

# LEADING THE WAY

FALL 2018 • VOLUME 10, NUMBER 3



DEPARTMENT OF SURGERY



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## From the Chair | Douglas B. Evans, MD

A few photographs highlight the cover of this edition of *Leading the Way* – one very philosophical and the others very practical. This photograph of Milwaukee was taken at dawn on July 19 – when the sun rises early. In addition to the beauty of Milwaukee (as seen from Lake Michigan), it reminds us that just about everyone in the Department of Surgery was awake and at/on the way to work at the time this photograph was taken. Quite different than the situation in other professions – something that has been written about in detail as we struggle with work-life balance (in medicine, and especially surgery) and the successful achievement of all three missions (education, research and clinical care). I used this photo at a recent scientific conference to emphasize the unique infrastructure we have (at MCW and particularly in the Department of Surgery) for advancing translational research—so critical for making needed improvements in how we care for (and operate on) patients. Such innovations are featured in all editions of *Leading the Way* by uniquely talented faculty and residents. Importantly, in the eyes of every patient, innovation, discovery, and research are synonyms for hope.

On a more practical note, the photographs below are of the WISN 1130 radio station to remind everyone that, beginning in January, “The Word on Medicine” can be heard every Saturday afternoon at 4:00 p.m. We have now recorded more than 25 programs and included more than 135 faculty, nurse practitioners, physician assistants, nurses, techs and many more. We have been so fortunate to have patients and their families also be a part of each program. In addition, “The Latest Word on Medicine” began this month and will air every Friday afternoon at 2:00 p.m., also on WISN 1130. This four-minute feature is designed to highlight the knowledge, experience, and vision of everyone who is the Medical College of Wisconsin—one of the best medical institutions in the world. This weekly feature will focus on a high-profile issue, personality, or current event related to medicine, and most importantly, will provide the perspective of an MCW physician or scientist. All previous programs can be found as podcasts on our web site at [mcw.edu/surgery](http://mcw.edu/surgery), or simply go to iHeartRadio, iTunes, Podbean, or Stitcher— just look for *The Word on Medicine* channel. •



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**MCW Surgery**  
*knowledge changing & saving life*

# Transforming Transplantation Through Technology, Talent,



**DAVID L. JOYCE, MD**  
Associate Professor  
Division of Cardiothoracic Surgery

*“We believe in deep collaboration and cross-pollination of our groups, which allow us to innovate in a way that others cannot. And frankly, we don’t settle for anything less than excellence every minute of every day.”*

—Vision Statement, Apple Inc.

This past December 3rd marked the 50th anniversary of the very first orthotopic heart transplant performed in a human.<sup>1</sup> Although the technical aspects of the current procedure resemble very closely those that were developed by Shumway and Lower, the innovation that has taken place in this field over the past five decades rivals even the most productive incubators of Silicon Valley. Compared to the state of advanced heart failure management that existed at our program’s inception in 1985, current therapeutic options offer creative strategies that were never dreamed of in the era of maps, pay phones, and the rolodex.

One of the most striking advances has occurred in the development of newer technologies to support the failing ventricle

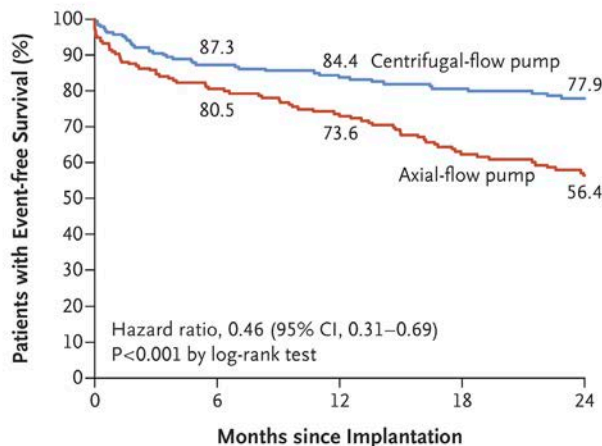
through mechanical circulatory support (MCS). The newest Left Ventricular Assist Device (LVAD) to gain FDA approval, Abbott’s Heartmate 3, was implanted for the first time in Wisconsin as commercial use at Froedtert and the Medical College of Wisconsin. Survival with this device has been shown in the recently published MOMENTUM 3 trial to exceed previous benchmarks, comparing favorably with cardiac transplantation.<sup>2</sup>

Meanwhile, in the management of cardiogenic shock, our program has witnessed dramatic improvements in survival through the immediate institution of short-term MCS, such as Abiomed’s Impella 5.0 device. With a menu of short-term MCS options to suit virtually any degree of cardiopulmonary failure, we can tailor this therapy to save lives even in situations where CPR fails to generate a perfusing rhythm. As early adapters of the newest generation of short-term devices, our program has seen unprecedented growth with dramatic benefits to our patients.

