Presidential Address

Of AANA and Excellence

Most associate an Arthroscopy Association of North America (AANA) Presidential year as a 1-year effort: an effort to lead a wonderful organization in the quest of educational, innovational, and advocacy excellence. In reality, that effort really takes 10 to 15 years, which is the true time frame of the commitment. As you might imagine, the time it takes to fulfill that commitment with a quality effort requires a team, and that team begins and ends at home. So without my lovely wife Lizanne's help, love, and support, none of my efforts on behalf of the members of AANA would have been possible. So, thanks to you, Lizanne, for all of your help, advice, and encouragement over the last decade. I couldn't have done this without you!

Thanks also to the staff at AANA. Laura Downes has assembled a team that gets the job of the Association done. It's a lot of work, and they do it with style. Thanks to Becca, Christine, Alex, Dave, Kim, Shantal, Frances, Beatriz, Kristi, Matt, Travis, Carrie, Adam, Lynnsey, Robert, Renee, and Kassie for all the help over the last few years.

Thanks also to my staff at home in the Westchester office. It's been busy juggling the work at Northwell and AANA simultaneously, and so to Katie, Phil, April, and Carla, my grateful thanks also.

AANA has been a big part of my life since 1991, when I was a fellow with Bill Beach and Mark Asselmeier at Tuckahoe Orthopaedics and Orthopaedic Research of Virginia (ORV). At ORV, we met Dick Caspari, Rick Meyers, and Terry Whipple. And of course, all the staff it took to do their magic, especially Nancy Hook, Terry Hughes, and Judy Cooper, their nurse assistants. Very important that they liked you, as they really ran the show!

The day I met the doctors at ORV was the day I decided that to emulate them would be a pretty good idea. They had it figured out. They had a busy, efficient, and productive practice. They were recognized as being at the top of their game locally, nationally, even internationally. They were able to control and determine their work environment and made it look easy in the process, which I found out the hard way, is not so easy! Their practice was something I had not encountered in my training in New York—in New York it really was kind of a job. Their practice was fun! They were pushing a new technology, a platform, and a treatment paradigm called arthroscopy to the limits of its capability. So not only was their practice fun, it was also exciting. They had interests outside the office and made sure we were included in those also. They were incredibly generous. When I went into medicine, I never considered an academic career, I always just wanted to be the local orthopaedic guy, the town doc. "Joe lunch-bucket orthopaedist," as Dick would say. Dick, Rick, and Terry showed us that you could be the local guy and also be published and reputable in national academic circles. That not only could you do research and teaching, but that it was important, even essential to do so! Not only that, you could become an innovator and design the cool stuff you get to use in the OR!

Their horizons were endless, and they raised our horizons accordingly. I cannot stress the impact this had on me as a young man beginning a career. It simply changed my outlook; it changed my life. The only reason I stand here today is because I imagined this might be possible because of those 3 men in Richmond, Virginia. I had never written or published anything prior to my fellowship in Richmond; I published 7 papers from the work we did at ORV in 1992. Last year, Rob Hunter spoke to us about mentors and their importance, especially in medicine and here at AANA. Mentors are essential.

The fellowship at ORV was much pretty thick as thieves, and Bill Beach and Mark Asselmeier are more like family than friends—and so are all the past fellows of ORV: Ray Thal, Sal Corso, Randy Jeager, Jim Scoggins, Cheryl Rubin, Buddy Savoie, Gary Lynch, Steve Weber, and Barry Kleeman, to name only a few. There is a bond there, a connection that can't be overstated. It has added a richness to life that is one of God's greatest gifts: the gift of deep and abiding friendship.

All 3 of them, Dick, Terry, and Rick, were very involved with AANA, so it was just natural that we all would gravitate toward this Association. Imagine my surprise when I got to my first AANA meeting in 1991 and found that there was an entire society of people *just like them*! I met Steve Snyder, Steve Burkhart, and others that week who had the same outlook as my

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teachers at ORV, and I knew that AANA was for me. AANA had it going on! It was inclusive, it was pragmatic, it was innovative, but most importantly, it was fun! So I started doing some teaching at the Fall Course—never missed one—and the brand new Orthopedic Learning Center (OLC) that had just been built in Chicago. AANA allowed an academic and learning component to be present in my practice, which had no real academic affiliation at all. It allowed an interaction with the best docs on the planet, all pulling the same oar of improving minimally invasive musculoskeletal medicine.

