Vascular surgery is the best kept secret in medicine and my thoughts on how we can change that

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Thank you Dr Upchurch for your very kind and humorous words. I know how much work goes into preparing the Introduction and I truly appreciate it. You are a good man and a good friend and will be an outstanding president of our society. Remember—You'll get yours next year!

It is hard for me to express what an incredible feeling of achievement it is to be standing before you as the forty-sixth President of the Society for Clinical Vascular Surgery (SCVS). So many great names in vascular surgery have preceded me that I hardly feel worthy of this honor. I remember being at the SCVS meetings as a fellow and young attending and experiencing the wonderful feeling of comradery. Vascular surgeons who I had looked up to as giants of our specialty engaged me and other young surgeons in conversation, which I greatly appreciated and, whether by their words or actions, so inspired me. There really is no meeting or society quite like the SCVS.

FAMILY

I would like to take this opportunity to recognize those people who have had the greatest influence on me in my journey to the present. I will start with the two people who were my greatest mentors—my parents, from whom I learned the most about being a man, a husband, father and a professional. My father was a kid from the streets of Hell's Kitchen in NYC and, although he never went to college, he wanted his children to be educated more than anything in the world. He ingrained in me that, with determination and hard work, there is no obstacle that can stand in your way. My mother was a soft-spoken New Englander from Worcester, Massachusetts, when she met my father. With great courage, she moved to NYC after she and my dad married. She was nurturing and kind, and instilled in me a deep belief in the goodness of human nature and a love of education. Both my parents passed too early and I wish they could have been here today (Fig 1).

I have three beautiful daughters. Allie, our first daughter, is the head of business innovation for a Manhattan advertising firm. Lizzie, our middle child, is a nurse in liquid oncology at the Hospital of the University of Pennsylvania where she is also obtaining her master's degree in nursing administration. Finally, Danielle, our youngest daughter (the baby), is an advanced practice nurse and works half the time in the postpartum unit at NYU and the other half in a private family practice office. My daughters are the lights of my life and I am so incredibly proud of their accomplishments and even prouder of who they have become as people. I hold my wife, Bonnie, 90% responsible (Fig 2).

The first time I laid eyes on Bonnie I knew I was going to marry her. I was an intern in surgery then and we have now been married for more than 30 (32) years. She is the love of my life and soulmate, and has nurtured a wonderful family for which I am forever indebted to her. She has also unselfishly given me the time and encouragement to pursue my dreams. On Valentine's Day of 2016, our lives hit the reset button. That was the day Bonnie received a heart transplant and a day that reminded me how wonderful it is to be part of a profession that produces miracles and how much I still treasured my beloved wife. Now when someone asks me how long I have been married I tell them 32 years, but it feels like 1 minute floating on water. I have a slightly different perspective now!

MENTORS AND FRIENDS

Dr William Baker was my first mentor in surgery. He was my surgical preceptor and the Chief of Vascular Surgery at the Loyola University Stritch School of Medicine, where I attended medical school. I admired his intellect, wit, and grace in and out of the operating room, and he made everything about vascular surgery interesting to me. Dr Baker was a powerful incentive in my choosing vascular surgery as a vocation.

Of all my mentors, Dr Frank Veith has had the greatest influence on my professional career. I was his fellow from 1988 to 1990. In those days, he was not the soft-spoken gentle professor that I often hear him referred to as by residents and fellows at NYU today. In those days, he lived up to his nickname, the Shark. He would bite your head off before you could yell "get out of the water." That said, his attention to detail in and out of the operating room was extraordinary. He painstakingly watched

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Fig 1. My parents, Fred and Dorothy.

Fig 2. My family (from *left* to *right*): Danielle, Me, Bonnie, Lizzie, and Allie.

and corrected, sometimes with four-letter medical jargon for clarity, every throw of an anastomotic stitch until it was done perfectly. It was only after I became an attending and started teaching residents and fellows that I realized how much patience and care it took for him to do this. His work ethic is without parallel, as are his contributions to vascular surgery. We continue to speak often and he has remained a great mentor for me throughout my career.

I have known Enrico Ascher, Larry Scher, and Russell Samson for 30 years and all have played an important part in my development as a vascular surgeon. I continue to learn from them all and I consider all three good friends.

Dr Keith Calligaro is both a mentor and my closest friend. The first time I met Dr Calligaro three decades ago, I was the first-year research fellow and he the second-year clinical fellow. He was exhausted and sleeping between cases. Even though sleeping, I sensed that greatness was in his future! Keith has gone on to an outstanding career in vascular surgery, one that I have tried to emulate in some small fashion. There is no friendship that I cherish more than his.

Dahlia Plummer has been my partner for the past 10 years and prior to that she was my resident. She has always been wonderful to work with and I can count on her to always have my back. I could ask for no better person to move through my professional life with than Dahlia. She is an excellent surgeon, a good person, and a true friend.

Over the long tenure of my participation in the SCVS, I have developed many close and lasting friendships. There have been so many memorable times together that I cannot even remember them all.

THE ANONYMITY OF OUR SPECIALTY

Last year, as I was daydreaming—or rather nightmaring—about a theme for this presidential speech, I struggled to find a subject not yet considered or covered that I felt passionate about. It seemed like we have talked about all the important topics already. Then I had an epiphany. I would talk about what we usually do not talk about—the relative anonymity of our specialty to the lay public, patients, and even other physicians.