Nevertheless, a finely crafted Stradivarius is of very little value unless you have a talented musician who knows what to do with it. Steve Jobs once stated: “It’s not the tools that you have faith in—tools are just tools. They work or they don’t work. It’s people you have faith in or not.” Although it is difficult to quantify the intellectual rigor that occurs each week in a selection committee that features voices from some of the most thoughtful and experienced providers in the heart failure community, the acceptance of five abstracts for presentation at this year’s major national meeting (Heart Failure Society

of America) provides some context. What makes the heart failure talent so remarkable at Froedtert is the diversity of perspectives and experiences that exist. When combined with a modus operandi that everything we hold to be true about the management of heart failure patients should be scrutinized, tested and only accepted after a group consensus has formed, this type of collaboration results in a synergy that is truly unique in the cardiac transplant community.

I recently had the opportunity to study the behavioral science behind this type of “crowd wisdom” in a leadership course at the University of Chicago. We were presented with a hypothetical scenario in which our team had crash landed a plane in the middle of Schefferville, Canada. We were each required to rank 15 items for their impact on survival and then divided in to groups where we were given the opportunity to revise our rank list. Finally,



No. at Risk	0	6	12	18	24
Centrifugal-flow pump	190	161	141	122	111
Axial-flow pump	176	134	114	90	75

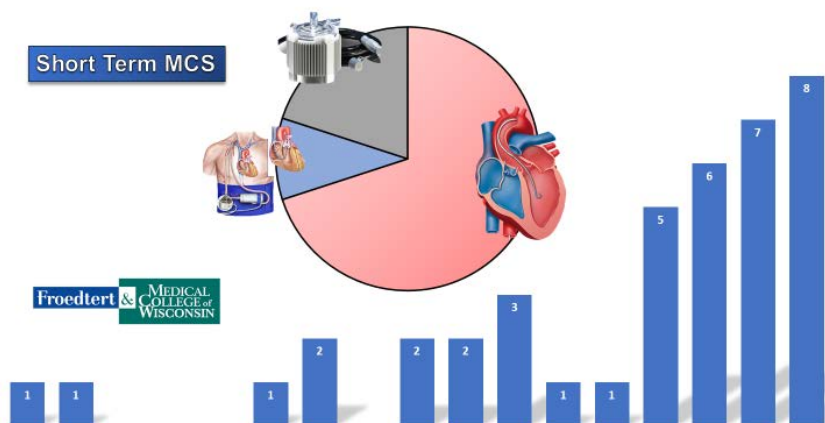
**Figure 1.** In the MOMENTUM 3 trial which randomized Heartmate II (an axial flow pump) with Heartmate 3 (a centrifugal flow pump), the experimental group demonstrated a higher rate of survival free of disabling stroke without the need for a device exchange over a two-year period.<sup>2</sup>

# and Teamwork

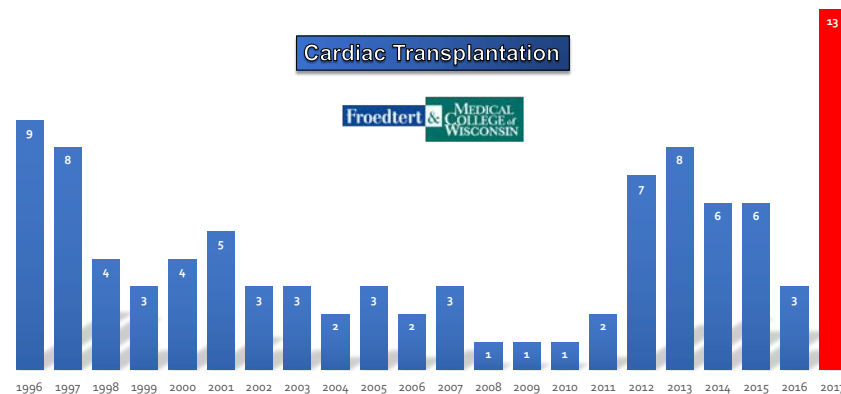
the results were compared with the official answer as determined by the “experts.” The findings were truly remarkable. The group with the highest performance was not the one with the best average individual score or the best overall individual score, but the group with the most migration between individual scores and group scores. In other words, the groups that were able to implement a synergistic problem-solving model were the ones that survived the subarctic conditions in this hypothetical scenario.

This type of synergy can be observed on both ends of the heart failure management spectrum in our program at Froedtert. For many patients, the first referral takes the form of a transfer through the shock pager. The system that has evolved for managing these complex patients leverages the skills of a diverse range of specialists—intensive care, interventional cardiology, heart failure cardiology, and surgery, to name a few. The brief discussion that follows can frequently change the trajectory of a patient in a way that transforms an inevitable mortality into recovery and restored quality of life. This same type of teamwork occurs in our group’s approach to managing the immensely complex strategic decision of whether to accept a particular donor organ for one of our transplant candidates. Through a series of group texts between the relevant care providers, we routinely arrive at higher quality decisions than anyone could have accomplished as an individual. The consequence has been a dramatic increase in the number of transplants attempted accompanied by a 100% survival rate over the past year and, for the first time in our program’s history, CMS certification.