While I remained active in AANA, the late 1990s brought on new priorities and challenges, and my involvement in AANA took a back seat for a while. I got married in 1997 to Lizanne, and we were determined to have family even though that proved difficult at first. We went from not being able to have children to not being able to stop having children and had 5 kids in 6 years! That many small children tends to focus one's attention. Our young family shared the ultimate challenge of a critically ill child when our daughter Fallon was diagnosed with a medulloblastoma in 2004. With faith, friends, and family, we saw Fallon through her illness but not unfortunately to a cure. Her 2-year old tenacity in the face of the curses of cancer care still inspires us. In many ways, she is still with us and always will be.

Around that time, I was reading a collection of articles by Michael Kelly, "Things Worth Fighting For."[1] Kelly was a great American journalist. Tragically, he was killed in the Iraq war, and he left behind 2 small sons. This is what he had to say about being a parent after the birth of his second son: "Being a parent is a good job, and one of the better things about it is the nice clarity it lends to life. Fathers and mothers relearn that the world is a simple enough place. They discover that their essential ambitions, which once seemed so many, have been winnowed down to a minimalist few: to raise their children reasonably well and to live long enough to see them turn out reasonably OK. This doesn't seem like a great deal to ask for until you find out that it is everything to you. Because, it turns out, you are everything to them." That just about sums up family life for me.

At work back then, the challenges of the emerging world of managed care were making the business side of practice difficult. That, plus the highly competitive and costly nature of the New York market, forced us to make some big decisions at my practice, Westchester Orthopaedic Associates. At AANA, I had learned from Jack Bert about ancillary services and the value they could add to your practice. We decided to diversify, differentiate, and grow the practice. We went from being a 4-man group with 6 employees to an 8-person group with MRI, Physical Therapy, Pain Management, and a surgery center with 50 employees. We added Electronic Medical Records (EMR) in 2002, 9 years before the Health Information Technology for Economic and Clinical Health (HITECH) mandate. Of course, none of us of learned about these things in school, so these additions required some remedial and on-the-job learning—nothing like on-the-job learning to make you humble!

Jack asked me to write about some of this stuff, especially the EMR, and poof, I became a "practice management expert"! In reality, my only expertise was in making big business mistakes and sometimes even learning from them. I then started working on the AANA Health Policy Committee with my old friend Bill Beach. That was like learning another language, one that no one else would ever understand, which is the whole point! The language of the never-ending alphabet soup of government regulation. For better or worse, our time at the Health Policy Committee coincided with the most rapid and significant intrusion of the federal government into the practice of medicine since the inception of Medicare and Medicaid in 1965; the HITECH Act in the stimulus bill of 2009 and the Affordable Care Act of 2010, to name just 2. I don't need to tell you here what these laws did to completely upend and disrupt the practice of medicine in the last decade. It was our job at the Health Policy Committee to help AANA members understand and comply with these onerous and costly laws. We took that job very seriously and were amazed at the lack of common sense, practicality, and anything resembling reality in the process. That led to some frustration and contention! I even famously got kicked out of some national coding meetings!

In addition, we had to fight the self-inflicted injury of the Clinical Practice Guideline (CPG) fiasco. We knew early on that the poor construction of the CPGs would limit patient access to care and spent considerable time and effort trying to reform them. We fought negative coverage decisions for arthroscopic procedures in Washington, Oregon, and New York, to name a few places.

Another significant challenge was the changing and increasingly adversarial environment surrounding the valuation of orthopaedic surgical Current Procedural Terminology codes. The value of our surgical procedures was under attack as being overvalued, in what we saw as a very conflicted and corrupted process. We took a very AANA approach to these problems: We would pragmatically address them to help members succeed in a new more regulated environment. It seems intuitive that that would be the best approach, but we actually met resistance from some who considered such an approach, let's say, unhelpful and not in keeping with "The Rules."

Luckily, sometimes at AANA, we don't care about the rules! We advocated vigorously for the value we here in this room bring to the well-being of our patients

without apology. We had some wins and a lot of losses but made our case. We made AANA's case, which was the case of patients and the practicing orthopaedic surgeon. The Board of Directors of AANA, realizing the importance of this effort, actually made advocacy part of the mission statement of the organization. This is no small change and recognition, as it gives value and visibility to advocacy, putting it on the level of our educational activities. What you do is what you value and who you are; AANA is about education, innovation, *and* advocacy. The Health Policy Committee, now the Advocacy Committee led by Eric Steifel, really has your back. AANA is for orthopaedic surgeons and their patients.