I started my career as a vascular surgeon almost 30 years ago when our specialty was relatively new, just starting to find its legs, so to speak. It was, therefore, understandable to me why many physicians and patients were unsure of what a vascular surgeon was. Regrettably, here we are three decades later and little has changed, except that now it is less understandable and a good deal more frustrating, constraining vascular surgeons professionally in everything from departmental and service line leadership to appropriate procedural reimbursement, and even jeopardizing our future as a distinct specialty.

Why are we still not recognized as the go-to physicians for the treatment of vascular disease? Why are we still fighting a battle for recognition that never seems to end? When will it change and how can we change it? Will our specialty survive? These are the questions that I think discomfit and challenge every vascular surgeon today, whether in private, employed or academic practice, and about which I have thought a great deal. Patients cannot know the best person to help them is a vascular surgeon if they do not know who or what a

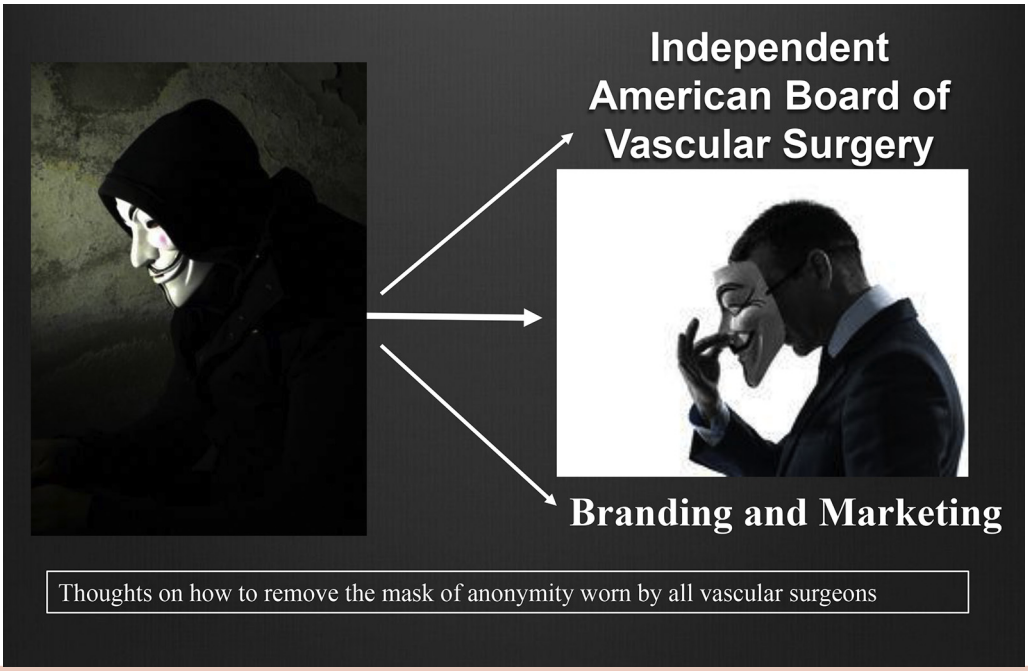


Fig 3. Thoughts on how to remove the mask of anonymity worn by all vascular surgeons.

vascular surgeon is. So, today I want to examine the issue of anonymity of our specialty through a look at two potentially significant factors—our lack of an independent board of vascular surgery and our need for branding (Fig 3).

THE AMERICAN BOARD OF VASCULAR SURGERY AND THE QUEST FOR AN INDEPENDENT BOARD

Now there appears to be no more controversial issue in vascular surgery than whether or not we should pursue independent board status. Please understand that my goal in raising this is not to be contentious, but rather to foster honest and factual discussions about it. To do that, we need to understand what has happened over the last 25 years regarding efforts at independence for our specialty. I believe that important lessons were learned from this endeavor that will help us in the future if we decide to go down this path again.

In 1990, Dr H. Brownell Wheeler, was the first to pose the question, "Should vascular surgery become an independent specialty?" in a presentation at the Critical Issues Forum at the Society for Vascular Surgery (SVS).[1] At that time, there were only 1045 surgeons with added or special qualifications in vascular surgery, nowhere near enough to handle all of the 547 000 vascular procedures done in nonfederal acute care hospitals that year. Even so, fewer than 10% of general surgeons in 1989 did 10 or more index vascular cases each year and 70% did not do a single aortic aneurysm.

At the same time, less than 10% of vascular surgeons did 10 or more of the most common general surgical procedures. Despite these findings, Dr Wheeler concluded that, "Organizationally, for purposes of accreditation and certification, there is no reason for vascular surgery to break off from the main body of general surgery."

Six years later, in Dr Frank Veith's well-known and prescient 1996 SVS presidential address: "Charles Darwin and Vascular surgery," Veith outlined three steps that vascular surgery needed to take to advance and preserve our specialty or face certain extinction.[2] First, vascular surgeons must acquire endovascular skills. Second, we must form multidisciplinary vascular disease centers. Third, we must change the relationship between vascular surgery as represented by the SVS/ISCVS and the bodies that govern it. His address concluded with the thought that, "Darwin would predict that Vascular Surgery would evolve into its own specialty, with its own board and residency review committee and that this would most benefit vascular patients."