While the accomplishments of the past year have surpassed even the most optimistic expectations, the team remains focused on the future as new opportunities begin to appear on the horizon. As we prepare for a new allocation system, the prospect of Donation after Circulatory Death (DCD) organs, and a product development pipeline that continues to churn out innovative new MCS options, there is a growing sense of confidence that by working together we can play an integral role in inventing the future of this specialty. •



**Figure 2.** Short term MCS implants have grown considerably at Froedtert and the Medical College of Wisconsin, primarily driven by the Impella 5.0 for left sided support, the TandemLife Protek Duo for right sided support, and various ECMO options for patients with more complicated presentations.



**Figure 3.** Transplant volumes in 2017 at FMLH have exceeded those of previous years, paving the way for CMS certification.

**FOR ADDITIONAL INFORMATION** on this topic, see references, visit [mcw.edu/surgery](http://mcw.edu/surgery), or contact Dr. Joyce, 414-955-6969, [djoyce@mcw.edu](mailto:djoyce@mcw.edu).

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# Robotic Cardiac Surgery at MCW: The Future is Now!



**GOYA RAIKAR, MD**

Associate Professor

Division of Cardiothoracic Surgery

The use of minimally invasive techniques has ushered in the advent of robotic cardiac surgical procedures. These alternatives to the standard median sternotomy incision became increasingly commonplace as advances in access and exposure, perfusion strategies, and myocardial protection were made. The advancement of these techniques led to the development of endoscopic visualization and instrumentation.<sup>1,2</sup> The benefits offered by robotic surgical systems include improved dexterity and degrees of freedom, tremor-free movements, ambidexterity, and the avoidance of the fulcrum effect that is intrinsic when using long-shaft endoscopic instruments. Operative visualization is vastly improved compared with direct vision and traditional videoscopes. Potential benefits to patients include less pain, shorter length of stay, improved cosmesis, and quicker return to preoperative level of functional activity.

In 1997, Dr. Alain Carpentier demonstrated the feasibility of the first robotically-assisted mitral valve repair in France.<sup>3</sup> This innovation led to completion of the first randomized trial headed by Dr. Randolph Chitwood in 2001,<sup>4</sup> and subsequent approval of the da Vinci® Surgical System for use in robotic cardiac surgical procedures. Robotically performed and assisted procedures have been adopted in all disciplines of surgery, including urological, gynecological and general surgery.

The adoption of robotic cardiac surgical procedures, including mitral valve repair, was much slower. This was due in part to the complexity of the operation, steep learning curve, and relative infrequency in the general practice of cardiac surgery. The current practice is limited to large volume groups and tertiary centers. In the U.S., only 3,429 cardiac surgical operations were performed last year (Intuitive Surgical industry data from 2017).

Uncorrected mitral valve regurgitation has deleterious effects on heart function and eventually leads to heart failure and decreased survival as compared to the patient's peers. There are several mid- to long-term results of robotic mitral valve repair suggesting that robotic repair offers less blood transfusion and higher rates of reparability of the



mitral valve (even for complex disease) with faster return to normal activities.<sup>5,6</sup> Correction of mitral regurgitation now has a class 2A indication for minimally invasive/robotic approaches, which is why it is paramount to offer patients this option as part of a comprehensive heart surgical valve team approach.<sup>7</sup>

The robotic cardiac program at MCW was started earlier in the spring of this year. Thus far, we have primarily performed robotic mitral valve repairs, but have also done robotically-assisted CABG and atrial fibrillation surgery. This has been accomplished by a comprehensive team of surgeons, assistants, cardiologists, cardiac anesthesiologists, and ICU and telemetry care teams. As we move forward to the future, we hope to add innovative techniques to improve the care of our complex cardiac patients. •

**FOR ADDITIONAL INFORMATION** on this topic, see references, visit [mcw.edu/surgery](http://mcw.edu/surgery) or contact Dr. Raikar, 414-955-7065, [graikar@mcw.edu](mailto:graikar@mcw.edu).

