations to join their coalition, and in my opinion, 25 of them have little to no interest in venous disorders. When I look at a map of where these organizations have their headquarters, I see Greek city states. All these organizations are competing for limited industry and government financial support. Many of these organizations promote themselves as representing venous disease patients and purport to be "THE" experts in venous disease. For many years, many of these organizations have implemented educational programs, awareness initiatives, and attempted government outreach all on their own and in an uncoordinated manner. The AVF was no different. For many years, we held our own national meeting and for the most part spoke to our core constituency of Vascular Surgeons with little effort at outreach. The explosion of technology and the rise of phlebology as a recognized American Medical Association specialty has invited many physicians from various healthcare training backgrounds to enter the venous world. In my opinion, the AVF has

watched many of these events unfold from the sidelines. Although we did not obstruct the efforts of other societies, we were not proactive in offering our own solutions. The lack of formal training in venous disease principles by physicians from nonsurgical or radiologic backgrounds has caused Blue Cross and Blue Shield of Massachusetts to question the qualifications of venous practitioners. Increasing interest in venous disease by multiple specialties and the need to develop uniform standards and qualifications for venous practitioners was one of many reasons the ACP created the American Board of Phlebology. This initiative was not universally supported by the AVF because graduate medical education in phlebology is not required for Phlebology Board designation and the American Board of Medical Specialists (ABMS) does not recognize the ABPh as a formal board. Furthermore, as pointed out by Mark Meissner in a debate with Tony Comerota at this meeting in 2010, it appears unlikely that the ABMS will grant board or sub-board status to the ABPh, based on their current criteria.

Based on these events, venous practitioners now face two major threats to our specialty. The first threat is a growing concern among third-party payers and the government over the qualifications of physicians claiming expertise in venous disease. The second threat is a concern among these same entities over the exponential growth of venous procedures performed in the United States. BCBS of Massachusetts has told the AVF and ACP they have restricted payment to vascular surgeons, general surgeons, and interventional radiologists out of safety concerns and have used the lack of uniform training as their justification despite no evidence that patients have been harmed by nonsurgeons and nonradiologists. This tactic is clearly meant to restrict access to care and limit the rate of venous related payments to physicians. The AVF and ACP jointly wrote letters to BCBS of Massachusetts protesting this decision to no avail. It was not long before other states like Wisconsin began adopting similar practice restrictions.

To address these threats, I would like to inform this group of the steps the AVF has taken on behalf of our members and our patients. The first step began 3 years ago with a concerted membership drive and becoming a more inclusive society. To be effective advocates, we need to shed our city-state mentality and have more than 300 active members. The Executive Council set a goal of 1000 members by 2014 and as of today, we have over 600 members with 90+ new members this year. One thousand members is large enough to generate operating income yet small enough to maintain access to our leaders and avoid a cumbersome bureaucracy that inhibits our ability to act and react to socioeconomic and political circumstances.

The second step was to implement the lessons taught to us by Themistocles and Leonidas at Thermopylae. Just as Themistocles had the wisdom and vision to realize the need for naval forces and alliances, we must demonstrate the same wisdom. Our equivalent of naval forces are our patients and data. The only weapon that affects insurance companies and government agencies is money, motivated