Later that same year, the American Board of Vascular Surgery (ABVS) was incorporated by the two major vascular societies, the SVS and the North American Chapter of the International Society for Cardiovascular Surgery (NA-ISCVS).[3] Its purpose was to have a dialogue with the American Board of Surgery and its associated Residency Review Committee, about the training of vascular surgeons and possible application to become a member board of the American Board of Medical Specialties (ABMS). It is only with recognition by the ABMS that a specialty can become an independent examining board, with its own, American College of Graduate Medical Education-approved Residency Review Committee.

In a 1997 survey sent to all practicing vascular surgeons in the United States and Canada sponsored by the SVS, NA-ISCVS, and Association of Program Directors in Vascular Surgery (APDVS), 91% of all American Board of Surgery (ABS) credentialed vascular surgeons favored the formation of an independent ABVS.[3] The American Board of Surgery rejected this idea. Instead, the ABS created the Vascular Surgery Sub-Board in 1998, later termed the Vascular Surgery Board of the ABS (VSB-ABS), with the mandate to advise the ABS on all issues related to vascular surgery. The ABS selected both the members and Chair of the sub-board with some input from the 2 major vascular societies. And although, vascular leadership recommended that the new VSB be allowed to manage all issues regarding training and certification of vascular surgeons, this suggestion was also rejected by the ABS.

Notwithstanding a second survey of SVS members in 2000, which showed continued support for an independent board, the majority of societal leadership voted for a 2-year moratorium on additional funding for the ABVS, and further, for continued support of the relatively unempowered VSB-ABS. This was a divided and ugly era for vascular surgery, pitting the leaders of our specialty against one another and the wishes of membership. In 2002, after some of the vascular societal leadership infighting had resolved, the executive councils of the major vascular societies came together with the APDVS in support of moving forward with applying to the ABMS for an independent ABVS.

The response from the ABS to the application was swift and highly unsupportive. In a memo to all ABS members, ABS executive director Walter Ritchie came out firmly against an independent board as "not in the best interests of general surgery, vascular surgery, the Board movement, or the public."[3] Without the support of the ABS, the negative response to the ABVS application by the American Board of Medical Specialists was not unexpected. Where did that leave us?

Having lived through this epoch, I can tell you there was true concern as to whether our specialty was going to survive. The impact of our lack of autonomy in vascular training was reflected in steadily decreasing fellowship applications in the early 2000s leading to 20% of available vascular surgical residency slots going unfilled by 2005. In response, in 2004, the ABS was given permission by the ABMS to grant a primary certificate in vascular surgery, not independence but the only primary certificate given by the ABS besides that in general surgery. This meant that training in general surgery was no longer required to achieve board certification in vascular surgery. It also allowed for the development of new and different training paradigms, such as the 0-5 integrated vascular residency, which is flourishing today. In exchange for the primary certificate, however, the ABS expected the ABVS not to pursue an appeal of the prior ABMS decision to deny membership and, therefore, independence. Although all parties supported the ABS primary certificate in vascular surgery, they also agreed that this should not be a final destination but rather a way-station on the road to independent board status. In a fourth and final survey sent out in May 2004, members of the vascular surgery community supported this concept. Thus, with the support of the SVS board, although divided, and almost unanimous support of the APDVS, the quest for independence continued. To the disappointment of many vascular surgeons, the ABVS appeal was once again rejected by the ABMS. Given continued opposition from our sponsoring board, the ABS, there was little chance of success.

More than 10 years have passed since that last failed attempt at achieving board independence for our specialty and some things have changed since then. The leadership of both vascular surgery and the ABS is different. Many of the former icons of surgery who were trapped in the constructs and mores of a previous era and opposed vascular independence have retired from leadership. But some things have not changed. Some still believe that we have an obligation to train general surgical residents in open arterial surgery. An abstract will be presented at the prestigious American Surgical Association meeting in April 2018 addressing these issues.[4] However, in the abstract at least, the authors fail to mention that there are not enough open arterial cases to adequately train vascular residents and fellows for whom these cases are critical, let alone general surgical residents, for whom they are not. So perhaps it is time to revisit our lack of control of our vascular surgery training programs and the pursuit of independent board status.

REASONS FOR AN INDEPENDENT BOARD

In November of 2017 at the forty-fourth annual Veith symposium in New York, I participated in an extracurricular meeting of concerned vascular surgeons to consider reviving the ABVS with a mission to again pursue an independent board and membership in the ABMS. Representatives of both academia and private practice were in attendance. I asked many of the participants how they thought an independent board would improve their circumstance. Their answers included issues of compensation/reimbursement, departmental and service-line leadership, control of our training programs, greater control of competing specialties, and enhanced specialty recognition by the lay public. I would like to address each of these as it relates to board independence.