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# Medical Futility



**MARSHALL A. BECKMAN, MD**

Associate Professor  
Division of Trauma and Acute Care Surgery

I recently met with some of our residents to address a question about medical futility. There had been several cases that were presented at our Morbidity and Mortality Conference that invoked a conversation about this topic. First, the residents had a general question about how futility is defined. It is not a stretch to say that defining medical futility in a way that applies to all medical situations is a challenge. As I discussed this question with the residents, we settled on a definition that is commonly used: futility is when a medical intervention is unlikely to provide any benefit to a patient. Additionally, it is inconsistent with the patient's stated goals. The challenge develops when one considers the concept of benefit. Who decides what is beneficial? One person may think that surgery for a patient or set of circumstances is beneficial, and another person may claim that that same surgical intervention is futile. There are two main types of medical futility that are described:

1. Quantitative futility is when a medical intervention on a patient is very unlikely to be beneficial.
2. Qualitative futility is where the quality of benefit of a medical intervention is exceedingly poor.

Either may be considered when examining the question of medical futility, but there is no consensus in what the maximal or minimal mark is in determining quantitative futility or what defines qualitative futility.<sup>1</sup>

In questions of futility, further misunderstanding can be one of medical rationing. There are not unlimited medical resources; economic realities are concerns with any type of medical treatment. The bigger question is whether a particular intervention allows the patient to achieve her/his stated goals or provides any benefit to the patient.

Many times, cultural or religious backgrounds can influence the perceived benefit of a treatment. When I was a surgical resident, I did six months of my training in Exeter, England. There was a patient whom I was caring for in his mid-seventies; he was diabetic and had pneumonia. I felt that he would be best served in the ICU. When I spoke to the intensivist, I explained the situation and asked that the patient be transitioned to ICU care. He said that the patient could not come to the ICU because he was elderly, diabetic, and had pneumonia. In the view of the intensivist, the ICU treatment for that

man would have been futile. This was certainly different than what I had experienced in medical school and as a junior surgical trainee in the United States. This is further demonstrated in some religious traditions. For example, some Orthodox Jews reject the concept of death by brain criteria and hold to the traditional cardiopulmonary collapse standard of death.<sup>2</sup>

Back to the question of how a surgeon should handle a situation which they feel may be futile. Froedtert Hospital has a medical staff policy (MSP-4.1) that states:

- If, in the judgment of the attending physician and a staff consultant, life-sustaining medical treatment would be futile, the attending physician may write an order withholding or withdrawing the treatment after notifying the patient or the patient's surrogate(s). Appropriate palliative care measures should be instituted.
- A life-sustaining medical intervention should be considered "futile" if it cannot be expected to restore or maintain vital organ function or to achieve the expressed goals of the patient when decisional.

Further details are available in the Froedtert policy. Essentially, two attendings are needed to deem an intervention futile. After that occurs, three other things are needed. One, the treating service must inform the family that that treatment is not medically indicated. Two, the office of the Chief Medical Officer should be verbally notified. Three, documentation should be done in the medical record explaining facts relevant to the decision and what time the patient or surrogate decision maker was involved.

It is difficult to boil down futility into a policy consisting of three-four paragraphs. The American Medical Association has a position statement on Medically Ineffective Interventions, consisting of several points:

- Discuss with the patient (or the surrogate decision maker) the individual's goals for care.
- Reassure the patient (and/or surrogate) that medically appropriate interventions, including appropriate symptom management, will be continued unless the patient declines those interventions.
- Negotiate a mutually agreed-on plan of care consistent with the patient's goals and with sound clinical judgment.
- Consult the ethics committee if the patient requests care that is judged by the physician to be medically inappropriate.

**CONTINUED ON PAGE 7**

# MCW/Froedtert Military-Civilian Partnership



**TOM HOVE, MPO, MHA**  
Program Manager – “Joining Forces” Military-Civilian Partnership Program  
Comprehensive Injury Center



**MARC A. DE MOYA, MD**  
Associate Professor and Chief  
Division of Trauma and Acute Care Surgery

Last year, the Medical College of Wisconsin/Froedtert Trauma Center launched the Joining Forces program, a collaboration initiative with the Department of Defense (DoD), in support of the endeavor to achieve ZERO preventable deaths from injury, whether in the community or on the battlefield. The program is administered through the Comprehensive Injury Center (CIC) at MCW, but is supported by the Departments of Surgery, Emergency Medicine, Orthopedics, Anesthesiology, and Neurosurgery. Dr. Marc de Moya and Dr. David Milia from the Division of Acute Care and Trauma Surgery, Dr. David Gourlay from the Division of Pediatric Surgery, and Dr. Stephen Hargarten from Emergency Medicine and the CIC are leading this initiative. The MCW/Froedtert Trauma Center is among a handful of programs nationally to galvanize this partnership.