voters, and hard medical data. To fortify our professions' armamentarium, we need to do a better job at generating real-world, patient-, and physician-derived outcome data that substantiates the therapies we are performing. At Thermopolae, the Spartans' superior tactics and better shields protected them against the poorly crafted arrows of the Persians and their poorly trained infantry forces. Similarly, we need better tactics and shields to accomplish our goals. The AVF's version of a Spartan shield is the American Venous Registry. The registry will be the mechanism whereby we collect real world, patient, and physician generated data. The American Venous Registry (AVR) is composed of five modules: varicose veins, venous stenting, pharmacomechanical therapies, vena-caval filters, and upper extremity venous thrombosis. As of the beginning of this meeting, the AVR is now available to any practitioner that wants to register to us it. The varicose vein module is up and running. The stent module is being revised, and the other three modules are in development. The registry has been prepopulated with data from several high-volume centers so that new users will be able to perform comparative effectiveness and outcomes assessments on their patients compared with a national data set. The registry meets the criteria for an electronic health record, and we are in the process of having the registry certified. This means that registrants who utilize the registry will qualify for the 2% Medicare bonus provided by the government and will satisfy the government's requirements that all physicians use Electronic Health Record in their practice by 2014. A further benefit is that the registry will satisfy your board's maintenance of certification requirements and has clinical practice tools that will allow you to generate letters, procedure notes, and data analyses. Research questions will be generated through the AVR steering committee or through requests from registered users. It is our hope that through the registry, we will gather and publish data on thousands of patients that will validate the effectiveness of the therapies we are currently providing.

The third step was to reorganize the way the AVF views fund-raising. The Athenians discovery of a silver mine gave Themistocles the financial support he needed to build a navy and prepare his country for the coming invasion. To become effective advocates and a stronger society, we have to strengthen our industry relationships, diversify our sources of funding, and hire professional fund-raisers. My wife often tells me that if I need my car fixed I will not go to a surgeon. The time for the AVF to hire professional fund-raisers has come and the addition of Suzanne Kouri as our Director of Development has elevated our business practices and established a model for society/industry partnerships worthy of emulation. The corner stone of our fund-raising efforts is our foundation. The board of directors of our foundation have worked tirelessly to reorganize and restructure the foundation in 2010. The foundation now has the tools it needs to increase our fund-raising efforts and help the AVF achieve its goals. I look forward to working with the AVF in the coming years to strengthen the AVF for future generations.

The fourth step was to further fortify our armamentarium. As Themistocles realized the need for a navy, the AVF understood the need to review the current evidence for varicose vein treatments and pharmacomechanical therapies. The AVF and SVS jointly performed an analysis of the current literature and developed an evidence-based set of guidelines that has been accepted for publication by the *Journal of Vascular Surgery*. I anticipate these guidelines will be published as a supplement to the *Journal* in the first or second quarter of 2011. I would like to publicly thank Drs Meissner and Głowiczki and the members of the outcomes committee for this Herculean effort. By assessing the current evidence and the quality of the data, we have a better understanding of where to focus our research efforts. Furthermore, these data can be used as a reference when talking to your local insurance carriers. This is crucial because insurance companies, to the best of their abilities, create medical coverage policies based on their interpretation of current and existing data. Using these guidelines and data from the registry, the AVF and its partners will reach out to local, regional, and national insurance carriers as well as state insurance commissioners with proposals for medical coverage policies. State insurance commissioners have an annual meeting, and it is my hope that the AVF can get on their program to discuss our positions and offer our expertise.

The fifth step was the creation of an alliance. Leaders from the AVF reached out to the ACP and SIR and all three groups agreed to form an intersocietal committee to address government and insurance regulations. Ted King from the ACP is the chair of this committee and my version of King Leonidas. He is very committed to the field of venous disease, well organized and well respected by all three organizations. For the first time in my memory, leaders from the ACP, AVF, and SIR sat at the same table to discuss areas of mutual interest to all three groups. I would like to personally thank Nick Morrison and John Mauriello, past and current presidents of the ACP, for their partnership, vision, and leadership in this joint venture. The registry and practice guidelines were made available to the committee and the AVF proposed that all three societies consider paying for a full time government relations individual who will monitor events of importance to the venous community. The AVF has also formed a government/insurance relations committee and named Mike Vasquez as the chair. Mike currently sits on the SVS government relations committee. The SVS government relations committee is extremely well organized and well respected by Centers for Medicaid and Medicare. This will be a good training ground for Mike who will represent the AVF on all venous-related matters. I also believe that the committee should consider contributing to the SVS Political Action Committee and that we utilize the SVS lobbyists to promote venous-related positions in Washington, DC.