Reimbursement. I will start with reimbursement. The physician work scale of the original Resource-based Relative Value Scale, in which very CPT code was converted into relative value units (RVUs) was developed by Hsiao and coworkers at Harvard in 1988.[5] Little attention was paid to vascular surgical procedures with only six

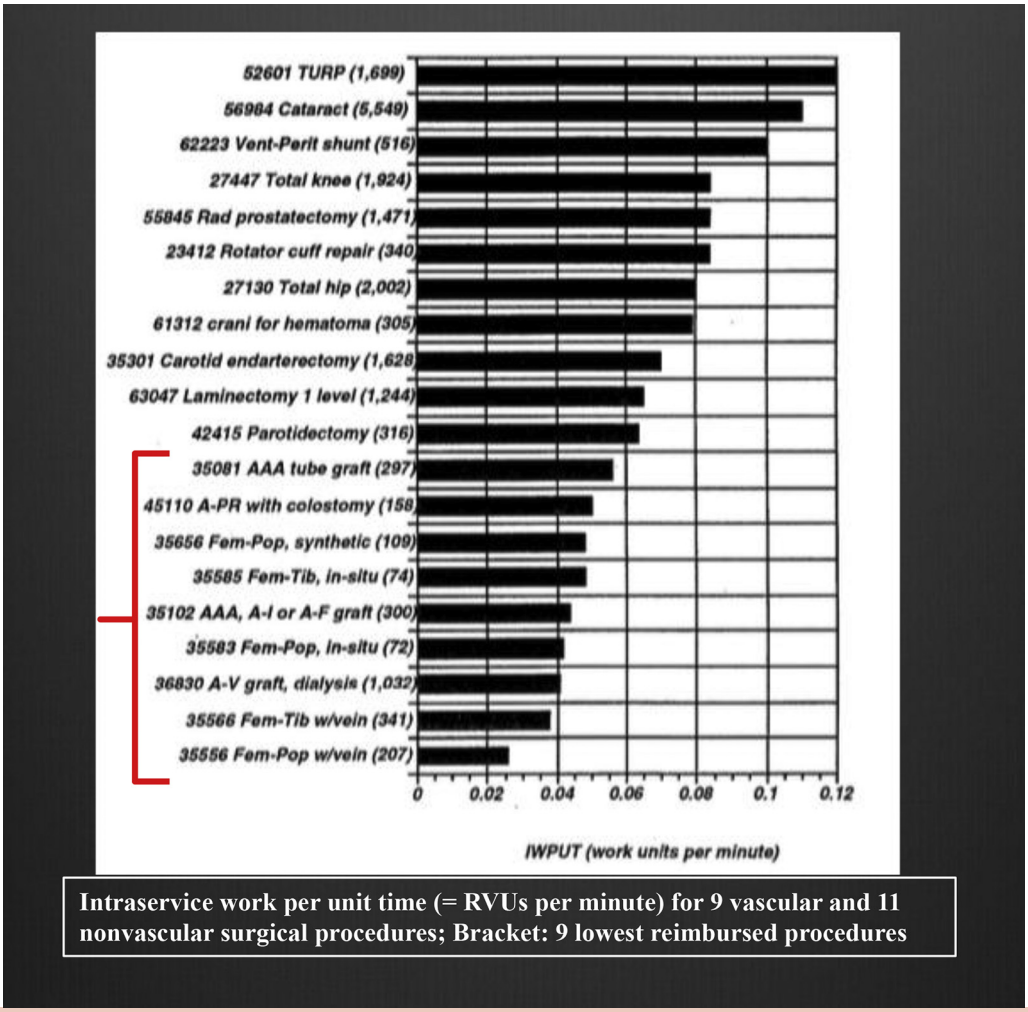


Fig 4. Intraservice work per unit time (relative value units [RVUs] per minute) for 9 vascular and 11 nonvascular surgical procedures. Bracket: nine lowest reimbursed procedures. *AAA,* Abdominal aortic aneurysm; *A-F,* aortofemoral; *A-I,* aortoiliac; *A-PR,* abdominoperineal; *A-V,* atriovenous; *Fem-Pop,* femoral-popliteal; *Fem-Tib,* femoral-tibial; *TURP,* transurethral resection of the prostate; *Vent-Perit,* ventriculoperitoneal. (Reproduced with permission from: Zwolak et al.[6])

procedures surveyed. Compounding this blunder, the Harvard researchers did not identify vascular surgery as a distinct specialty and the surveys were sent to surgeons who may have had little or no vascular surgical experience and were most likely general surgeons. In an article by Bob Zwolak published in 1997, the then head of the Government Relations Committee of the SVS/NA-ICVS, the number of RVUs generated per minute for vascular procedures are compared with other surgical procedures.[6] Eight of the nine lowest RVUs per minute were assigned to vascular operations (Fig 4).

The battle for proper reimbursement has continued ever since by SVS representatives Bob Zwolak, and more recently Sean Roddy and others as well. The SVS will continue to represent us in this and other governmental issues, because this is not the function of a board. On the other hand, had there been an independent board from the outset, we would have been represented by vascular surgeons, rather than general surgeons and the RVUs per minute worked would surely have been more favorable. Government reimbursement strategies have changed significantly since then and will continue to do so. It is debatable as to whether remaining under the umbrella of the ABS, which represents us as well as other subspecialties, would be to our advantage or even matter. I would still argue that a singularly focused board would serve us better overall. Even a relatively small one.