The Joining Forces program has four core aims: Training & Education, Advancements in Clinical Care, Research, and Community Engagement. To date, the program has established a solid foundation in creating a nation-leading effort in DoD collaboration:

- Last December, the program held its first Annual Research Symposium at MCW. It was attended by more than 50 people from MCW, UW-Milwaukee, Marquette, and U.S. Senate offices, as well as various members of the military. Speakers from the US Air Force and the University of Alabama-

Birmingham both spoke of the benefits of the trauma skills-sustainment partnerships. The keynote speaker, Colonel Todd Rasmussen, MD, (USAF) from the Uniformed Services University of the Health Sciences, also spoke on the importance of these partnerships, as well as the National Security implications of

continued foundational and clinical research with the military. The symposium also included an opportunity for MCW researchers to showcase their work in front of this audience, which has led to a Division of Acute Care & Trauma Surgery faculty member submitting a grant proposal for funding from the DoD. The next annual symposium looks to expand upon the successes of the first.

- In December 2013, representatives from the Division of Acute Care and Trauma Surgery and the CIC traveled to Washington DC to meet with the offices of Senator Ron Johnson and Senator Tammy Baldwin, to drum up support for the MISSION ZERO Act, which would provide grants to institutions who embed active duty military providers for skills sustainment programs. The bill has since passed both the US House of Representatives and the Senate Committee on Health, Education, Labor & Pensions. It has not yet been discussed on the Senate floor.
- The program is currently finalizing an agreement with the US Army Special Operations Command (USASOC) which, starting this fall, would allow Special Operations Combat Medics to participate in 4-week trauma and emergency medicine-oriented clinical rotations at Froedtert Hospital and Children’s Hospital of Wisconsin. The program is also looking to launch an innovative pilot program with USASOC in early 2019, which provides 4-week trauma & emergency medicine clinical rotations for physicians and physician assistants assigned to Special Operations Units, but who may or may not have a specialization or extensive experience in those fields. Finally, the Milwaukee Regional Medical Campus is projected to be selected as a trauma skills sustainment platform site for an Army Forward Resuscitative Surgical Team. This team, consisting of a General Surgeon, an Emergency Medicine physician or Orthopedic surgeon, an Emergency Medicine nurse, Critical Care nurse, or a Med-Surg nurse, and a CRNA, would embed for up to three years, providing direct patient care and functioning as adjunct faculty and staff within Froedtert Hospital and Children’s Hospital of Wisconsin.





Moving forward, the Joining Forces Program will continue to work to solidify these partnerships, while seeking other opportunities for DoD collaboration in research or clinical practice. •

**FOR ADDITIONAL INFORMATION** on this topic, see references, visit [mcw.edu/surgery](http://mcw.edu/surgery), or contact Dr. de Moya, 414-955-1734, [mdemoya@mcw.edu](mailto:mdemoya@mcw.edu).

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## FUTILITY: CONTINUED FROM PAGE 5

- In the rare event that the disagreement cannot be solved, transfer to another physician or facility can be initiated.<sup>3</sup>

Froedtert Hospital has taken these principles and placed them into their policy. It does not eliminate the challenges of the futility discussion, but gives a framework to follow. Please do not hesitate to involve the ethics consultation team for help with these critical issues.

**FOR ADDITIONAL INFORMATION** on this topic, see references, visit [mcw.edu/surgery](http://mcw.edu/surgery), or contact Dr. Beckman, 414-955-1732, [mbeckman@mcw.edu](mailto:mbeckman@mcw.edu).

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Check us out on YouTube:

# MCW Medical Moments

MCW Medical Moments features videos from medical experts within the Medical College of Wisconsin Department of Surgery. These videos highlight and discuss a variety of individual disease processes, from diagnosis to treatment.

# MCW Department of Surgery Awarded for Outstanding



**DAVID J. MILIA, MD**  
Associate Professor  
Division of Trauma and Acute Care Surgery



**JACOB R. PESCHMAN, MD**  
Assistant Professor  
Division of Trauma and Acute Care Surgery

On April 21, 2018, the Department of Surgery at the Medical College of Wisconsin was presented with the Seven Seals Award by the Wisconsin Committee for Employer Support of the Guard and Reserve (ESGR) for its outstanding and ongoing support of members of the United States Armed Forces Reserve component. The ESGR is a program that was established by the US Department of Defense in 1972, with the purpose of promoting cooperation and understanding between uniformed Service members of the National Guard and Reserves component and their civilian employers.

The ESGR's mission is to develop and promote "supportive work environments for Service members in the Reserve Components through outreach, recognition, and educational opportunities that increase awareness of applicable laws, and resolves employment conflicts between the Service members



LCDR Peschman leading Operational Readiness Training Exercises at Expeditionary Medical Facility Djibouti in 2018.

and their employers". In order to recognize the commitment, support, and sacrifice that civilian employers provide to Service members and their families, the ESGR has established a series of awards to recognize individuals or organizations.