The last step was for the AVF to be more proactive in the issue of board certification for venous practitioners. The American Board of Phlebology (ABPh) is now a separate and independent entity. There are seven vascular surgeons

on the ABPh board of directors. Six of them are prominent AVF members and three are past presidents. It is no coincidence that one-third of the 24 board members are current or past leaders of the American Venous Forum. The positions, discussions, and votes that these individuals cast will be viewed as either implicitly or directly representing the views of the American Venous Forum. Therefore, I have reached out to several members of the ABPh board and shared with them my major concern with the current board certification process and issues over the use of the word "board certification." In the United States, the term board certified means that an individual has completed an Accreditation Council for Graduate Medical Education (ACGME)-approved graduate medical education program and passed a qualifying and certifying examination. As you all know, there is no ACGME-approved phlebology residency and I therefore have a problem with the term "board certified" in phlebology. I believe this term is misleading to the general public. I realize that to be eligible for the ABPh board examination, a candidate can choose one of four paths that documents how the candidate achieved graduate medical training in phlebology. Eligibility under pathway 3 states that a description of your phlebology training and experience supplied in the form of a letter written by the applicant, a case log of your last 100 cases, and three letters from board certified phlebologists, will qualify an applicant to sit for the examination. I understand why this pathway exists and what its overall intent is. However, self-education and self-reporting is no substitute for a formal graduate medical education training program. I have therefore instructed Dr Wakefield, one of our past presidents and a new ABPh board member, to bring these concerns to the ABPh board and suggested they change the designation to added qualifications and drop the term *board*. In this manner, venous practitioners from nonsurgical and nonradiological specialties will have some validation from an outside agency as to their cognitive proficiency and the beginnings of a mechanism for policing the specialty. Although this is a good first step, it does nothing to address the technical skill sets of practicing phlebologists. What can be done to address technical competency? I want to remind this group that vascular surgery training programs were not ACGME approved when they first started out. Training programs were initiated through the ISCVS/SVS and had to go through the PEEC approval process in the early days.

Even today, transplant surgery is not an approved ACGME residency. Transplant programs are regulated through the transplant societies and transplant surgery is still considered a primary component of general surgery. I do not believe that phlebology has matured enough to be considered for sub-board status in vascular surgery or radiology. I believe that just as in transplant surgery, society-sponsored phlebology training programs will slowly develop and the ACP has in point of fact started this process. These programs must focus on developing complete phlebologists and not just individuals who specialize in superficial disease. I am convinced it is time for the AVF to become part of the solution to this problem and I have charged the Education Council of the AVF to assist AVF members on the ABPh board with the development of graduate medical education training curricula. The AVF acknowledges that a wide variety of medical specialists are now practicing phlebology. I believe the AVF should create a joint taskforce with the ACP and SIR to address each society's concerns regarding the best way to regulate quality of care and to develop a process for regulating the field. I believe all three societies should work on defining the specialty and developing mutually agreed upon training curricula. I believe this effort should occur concurrently with discussions occurring at the board level of the ABPh. Each society now has representation on the ABPh and we should work together to elevate and strengthen the field.

In conclusion, the AVF has achieved the original goals of our founders. It has been 4 years since the AVF decided to add patient and physician advocacy to our mission. We have made a great start and I hope I have convinced you how important your membership and support is. I hope I have shown you how hard the AVF leadership is working on your behalf. I would like to finish this speech with this one thought. Before leaving for battle, Spartan women handed their husband's or son's shields to them and spoke the following words when bidding them farewell, "Ἡ τάν ἢ ἐπί τάζ." Loosely translated, this means "Come back victorious or dead on it." Our specialty and field is under great pressure from outside forces. If we do not act in our own self-defense, we are at risk for being conquered and depreciated just as the ancient Greeks were confronted with becoming the next conquered peoples of the Persian Empire. Ἡ τάν ἢ ἐπί τάζ my friends. Ἡ τάν ἢ ἐπί τάζ. Thank you.