I am most appreciative of the members of the Society of Laparoendoscopic Surgeons for the privilege of serving as President for the past year.

Laparoscopy has been a field in ferment for three decades. There have been many significant events over this period, and I would like to share some personal thoughts with you concerning some of them.

The advent of image-guided, laparoscopic surgery in the United States began quietly enough in the 1960’s. Certainly, the laparoscope was used for diagnostic and therapeutic purposes before then, but its use was limited. The marriage in 1960 of the Hopkin’s rod-lens system and Storz laparoscope with its fiberoptic light delivery system enabled physicians to view body cavities with greater illumination, clarity, and field of view than ever before. During those times, ENT endoscopic surgery blossomed, and the era of gynecological “Band-Aid” surgery began.

There were visionaries in the early days to whom it was obvious that a laparoscopic method of accessing body cavities held great promise—Raoul Palmer in France, Hans Frangenheim in Germany, Patrick Steptoe in England, Jordan Phillips and George Berci here, and others.

A brilliant German gynecologist, Kurt Semm, was the first to remove an appendix laparoscopically in 1982. A few others dreamed of expanding the horizons of laparoscopy even further. But the question remained - how to accomplish it?

Lectures and scholarly articles had limited audiences, and, advances in one discipline were not readily known in another. In fact, there was little information transfer between countries and, even less, between specialties. At that time, the specialties were divided by sharply demarcated lines of interest in an organ system or body part. There was little dialogue between the different disciplines.

The use of minimally-invasive, laparoscopic surgery, however, crossed all specialty lines. Laparoscopic instrumentation, technique, and management protocols are used to good advantage by many different kinds of surgeons. SLS was started with the notion that it is important for surgeons—all surgeons—to have a dialogue with one another. You might ask, what is SLS?

Well, SLS is a different kind of surgical society. It is, to be sure, an energetic society that crosses national boundaries, attracts surgeons of all ages and counts world leaders in laparoscopic surgery as its members. But there are other societies that lay claim to similar membership.

What makes this society truly different is one dominant characteristic—SLS is a multidisciplinary society. Multidisciplinary, but, with several unifying themes:

First, SLS is a community of surgeons who are as one, in their desire to decrease the trauma of a surgical experience. Diagnostic surgery, tissue sampling, revision of a diseased body part, organ extirpation, even vascular and spinal surgery need not be done at the expense of a large access incision. There is a better way, and that is “laparoscopy.”

Second, as mentioned, SLS is multidisciplinary. It was a radical concept in 1990 that different specialties might want to get together, share experiences and, yes, even learn from one another.

For many years, medicine had lapidified into groups, subgroups and even smaller groups. Super-specialists were so focused that few outside their area of interest were aware of, or even understood, what these specialists were doing. We continued that way for a long time.

Distinction between specialties became barriers and the barriers grew with time, preventing whole groups from communicating with one another. The early founders of SLS recognized that these barriers were interfering with the learning opportunities and professional growth of whole segments of the surgical professions. The constraints were ingrained but, they were, and are, artificial.

Members of SLS learn from one another by interacting through conferences, seminars and, now, JSLS, the journal of our society. A collegiality has developed between members of different specialties, different institutions, and (aided by the Internet) even between different countries, that would not have been possible before. Stunning examples of information transfer include the delicate, gynecological, micro-surgical suturing techniques developed for Fallopian tube procedures, now being applied to coronary artery surgery - cardiovascular surgeons being taught by gynecologists. Imagine.
In my own field of general surgery, "Johnny come lately," general surgeons have also contributed. The free use of multiple ports, bimanual dexterity and an "I can do anything in the abdomen" attitude of general surgeons has helped expand horizons for urologists and gynecologists. The intense interest of the urologist in kidney disease has helped explain some of the function of this important organ when stressed by a pneumoperitoneum.

I could go on, but the point is obvious. Cross-fertilization of knowledge between two disciplines frequently "cata-pults" one of them to a higher level. Surgeons are more capable and more proficient when they share experiences, develop new techniques and teach one another.

This, then, is the enduring legacy of SLS - the breaking down of barriers between the surgical specialties and allowing knowledge gained by one discipline to be shared by others. There have been significant developments even during my own term in office. Allow me to comment on a few.

At the end of last year, following general trends, it appeared there might be a drop in membership. After years of explosive growth, SLS membership seemed to be leveling off. The halcyon days of exponential growth and expansion for the society seemed to be at a close.

The effect of this possibility was like a cold shower, shocking—but salutary. The leadership of SLS looked at everything. Were appropriate member services being provided? Were programs strong? Were we focusing on one issue and losing sight of the big picture?

Substantive changes were made in administration. Costs, which had been closely watched, were even more carefully scrutinized than before. The internal structure of the society was expanded and strengthened. Publication and Internet activities were increased. Many changes were made—all to the good.

As the year unfurled, however, membership did not decline. Rather, it increased. Non-member interest in the society also increased. Weekly Internet "hits" at the SLS website rose dramatically and remain high.