The Department of Surgery was a nominee for the Secretary of Defense Employer Support Freedom Award, which is the highest recognition given by the US Government to recognize outstanding employer support of employees who serve in the Guard and Reserves. The Department was ultimately awarded the Seven Seals Award, which is given after selection by the ESGR's State Chair or Senior Leadership Counsel to recognize significant organizational achievement, initiative, or support that promotes and supports the ESGR mission. In the nomination, Dr. Douglas Evans, Chair, and the Department of Surgery were specifically acknowledged for going "above and beyond in supporting faculty members who also serve as surgeons in the US Armed Forces. With multiple reservists in the Department, significant effort is made to allow flexibility in our scheduling to allow for mobilizations, drills and annual training (AT). This includes optimizing work schedules so vacation or sick leave is never required for drills or AT, and fostering a culture of appreciation for military members so that other faculty members gladly step up to cover calls, services, and other work requirements to allow reservists to meet their obligations. Additionally, our Department supports the hiring of temporary replacements for military members on 6 month+ deployments even while supporting the salary of the deployed member." In addition, Dr. John Weigelt, Professor in the Department of Surgery, was awarded the Patriot Award at his retirement Festschrift last November to honor his personal efforts in support of service members during his time as the Chief of the Division of Trauma and Acute Care Surgery.

These awards not only honor the commitment of the Department of Surgery as a whole to the military, but reflect the sacrifices of the five members of the Department currently serving in the Reserve Forces. Commander Tom Carver (Associate Professor, Trauma and Acute Care Surgery) and Lieutenant Commander Jake Peschman (Assistant Professor, Trauma and Acute Care Surgery) have served the Navy on multiple deployments, including to Afghanistan, Africa, and aboard Naval vessels. Colonel Lewis Somberg (Professor, Trauma and Acute Care Surgery), Colonel David Gourlay (Professor and Chief, Pediatric Surgery), and Lieutenant Colonel David Milia (Associate Professor, Trauma and Acute Care Surgery) have served on the Army side and have been deployed to Iraq, Afghanistan, and Kosovo. For his 28 years in military service, COL Lewis Somberg was recently recognized with the Military's prestigious Legion of Merit Award. The Legion of Merit (LOM) is given for exceptionally meritorious conduct in the performance of outstanding services and achievements. The LOM is sixth in order of precedence of all US Military awards, and is typically awarded to senior officers in



# ing Military Commitment

their respective services. COL Somberg has had numerous forward deployments, including Afghanistan and Iraq, and has commanded several medical units during his prestigious career. •

**FOR ADDITIONAL INFORMATION** on this topic see references, visit [mcw.edu/surgery](http://mcw.edu/surgery), or contact Dr. Milia, 414-955-1732, [dmilia@mcw.edu](mailto:dmilia@mcw.edu).



COL (RET) Somberg, LTC Milia and COL Gourlay at Forward Operating Base Shank in Logar Province, Afghanistan (2012).



CDR Carver (front left) and the Naval Medical Team outside Expeditionary Medical Facility Djibouti in 2016.

## WELCOME CHIEF RESIDENTS

The MCW Department of Surgery welcomes the incoming 2018–2019 Surgery Chief Residents:



Justin Dux, MD



Nathan Kugler, MD



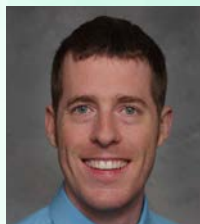
Rachel Landisch, MD



Gregory Larrieux, MD



Stephen Masnyj, MD



Robert McMillan, MD

## American College of Surgeons Clinical Congress Boston, MA | Oct. 22, 2018

Plan to join us on Monday, October 22, 2018 at the MCW Department of Surgery/ Marquette Medical Alumni Association reception during the American College of Surgeons 104th Annual Clinical Congress.

The reception will be held 6:00 p.m. to 8:00 p.m. at The Boston College Club, 100 Federal Street, 36th Floor.

# Well-Being and Resilience in Surgery



**Christopher S. Davis, MD, MPH**  
Assistant Professor  
Division of Trauma and Acute Care Surgery

In September 2016, our Department heard Dr. Steven Stain’s Grand Rounds presentation on “Duty Hours, Professionalism, and the Clinical Learning Environment.” Dr. Stain discussed various avenues to improve resident well-being, and the concerns over the persistently high rate of suicide amongst residents of all specialties. With optimism, I can report that both the Department of Surgery and the Medical College of Wisconsin (MCW) are taking strides to address the issues of well-being and suicidality for students, residents, and faculty alike. One example is the MCW Surgery Resident Well-Being and Resilience Committee our Department has formalized. Entities such as the Office of Faculty Affairs, Graduate Medical Education, and the Robert D. and Patricia E. Kern Institute for the Transformation of Medical Education have formed robust working groups and dedicated measurable resources to researching and improving clinician well-being, as well as the clinical learning environment across our campus. Yet, as eluded to by Dr. Cochran’s recent presentation on disruptive surgeon behavior, improving culture is a constant endeavor. From my own work, I have come to understand that the way forward involves honesty, understanding, introspection, and diligence. To these ends I share with you my own story and provide an up-to-date appraisal of Well-Being and Resilience in Surgery.