Departmental leadership. Regarding hospital or medical school departmental leadership, some believe that if we have an independent board we would have our own departments of vascular surgery and no longer be subservient to chairs of surgery who are in most instances either general or cardiothoracic surgeons. In average sized and smaller medical institutions in the United States, however, it is unlikely this would have any

Year	Age > 65	DM	HTN	HPL	Obesity	Surgeons
2015	18.4	60.1	6.9	8.8	6.2	4.2
2020	39.0	96.1	13.9	9.9	24.8	8.4
2025	61.5	132.6	20.8	14.3	44.4	12.6
2030	80.7	165.9	27.8	18.6	65.0	16.8

DM: Diabetes mellitus; HTN: Hypertension; HPL: Hyperlipidemia.

Predicted % change of PVD risk factors and vascular surgeons

Fig 5. Predicted percent change of peripheral vascular disease risk factors and vascular surgeons. DM, Diabetes mellitus; *HTN,* hypertension; *HPL,* hyperlipidemia. (Reproduced with permission from Williams et al.[8])

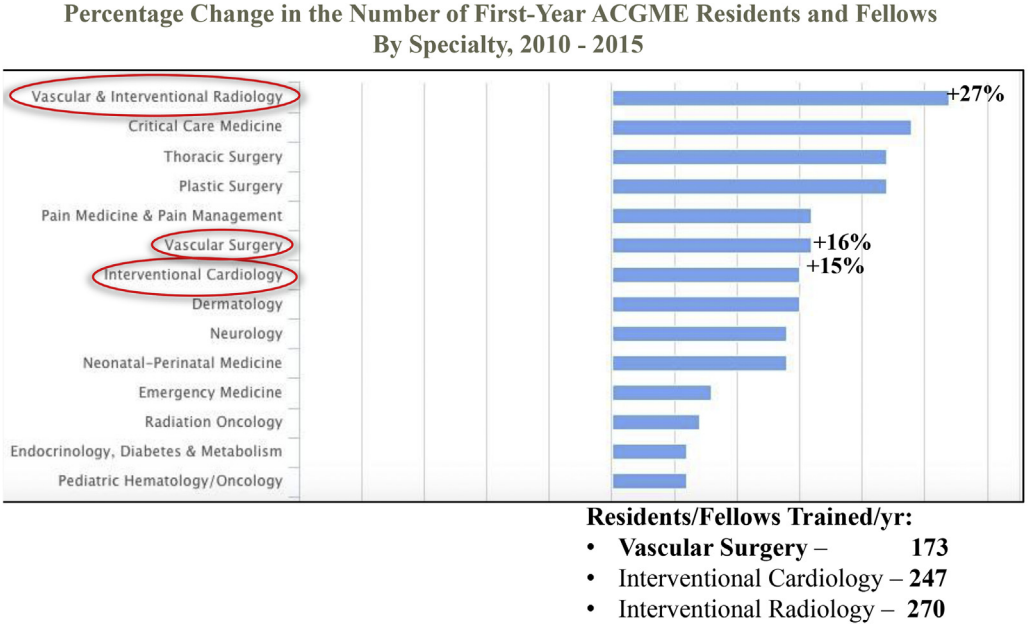


Fig 6. Percentage change in the number of first-year American College of Graduate Medical Education (ACGME) Residents and Fellows by specialty, 2010-2015. (Source: Association of American Medical College 2016 Physician Specialty Data Report.)

bearing on organizational structure because of the administrative and other costs associated with establishing a department. In academic and or larger hospitals, though, separate departments of vascular surgery would undoubtedly increase the level of respect for vascular surgical leadership by the hospital administration and other department chairs. Over time, the elevated presence would lead to greater awareness of our specialty, at least within medicine. It might also improve the chances of vascular surgeons being given greater consideration for chair positions in surgical departments in which a department of vascular surgery does not exist.

Service line leadership. With respect to service line leadership, it appears to me that cardiologists are most often selected. I suspect that the sheer numbers of cardiologists and their bigger economic clout is the reason. But this is only speculation. Would greater consideration be given to vascular surgeons if we had

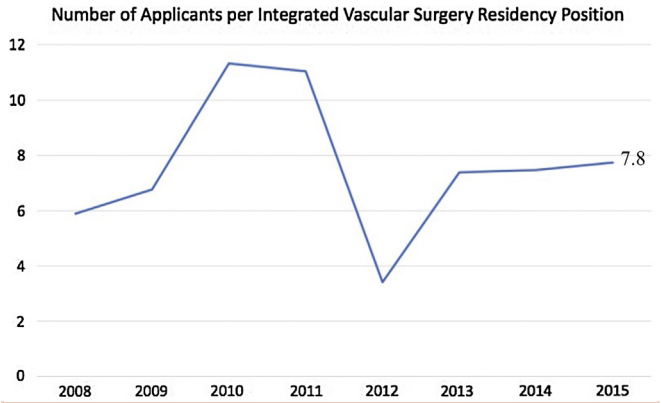


Fig 7. Average number of applicants per integrated vascular surgery residency position. (Reproduced with permission from Arous et al.[10])

an independent board? I would suggest that it might and that the service line leadership selection process, might be more greatly influenced by the chair of an economically robust department of vascular surgery than that of a division chief.