I got to join the Board of Directors of AANA in 2010 and worked with the men and women I admired most in medicine. It was a dream come true and an exceptional treat. Not since I played rugby in college have I been on a team so united and determined in a common goal and the unselfish attainment of that goal. (The AANA Board just doesn't drink as much beer.)

That's my AANA story, but what I want to share with you today is what I learned by being part of AANA, the Board, and the Presidential Line. It is what I have witnessed and learned from the people in this room. That something is about the nature of excellence and how to both attain and maintain it in your practice and yourself.

A discussion of excellence is especially germane for us today because of discussions of quality in medicine. You would hope that quality is really meant as a synonym of excellence. You have all seen this equation in talks on the new payment paradigm of quality: Value equals outcome divided by cost. It's from the work of Michael Porter at the Harvard Business School, so it must be true and important! I know you're thinking: God help us, he's launching into another of those depressing and tedious regulatory lectures on coding or regulation. No worries, not going to do that, promise. So, this equation is OK, but value might be better defined as outcomes *plus* service divided by cost. Better service *is* better quality and has more value! We could go on and include other variables, but the bottom line is the same: Attempts at identifying and then measuring the value of what we do are here and should not only be embraced but should also provoke a larger discussion of not just value, quality and all the buzzwords of the practice management gurus, but something more essential.

I think the essential discussion is one of excellence. So let's discuss the concept of excellence and how it relates to what we do here at AANA and how we seek to bring that excellence to our practices, our hospitals, and our homes.

We of course are no strangers to excellence, because as orthopaedic surgeons we are all by our very nature excellent! Why else devote so much time and effort to acquire, practice, and improve upon the arts and science of musculoskeletal medicine if one is not going to be utterly excellent? Just ask any surgeon in this room about excellence, and I'm sure you will get a running dialogue of all the tremendous excellence that exudes from their practice of orthopaedics. Our opinions of our own excellence are obviously fatally biased and may speak more to the confidence it takes to assume the risks we do more than to an overly inflated opinion of ourselves. We think we are all excellent because we inherently understand that we must aspire to be so because of the nature of the work we do on behalf of our fellow human beings. To be less than excellent would be to let our patients down and to destroy the trust established between us, both as individuals and collectively as a profession.

We all know what excellence looks like but perhaps have a harder time defining it because of its many different facets. It's similar to the problem faced by Supreme Court Justice Potter Stewart when he was trying to define obscenity in 1964. He couldn't think of a set definition but rather wrote simply: "I know it when I see it."

Excellence does not live in isolation and demands comparison. If some things are excellent than there certainly are some things that are not. The difference between those two, however, may depend on the viewpoint of who is making the distinction. What is excellent to me might not be to my patients or hospital administration or the covering insurance company or the government, for a myriad of reasons. Does this mean we need to include perspective in assessment of excellence? Perhaps things that are truly excellent cross boundaries of perspective. I think medical care is one of those things. Excellent care is accessible, efficient, safe, effective, and affordable. I think everyone would agree with that as long as we could define "affordable"! Determining excellence also requires that we make judgments, something that may not be in style today. We must discern what is excellent, aspire to that, and abandon those things that are not.

Perception affects our ability to discern: Is something excellent because it is or because it is perceived to be? We see this all the time as reputation. Sometimes they are deserved, sometimes not. Branding may obscure our ability to discern while it attempts to promote the perception of excellence. I don't think any of us would like to be perceived as excellent but to not really be so. That would just simply be dishonest. We must be careful to discern perceived excellence from the real thing.

Excellence can evolve: What was excellent 40 years, even 5 years ago may not be so excellent today! It is not that excellence is a moving target but rather that complex processes such as medicine have a modern anticipated trajectory of improvement that renders much

excellence obsolete with innovation and advance. We are expected to be excellent and to improve; what is truly excellent may evolve over time for us.

The most important aspect of excellence is that it thrives in competition. We all realize this inherently and I think that goes a long way in explaining our deep connection to athletics and sporting competition. We all love the zero-sum game of an athletic contest. Competition is essential for excellence because none of us have all the answers. We need to be pushed by others in our quest. Excellent people put pressure on all around them to "up the game." To be excellent is to respond to that pressure with efforts at improvement. If you chase perfection, you often catch excellence.