Just prior to Dr. Stain’s visit, my wife and I had been reflecting and taking a deep breath following our nine-year journey through training, research, and fellowship. We sadly recalled the colleagues-in-training who over the years had required inpatient psychiatric admission for suicidal ideation or died tragically in automobile collisions visiting children out-of-state or while dealing with marital discord. We also recounted our own private and personal struggles, and how difficult these were to tackle within the typical confines of general surgery training. I share my experience because all of us can relate in

some way, if not in the least regarding those who have taken their own lives.

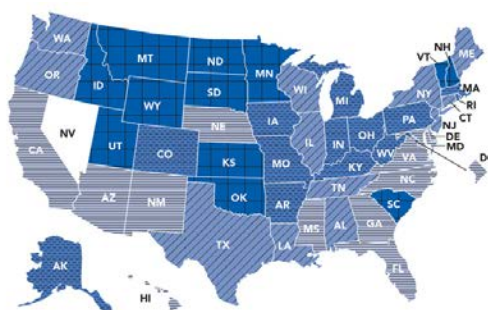
As a society, we have to some degree come to ignore and even normalize the rising rates of suicide. Concurrent to the recent celebrity deaths of Kate Spade and Anthony Bourdain, the Centers for Disease Control and Prevention reported that the national rate of suicide is up 30% since 1999, and that greater than half of those who die by suicide have no known history of a mental health disorder (Figure 1).<sup>1</sup> How this translates to medicine and our unique world in surgery remains unclear. However, it is a fact that the rate of suicide amongst physicians is twice that of the general population (NAM) (Figure 2).<sup>2</sup> Furthermore, the rate of suicidal ideation among surgeons aged 45-54 years is 1.5 to 3 times higher than the general population. This is concerning because these individuals typically have associative factors that should reduce their risk of SI, such as being educated, married and employed.<sup>3</sup> These data indicate that depression and suicidality apply to all of us in surgery, and that from top to bottom we are all in the battle “to get better” together.

The basic essence of the problem is not unfamiliar. Whether before, during, or after training, we traditionally plough ahead with our blinders on, work our hours, say little, and try to be “productive” so that we may proudly say that we “made it.” Along the way, we have historically worn our long hours and passing out in hallways from exhaustion as a badge of honor. On the other end, even mild dissent to this inhumanity has been traditionally met with the ever-present echo, which rings: “Well, back in my day…” At its core, this historical environment is destructive to the spirit of the individual. It has created barriers to trust and communication, and the historical rift on either side of the aisle between student, resident, and attending is that “he/she does not get it.” There is often then a regression into further isolation, which we know is dangerous, as loneliness in and of itself may be as lethal as smoking 15 cigarettes a day.<sup>4</sup>

Of course, everyone is entitled to their opinion about what medicine used to be, what medicine is today, and what medicine should be. Yet, it is easy to get lost in the business of medicine. My wife often reminds me that medicine is about the relational nature between people and not the transactional one it has become in some environments. Moreover, medicine is about the relationships we choose to form, and not the ones we are made to partake simply to satisfy a status quo. Further still, medicine is about forming relationships based on values shared, where greater cohesion can be created through a common purpose and vision. Just as it takes a village to raise a family, it too takes a village to remain grounded amongst all the noise. And believe me, there is no shortage of noise in our particular work environment.

So, if there is so much noise, then the question remains: what takes us beyond the status quo and soul-numbing stream

Suicide rates rose across the US from 1999 to 2016.



SOURCE: CDC's National Vital Statistics System; CDC Vital Signs, June 2018.

**Figure 1.** Rates of suicide in the United States, 1999-2016.

of survey-driven data with often embarrassingly low response rates to ideas that truly change the culture of well-being and resilience in surgery? Answering this question is “True North,” and not just for us in surgery, but across all specialties. According to the National Academies of Medicine (NAM), which has recently formed an Action Collaborative on Clinician Well-Being and Resilience, we must move past the social hierarchies in medicine so that we can begin to see each other with dignity and respect for who we are as people, rather than from some preconceived notion dependent upon how hard we work, where we come from, where we were educated/trained, and whether or not we are perceived to be “accomplished.”<sup>5</sup> Seemingly, the doctrine of historical American medical education and training has created this conception, and we in surgery are the flag-bearers.