Competition. There is the challenge of other specialists entering what we consider our domain and performing vascular interventions. Although having an independent board would not prevent that, had we had an independent board 20 years ago, it might have made a difference with respect to credentialing of interventional specialists and having adequate numbers of vascular surgeons today. It seems that, in most medical institutions, guidelines for credentialing in vascular interventions are not recognized across specialties. Alternatively, guidelines developed by the SVS and supported by the gravitas of an Independent Board of Vascular Surgery, might garner greater acceptance by hospital credentialing committees, and be applied to all interventionalists, wishing to perform these procedures, no matter their specialty of origin. Another fundamental reason why other specialists have entered the vascular space is one of numbers. Simply put, not enough supply of vascular surgical specialists to treat the plethora of patients in need of vascular procedures.

Control of training. Our population is aging rapidly and with it the incidence of vascular disease. Back in 1996, Jim Stanley predicted that, without the ability to increase the number of vascular surgical trainees, there would be more patients with vascular disease than there would be trained vascular surgeons to treat them.[7] A more recent paper by Williams et al,[8] looking out to 2030, confirms this (Fig 5). The lack of supply has stemmed largely from our lack of control over residency and fellowship training.

As shown in a 2016 Association of American Medical Colleges specialty workforce report, we train many fewer residents than interventional cardiology and interventional radiology (Fig 6).[9] Previous mandates by the ABS RRC-S—to provide general surgery residents with a significant operative experience in vascular surgery at the expense of training adequate numbers of real vascular surgeons—has created a void in vascular disease care that has been filled by insufficiently trained, nonsurgical specialists, often for the economic opportunity that it provides rather than the need to deliver best care.

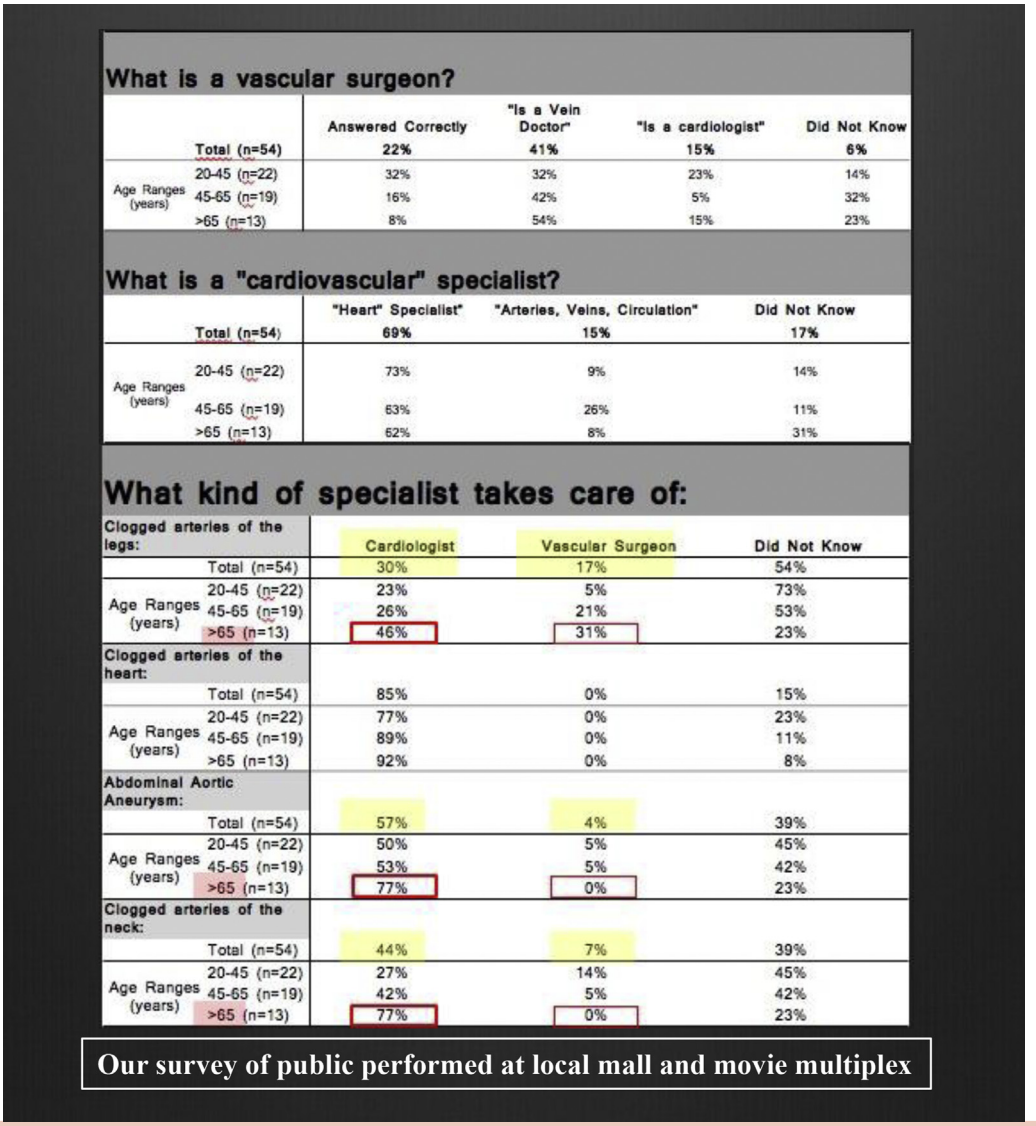
In a presentation at the 2017 APDVS it was shown that in 2015 there were almost eight applicants for every 0-5 vascular surgery residency position available[10] (Fig 7). The decision to increase the number of residency positions and avert the predicted shortages in vascular surgical manpower should rest solely in our hands. It does not.