Economic uncertainty in the U.S. has contributed to a decline in attendance at all medical meetings—across the board—and even a decline in membership of some organizations. But membership and interest in our society has increased. There are many reasons for the surge in vitality of SLS. I would like to review three of them.

First, a compilation of the vast experience with laparoendoscopic complications, discussed during four separate SLS conferences, was patiently gathered. Authors were selected, who crystallized their experiences into chapters which reflected the interdisciplinary nature of the society. This work, "Prevention and Management of Laparoendoscopic Surgical Complications," is a logical, joining together of the experiences of many specialties in laparoscopic surgery. It is not a "how I got into trouble" book, but a book that develops each "problem" topic such that it can stand alone, or the topics can be read together in sequence. The text will be a significant milestone in laparoscopic surgery.

Another seminal event, placed into motion this year, was the expansion of the committee structure of SLS. Heretofore, a small number of key committees, manned by very dedicated members, helped establish the society and performed many of its vital functions. The society, however, has grown. Not only in numbers, but in the need for sophisticated techniques to run an organization of highly-educated professionals. The committee base has been expanded to meet these needs.

Involvement at the committee level naturally leads to a leadership role in the organization. Those wishing to make a contribution to the development of surgery are welcome to participate on the committees and help shape the society for the future. All of the new committees are important, and membership on them offers a voice to those concerned with the development of laparoscopic surgery.

Finally, a topic most close to me has been the inauguration of the journal of the society—JSLS, The Journal of the Society of Laparoendoscopic Surgeons.

Planning for JSLS began almost two years ago when it became apparent that there was need for a legitimate publication that would serve to disseminate the scholarship and experience of our members. There were, however, questions:

Is there a need for another journal?

Is there a market for it?

Will it serve a useful purpose?

The answers to all of these questions has been answered with a resounding YES!

In a most basic sense, there is always a need for things of quality, of excellence. For, unfortunately, in our everyday world, there is an abundance of mediocrity, an abundance of commonness.

There is need for a quality, responsive, journal of minimally-invasive, image-guided surgery. But more than that, we have shown that there is almost a thirst to share experiences among the surgeons of all disciplines who perform laparoscopy.
If there is a principle of basic science, if there is a technique, an instrument, a better way to perform minimal-access surgery, then it is of interest to all practitioners who labor in this field. Consider the fact that laparoendoscopic surgery invokes less of an immune response than open surgery. This information is important to all specialties; it crosses all specialty lines. It does not matter if the person is a general surgeon, gynecologist, urologist, orthopedist, or vascular surgeon—this knowledge is important to all and should be known by all.

Developments have been rapid in minimally-invasive surgery, and there should be, and now, there are, no barriers to the sharing of these developments between members of the Society.

Before JSLS, there was not one unifying source dedicated to providing information of interest to minimally-invasive surgeons of all disciplines.

Each specialty has its own journal and, typically, reviews topics only in that specialty. Older, well-established surgical journals have sections of laparoscopic surgery but not necessarily a commitment to this form of surgical access. Newer journals, some produced primarily for profit (with a few notable exceptions) are riding the current wave of popularity of laparoscopic surgery. It will be interesting to see, as the publics’ attention is inevitably diverted to another “hot topic” in medicine, if these journals long survive.

\textit{JSLS} will survive. As long as there is a need for information transfer, for cross fertilization of ideas across specialties, this interdisciplinary society, SLS, will serve that purpose, and there will be a \textit{JSLS}.

I am pleased to report that \textit{JSLS} has been in production for one full year, and during that time, we have printed 5000 copies per issue to cover our readership base. Demand, however, has increased. As of the last issue, we have begun printing in excess of 6000 copies per issue. The base has increased.

That's quite a record for a first year effort and is, in large measure, a tribute to all members of the society who have contributed articles. It is also a tribute to the very dedicated, productive, and pre-eminently qualified members of the editorial board. These men and women, scientist-surgeons all, have given freely and selflessly so that the journal would be a success. I thank them.

Many of you have served as independent reviewers and have contributed time and expertise so that \textit{JSLS} would be a high-quality publication. I thank you all, and welcome any others who would like to serve as an independent reviewer.

Most of all, I would like to thank Dr. Paul Wetter, Managing Editor of the journal and the administrative staff:

Janis Chinnock, operations officer; Charlotte Donn, director of administration and publications; Marcy Grosso, graphic designer and production coordinator; Flor Tilden, circulation coordinator; and advertising representative, Dresden Ferrer for their work.

Without you, the journal would not have happened. From the rest of us, Thank You!

In closing, I would like again to express my sincere appreciation to the members of the society for the privilege of leading for a short while.

It is time for me to step down. I do so with confidence in those who follow, Dr. Childers and Dr. Fitzgibbons, and the firm conviction that surgeons must encourage discourse amongst themselves, must cross specialty lines.

Only in this way can the brilliant minds that have characterized surgical specialties of the last two centuries augment one another and light the way into the next millennium.

Thank you.

Michael S. Kavic, MD
President