Excellence is competitive but often requires cooperation; the ultimate irony. Excellence in medicine definitely requires a team. When Bill Beach was president his address was about *the team*. We can't get it done without a team, especially a complex effort like delivering medical care or surgical skills education. Any one of us could be excellent, but if our team is not, we all fall to the lowest common denominator. Today especially, with the emphasis on cooperation and coordination in medicine, the team is essential.

Lucky for us, our pursuit of excellence is not a zero-sum game but is additive. Our excellence today is built on the excellence of those that have gone before us. The realization that our attempts at excellence can only succeed with efforts of those that have preceded us leads us to an important appreciation of the past and the challenges of our mentors. That appreciation of the past promotes another important characteristic of excellence, which is humility. Excellence is humble and abhors arrogance.

I think ultimately, excellence is linked and bonded to happiness. In her book, "The Greek Way,"[2] Edith Hamilton wrote that the Greek definition of happiness was the use of all of one's faculties along lines of excellence. (By the way, she wrote this book, her first, at age 62, so there's still hope for all the would-be authors out there!) I think that this concept of happiness and excellence is important also when considering the work of Thomas Jefferson. Jefferson of course wrote that it is self-evident that men pursue happiness. Much has been written tying that pursuit to virtue, but I think it is more tied to excellence; the pursuit of happiness in his Declaration has a classic Greek connotation of individuals striving toward excellence, of using all their faculties along those lines. So, excellence is tied to happiness. Excellence is happy; excellence is fun, and you can't beat fun.

Excellence is a pursuit, a process, a dedication. St. Paul in 1 Thessalonians tells us to "explore everything and hold what is excellent." To discern and hold what is excellent requires measurement and analysis. If we do not measure the attributes of excellence in our profession than how do we prove our efforts to be excellent? We have seen equations for quality, but what's the equation for excellence? I think finding that is the most difficult aspect of our pursuit. So many questions and variables to consider. How to narrow it down? Here are a few suggestions: Do our measurements really capture the essence of what we are trying to measure? Is our process validated and does it prove real difference? Most importantly, does it reflect the real world; is it externally valid? I think we are struggling with the conundrum of measuring excellence now and trying to find answers in registries and other data repositories. But it is a mighty and contentious struggle. Mighty expensive too!

As an example of complexities of trying to measure quality, value, and excellence, consider the robust and growing body of literature that finds that arthroscopic meniscectomy is no better than other treatments or a sham procedure in improving patient outcomes for the treatment of meniscal tearing. There are currently no fewer than 13 high-level randomized clinical trials studying the question of the benefits of meniscectomy.[3-16] These studies, despite their level I distinction, suffer from several limitations and potential biases. The first is selection bias. Many patients, up to 70%, decline randomization, so is the sample really random? The second limitation is 1-way crossover. Up to 30% of patients enrolled fail the nonoperative treatment arm and elect to have arthroscopic surgery instead. Amazingly, in intention-to-treat analyses, these patients are considered in the nonoperative arm of the results! I don't know about you, but I think that's a little crazy. Finally, only 2 of the 13 randomized controlled trials have a defined mandatory prerandomization period of nonoperative care. Since most patients in the real world undergo such a trial of care, Liebs et al.[17] have contended that these studies lack external validity; they don't address situations that occur in current day-to-day clinical practice. So, despite the considerable effort and cost of these studies, questions of the quality and excellence of arthroscopic meniscectomy remain. We could extrapolate this line of inquiry to just about everything we do in an evidence-based approach to treatment. It's a real dilemma.

In reality, our ability to measure and study value, quality, and excellence in orthopaedic medicine is constrained by the myriad and inconsistent variables inherent in human interactions. Joseph Jebelli, in his book on Alzheimer's Disease, "In Pursuit of Memory,"[18] has a great quote, "Science only orbits the truth, it does not live there." Our measurement of excellence will always be limited by some bias. But just because measuring and analysis are difficult and fraught with potential bias does not insulate us from the task of doing them. We all need to adopt behaviors and processes that help us pursue excellence even while

recognizing their limitations. The take-home message here specifically regarding meniscectomy is not that meniscectomy is effective or not but rather that our treatment of meniscal tears and degenerative arthritis in general is severely deficient and worthy of concerted efforts toward improvement. Thus: a recent trend of decreased utilization of arthroscopic meniscectomy and an interest in meniscal repair and regeneration. So, the excellent response to this type of analysis is to research ways to improve our treatment of degenerative disease. That and also to advocate for the value of arthroscopic meniscectomy where it is appropriate.