Approximately 1 year ago, Ash Mansour wrote an informative article for the Vascular Specialist outlining the current composition and activities of the Vascular Surgery Board of the ABS.[11] Without question, great strides have been made in addressing many of the needs of vascular surgery through the Vascular Surgery Board of the ABS. Nevertheless, we still do not have our own RRC nor complete control of the composition of the members of the VSB, the chair of which must have both current certifications in vascular surgery as well as general Surgery and who is still ultimately selected by the ABS. To train vascular surgeons and manage our profession to meet growing demand with high-quality care is the most crucial reason to have an independent board. Absent this control, we have limited ability to guide our own destiny, as you can see from all the challenges I have just outlined.

Recognition. Russell Samson noted in a recent editorial in the *Vascular Specialist* that every year *US News and World Report* puts out a list of best hospitals by specialty that includes cardiology, cardiothoracic surgery, and ENT among others—but not vascular surgery.[12] Samson suppositions that this would be an unlikely occurrence if vascular surgery were a member board of the ABMS rather than a sub-board of the ABS. He concluded with a pertinent question asked of him by Enrico Ascher—not why we should have an independent board that would allow us to control the most important aspects of our profession and afford us greater recognition, but rather, why not? I would further add that we do not know what potential, new, and disruptive changes and technologies await vascular surgery in the future. Who would have predicted the endovascular revolution? Would it not be in our best interest if our ability to respond to these changes is solely our own? That's a rhetorical question!

WE CAN AFFORD AN ABVS?

One concern of having an independent board is the associated cost of running it. Is it prohibitive? To find out, I spoke with the COO of the American Board of



What is a vascular surgeon?

		Answered Correctly	"Is a Vein Doctor"	"Is a cardiologist"	Did Not Know
	Total (n=54)	22%	41%	15%	6%
Age Ranges (years)	20-45 (n=22)	32%	32%	23%	14%
	45-65 (n=19)	16%	42%	5%	32%
	>65 (n=13)	8%	54%	15%	23%

What is a "cardiovascular" specialist?

		"Heart" Specialist"	"Arteries, Veins, Circulation"	Did Not Know
	Total (n=54)	69%	15%	17%
Age Ranges (years)	20-45 (n=22)	73%	9%	14%
	45-65 (n=19)	63%	26%	11%
	>65 (n=13)	62%	8%	31%

What kind of specialist takes care of:

		Cardiologist	Vascular Surgeon	Did Not Know
Clogged arteries of the legs:				
	Total (n=54)	30%	17%	54%
Age Ranges (years)	20-45 (n=22)	23%	5%	73%
	45-65 (n=19)	26%	21%	53%
	>65 (n=13)	46%	31%	23%
Clogged arteries of the heart:				
	Total (n=54)	85%	0%	15%
Age Ranges (years)	20-45 (n=22)	77%	0%	23%
	45-65 (n=19)	89%	0%	11%
	>65 (n=13)	92%	0%	8%
Abdominal Aortic Aneurysm:				
	Total (n=54)	57%	4%	39%
Age Ranges (years)	20-45 (n=22)	50%	5%	45%
	45-65 (n=19)	53%	5%	42%
	>65 (n=13)	77%	0%	23%
Clogged arteries of the neck:				
	Total (n=54)	44%	7%	39%
Age Ranges (years)	20-45 (n=22)	27%	14%	45%
	45-65 (n=19)	42%	5%	42%
	>65 (n=13)	77%	0%	23%

Our survey of public performed at local mall and movie multiplex

Fig 8. Survey of public performed at local mall and movie multiplex.

Allergy and Immunology, an ABMS member board similar in size to our own. When they first became an independent board in 1971, they shared office space with the American Board of Internal Medicine and leased their employees to save money. Now they have their own space with seven employees, supported with annual membership dues and annual maintenance of certification fees. An independent ABVS could do the same.

As I have outlined, there were many twists and turns in our prior pursuit and failed attempt at becoming an ABMS-recognized specialty. It is now clear that if we are going to move forward with seeking an independent ABVS, then the leaders of our most important vascular society—the executive council of the SVS—must be united in their efforts to achieve this goal and, in turn, must obtain support from the American Board of Surgery, without which we are not likely to be successful. If there are those in leadership, all of whom I know well and trust, who do not believe it is in our best interest to move forward with pursuing an independent board then they must enlighten the membership with their raison d'être. These reasons, however, need to be based in facts and not personal sentiment. Transparency is critical, and something that was missing when we went down this road in the not too distant past. This is no time for a Jack Nicholson approach ie —if there is a truth—we can handle it!

BRANDING AND MARKETING OF OUR SPECIALTY

In the event that we were to achieve independent board status, would that solve our problem of anonymity with the public? Possibly with time, but very unlikely in the short term.