With questions of value, efficacy, and excellence in mind, AANA is adopting a new process and methodology for identifying core deficiencies in our knowledge base and funding high-level studies to address those deficiencies. In collaboration with the Orthopaedic Research Society and the Orthoregeneration Network, the ON Foundation, AANA had our first Clinical Translational Forum on Improving Rotator Cuff Healing, an area with as many questions—or more—than arthroscopic meniscectomy! This project is made possible by the Geistlich family of Geistlich Pharma. This is an exciting and innovative collaboration that seeks to establish and facilitate a process that brings advances in basic science to clinical practice in short order. The Symposium included what Brian Cole, Scott Rodeo, Andrew Kuntz, and Jason Dragoo can teach us about how we can bring biologics in to improve our treatment of rotator cuff disease.

So how do we all become and remain excellent without the effort overwhelming our day-to-day tasks? We all still need to see our patients, perform surgery, take out the trash, and get the kids to school. Well, we can't be excellent alone; we all need help. We need each other in this pursuit. None of us in this room can learn enough on our own to improve. We need the experience and insight of the collective wisdom assembled here. Everyone here in this room has something to teach, and each of us many, many things to learn. We are dependent on the communications of our peers and colleagues in our pursuit of excellence. We are blessed today that those communications come across multiple platforms with instant access. But it doesn't just happen. It requires a dedicated and committed entity and effort to assemble and communicate our individual and collective knowledge with the goal of improvement and ultimately excellence.

AANA is, I think, the essential entity in our pursuit of that excellence. Without AANA, its members, its meetings, its courses, our Journal *Arthroscopy*, the video journal *ATech*, and all the other efforts of the Society, we can't be excellent at minimally invasive musculoskeletal medicine! We need the content, the criticism, and peer review assembled in this hall to establish and promote what is excellent in our profession of arthroscopic and related surgery. When John Kelly was chair of the Membership Committee his pitch was, "Join AANA and operate like a Champ!" Becoming involved with AANA and its educational endeavors will up your game. It will challenge you to improve and adopt new concepts and techniques. It will tempt and encourage you to step out of that clinical comfort zone that we all adopt and to push the possibilities of practice to the betterment of our patients.

Much today is made of "physician burnout." Excellence never gets burned out! Get involved with AANA and burnout is out the window! You can learn to be burned out, but you can't be burned out when you are learning! The antidote to burnout is new pursuits and learning. Concentrate your mind on what Jim Lubowitz and the excellent editorial staff of our Journal publish every month. The Journal is the crown jewel of AANA's educational content and is your written guide to excellence. Read and study the Journal and be excellent. How could you be burned out learning about Rick Angelo's ground-breaking teaching methodologies in the Copernicus Project? Or the surgical simulation that Joe Tauro is leading at the OLC, imbedding all of our collective surgical skills into VertaMed's simulation machines? These amazing simulation devices will be the teaching and testing platforms of the 21st century. Do you think there's a lot to learn here in the US? How about going to teach and learn across the globe with Pietro Tonino and the International Committee? We have much to teach the world and the world has more to teach us! We are blessed and lucky to have had 2 guest associations in Orlando helping to make our meeting excellent. Thanks to Ireland and Argentina in helping with a global pursuit of excellence!

I've never heard an innovator complain of burnout; they're too busy figuring out a better and improved way! Want to innovate? Follow Al Stubbs, Jon Ticker, Ray Thal, and the new Innovation Exchange AANA has established to promote and facilitate our members' ability to bring new and exciting ideas into our treatment paradigms. Innovate and be excellent! Another group of people who are never burned out are those who give back, men and women in service for others. Get involved in teaching at AANA, especially teaching at the OLC. Teach and mentor and be excellent. A special teaching opportunity is our relationship with the Society of Military Orthopaedic Surgeons (SOMOS); military surgeon training started by Rick Ryu is now in its 10th amazing year. Our SOMOS collaboration brings the latest and greatest treatments and techniques to those who care for the soldiers who serve and protect us in the military. They are an amazing and talented group of surgeons. With the help of Rob Hunter and his many trips to Washington, DC, to lobby for this teaching effort, it will be funded as part of a grant from the federal government.

You really want a challenge? You really want to tilt at some windmills? How about confronting the federal government, state governments, insurance companies, and others who occasionally think they know better than us how to deliver excellent orthopaedic care? Take the gloves off and work with Bill Beach, Jack Bert, and Eric Stiefel at the Advocacy Committee. Maintain and improve our ability to provide patients access to orthopaedic care and be excellent!

What is truly amazing is that all of these excellent things are accomplished through the work of volunteers. AANA has a great and talented full-time staff that makes all our efforts operational, but ANNA is a volunteer organization. The volunteer tradition in America is part of our national DNA, the fabric of our republic. Alex De Tocqueville came to the United States in the 1830s to study the young American republic. He toured the nation and wrote of Americans that: "In the United States, as soon as several inhabitants have taken an opinion or an idea they wish to promote in society, they seek each other out and unite together once they have made contact. From that moment, they are no longer isolated but have become a power seen from afar whose activities serve as an example and whose words are heeded."[19]

That was written 190 years ago but is still true today. AANA volunteers give generously of their time, expertise, and spirit. That spirit of generosity is the most striking thing about our profession and especially about AANA. It is not too difficult to give one's time, but to volunteer spirit, to convey that part of you that inspires others, is much more difficult and personal. That takes true and honest generosity and generosity is excellent. We honored Richard Caspari with the formation of the Caspari Society to recognize those who have given to AANA at the highest level. I think Dick defined that generous spirit. An open and indominable spirit. So, volunteer and beat burnout. Volunteer and be generous. Volunteer and be excellent.

Excellent institutions are well led and well funded and have growing memberships. AANA checks all 3 boxes and is in excellent shape thanks to leadership decisions that have been made over several decades. Transformational and visionary leadership such as Rick Angelo's Copernicus Initiative will position AANA as the experts in teaching and testing arthroscopic surgery for decades to come. The commitment and determination of the Board of Directors to see projects like Copernicus through show the leadership necessary to do the hard things that will transform the surgical skills educational environment. The formation and prudent management of the AANA Education Foundation and Development Committee efforts at fundraising ensure a sound financial backing for AANA's educational endeavors. There is a saying, "No money, no mission"—and it's true! Recent fiscal analysis and reorganization of our educational portfolio by Second Vice President Brian Cole, Kevin Plancher, and Treasurer Jim Stone, with the essential help of AANA staff, have led to 3 consecutive years of strong financial performance by the Association. All this in a very fluid and competitive educational environment where the needs and desires of course attendees are changing significantly. Our Journal, under the leadership of Editor Jim Lubowitz, is in terrific shape, and Chair Nick Sgaglione and the Journal Board of Trustees have recently renegotiated our contract with publisher Elsevier for 5 more years with the addition of a new open-access journal to start later this year! Your upcoming President Larry Field initiated AANA 5000, which commits the Association to having 5,000 members by the end of 2020. This ambitious goal is attainable; we are currently at 4,600 members and have an international outreach to facilitate the goal. AANA is in excellent shape!

We do face future challenges and I think the biggest and most existential one is funding. We have traditionally relied on member dues, course fees, journal revenues, Education Foundation grants, and generous industry corporate support to fund our Association. We are on solid footing now, but the future may present financial challenges. Changes in the orthopaedic industry, some driven by government, some by natural maturation, have led to considerable consolidation, limiting the number of sponsors who support us. Compliance issues have made it more difficult and constrained in the type of giving and granting possible. We face a future of diminishing support from industry. We are addressing this with campaigns for member giving and this year have raised more than $500,000 with that effort. Thanks to all who have generously donated to AANA! We are seeking to diversify our pool of corporate and foundational donors who recognize the value that AANA brings to the health care landscape. We have an ongoing effort with the Department of Defense to provide funding for educational courses for military surgeons to have government as a support partner. We recognize the future challenge and will make sure AANA is here to promote the art and science of arthroscopic surgery. To promote, facilitate, and measure excellence.

So why would I know anything about excellence in arthroscopy and arthroscopic education? How is it that I can comment on excellence? I'm just a country doctor! I know it because I have learned it and seen it in you, the membership of AANA. I've seen it in the Board, the courses, the OLC, the Journal, the industry partners, but most especially in AANA members. I am always amazed at the talented, excellent men and women who are drawn to this organization; who volunteer their time, who volunteer and give of their spirit. Who give and inspire. I am a better orthopaedic surgeon and person because of my involvement in AANA. It has

been an honor and pleasure to serve as your President. It has been absolutely and utterly excellent!

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