So then, how can we distinguish ourselves from other specialties that claim to do what we do? How can we

Fig 9. V-AWARE magazine.

make the public and referring physicians aware of what vascular disease is and why we, vascular surgeons, are the most prepared of all physicians, to treat it?

I would suggest then that we need to commit to some hard work through our societies to focus on education and the branding and marketing of our specialty.

Where does our brand stand now in the public domain? In an informal survey that we conducted at public venues, we found that only 22% of people correctly identified what a vascular surgeon was (Fig 8). Almost as many thought a vascular surgeon was a cardiologist. Seventy percent perceived a cardiovascular specialist as a heart doctor and only 15% thought it was someone who treated circulatory problems. Most people thought that cardiologists manage peripheral artery disease, aortic aneurysms, and carotid disease, especially those in the age group most likely to have these diseases.

The term "brand" takes its roots from the old west—that mark seared onto the hides of cattle to designate ownership. Of course, the concept has evolved greatly since then, but its implicit meaning is still the same. A brand is something that marks your company or service, in our case specialty, as unique. Our culture is dominated by brands. When we see a familiar brand, we understand the meaning without having to hear the whole story. For our specialty to have an effective brand, we must start by describing ourselves clearly. To this point, there is a word that has become part of our descriptive lexicon, a remnant of a prior era, prior to the origins of our specialty but that today serves to obfuscate and confuse both the lay public and many physicians about what vascular surgeons are and what we do. That word, *cardiovascular,* a conjunction of the words cardiac and vascular, has become a marketing term, a catchall for any disease that pertains to the heart, and on occasion, the vasculature as well as to erroneously define who we are, as in: cardiovascular specialist. It is a misleading term used by pharmaceutical companies to sell drugs and by misguided hospital administrators to sell services to the inexpert lay public. We must insist that this word not be used by those on whom we have some professional influence, whenever and wherever possible. It is crucial that the lay public and referring physicians see the word *vascular* often and unfettered or proceeded by the word cardio when referring to us and the diseases we treat. Only then will the majority of referring physicians and patients know who to seek out for their vascular care. Knowing us is to properly name us.

Once we clearly describe and define our brand, we have to communicate it through marketing. Fortunately, there are more ways—from low tech to high tech—than ever before to get our message out. In one low-tech example, the Eastern Vascular Society's (EVS) Committee for Community Physicians and Outreach, which I chair, is currently testing the distribution of an informational magazine, V-AWARE, via direct mail to patients and referring physicians (Fig 9). Each issue of the magazine will cover one topic and three to four issues will be sent out over the course of the year. All articles are written at a sixth-grade level.

Recipients will be surveyed to evaluate the effectiveness of this mode of messaging. V-AWARE was developed by Manny Mehta and generously loaned to the EVS through the Center for Vascular Awareness, Inc., a nonprofit organization. A more ambitious, national branding effort, in which small pieces of content are sent out through different mediums (Facebook, Snapchat, Twitter, etc) and to different target audiences can be led by the SVS. With digital advertising and social media, there are multiple outlets through which we can inform, educate, and teach audiences to associate vascular disease solutions specifically with our specialty. There is more ability to reach more people in targeted ways than ever before and for less money than traditional media advertising. Even so, traditional advertising venues like TV, still matter. Although not as expensive as it used to be, it is still a substantial investment. One which may exceed our budget. Alternatively, Tesla, one of the best known and respected brands there is today, spends zero dollars annually for advertising and marketing of their vehicles.[13] They did this by disrupting the typical means for marketing—placing their car showrooms in malls and employing social media and not using TV or print media. Last year, Tesla held a contest for fans to create ads for their vehicles. Tesla received videos from around the world. These videos were seen on

multiple online and social media sites. In addition, the contest received free TV and print news coverage.

We can do this too. But first we need a message. I ask you all: What is our message? Yes, we are *the experts* in vascular disease but that is only part of it. I am not suggesting that I have created the message—although I would love to do that. That is the collective task of all of us. And whatever that message is, we need to begin delivering it as often and through as many mediums as our funds will allow. The SVS is the voice of our specialty and has critical roles in government relations, reimbursement, coding, and establishing practice guidelines. Branding and marketing are also integral parts of the bigger effort to secure the future of our profession. The SCVS represents the clinical vascular surgeon and is well-suited to partner with the SVS in establishing branding and marketing strategies. For this reason, I have established an ad hoc committee to explore this further. Although vascular surgery is a small, often unrecognized specialty, being small is not why we cannot do branding. It is why we must do branding. And why we need to start now!

CONCLUDING THOUGHTS

Like my children, who are now grown and out on their own, our specialty has also grown, in size, complexity, and exceptionality from other specialties. It is time for us to be on our own as well and do the things we need to do to have our own identity. We need to forge our futures by ourselves for ourselves with the help of our friends and the surgical family at large along the way. I, like all of you, love our chosen profession and I truly believe in my heart, *arteries, and veins* that, if we act together and focus our energies on what I have discussed with you today, standing on our own and delivering our message, then the future of vascular surgery as a profession and as a service to patients everywhere is extremely bright.

It has been a distinct pleasure and privilege to serve as your forty-sixth president of the SCVS. An honor that I have cherished and will never forget.

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