As surgeons-in-training (and as surgeons-trained), we are often neglectful of innumerable family events and even the normalcy of life. As noticeably, we are oftentimes neglectful of one another as colleagues. Just as much as it is gross negligence to ignore a patient’s illness, so too is it grossly negligent to not take care of one another, particularly our residents and students, who are the true future of our profession. Though the 80-hour work week is in effect, it does not alleviate the many contemporary stressors facing the current generation of surgical trainees, nor does it address the many who come from unique and difficult backgrounds.<sup>6</sup> Indeed, many have crossed oceans to train, giving up all they know to chase a dream only to be forgotten by a system that typically lacks adequate resources and people to capture the essence of who they are as individuals. Without coincidence, minorities (and women) in surgery have higher attrition rates.<sup>7</sup> And while medical schools and residencies claim they want well-roundedness, the question remains if all populations are adequately represented across academic medicine. Without adequate representation, various cultures will remain stagnant, and we will not regain the ability to connect with others on a personal level, maintain a supportive work environment, and enhance what we truly value in our profession – all of which are key facets to improving clinician well-being.<sup>8</sup>

Finally, it is crucial to understand that burnout is not merely a buzzword. More than half of physicians are affected by emotional exhaustion, depersonalization, and a low-sense of professional accomplishment.<sup>8</sup> Of course, this leads to reduced job performance, high job turnover, medical errors, and suicide.<sup>8</sup> Importantly, reducing the impact of burnout transcends all aspects of American medicine, from the medical student to the highest ranks of leadership. The tipping point has come, and evidence-based approaches to improving the culture of well-being across entire organizations is at hand. As with any campus, there is undoubtedly much work to be done. As for the Department of Surgery, we are well-positioned to be leaders in this endeavor at the Medical College

of Wisconsin, and we will partner with recent commitments from the Dean’s Office and the ingenuity of the Robert D. and Patricia E. Kern Institute for the Transformation of Medical Education in resolve to do so.<sup>9,10</sup> •



**Figure 2**

**FOR ADDITIONAL INFORMATION** on this topic see references, visit [mcw.edu/surgery](http://mcw.edu/surgery), or contact Dr. Davis, 414-955-1731, [chdavis@mcw.edu](mailto:chdavis@mcw.edu).

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# High Voltage for Cancer Research

By: Meg M. Bilicki, Director of Development for the Department of Surgery

Raising money for cancer research has never been this loud, or cold. After more than 30 years, Ron Brefka brought a historic ice-racing event back to Milwaukee. Several thousand people attended the Winterval Classic Ice-Race Championship on January 14, 2018 as part of the High Voltage Motorcycle Ice Races on the lagoon at Wilson Park. The 2019 event will be held on January 13 at Wilson Park—*mark your calendars!*

Ron Brefka has been battling the effects of pancreatic cancer since 2014. Most of the planning of this event happened from Ron's hospital bed. "The whole idea was for everyone to come out and have some fun and enjoy the race. I am a cancer survivor, so the High Voltage show is a fundraiser for pancreatic cancer research," says Ron.

Susan Tsai, MD, MHS, Associate Professor, Division of Surgical Oncology, and her team successfully completed the world's first personalized medicine trial for patients with localized pancreatic cancer. "Ron's personal participation in this clinical trial, and the financial support from High Voltage are helping to change the future for patients with pancreatic cancer," says Dr. Tsai. "The physicians and scientists at MCW are in pursuit of effective therapies for patients with pancreatic cancer, and our goal is to deliver personalized therapies to each patient by transforming conventional chemotherapy into targeted chemotherapy." While not every patient can participate in a clinical trial, most patients are eager to contribute to research by donating blood or tissue.



Photo: Chris McMorrow

2018 High Voltage Motorcycle Races



Ron comes up with some amazing fundraising ideas and his good friend Chris McMorrow turn them into reality – all to support cancer research. Ron and Chris' recent adventure, the High Voltage Motorcycle and Chopper Block Party, was held September 8th at Humbolt Park and featured over 200 vintage motorcycles and choppers, bands, bikes, food and tons of raffle prizes raised funds for the We Care Fund for pancreatic cancer at the Medical College of Wisconsin.

If you are interested in learning more about upcoming events, you can visit the High Voltage Facebook page at <https://www.facebook.com/highvoltage/> or contact Meg Bilicki at (414) 955-1841 or [mbilicki@mcw.edu](mailto:mbilicki@mcw.edu). •

## Maximizing Your Giving: Capital Gains Tax Is Optional

By: Robert L. Vrakas, CPA

If you use appreciated assets held more than a year to make significant charitable gifts you can generally deduct the fair market value for tax purposes and avoid capital tax on the appreciation. Common stock is often used for this purpose, but you can also use other appreciated assets.

Assume you bought XYZ stock for \$10,000 and it's now worth \$15,000. You want to make a gift to a worthy, qualified nonprofit organization, like Froedtert & Medical College of Wisconsin. Donate the security and take an income tax deduction of \$15,000. The \$5,000 gain is not taxable. I have used this device many times, and I always smile on my way to the post office to mail my tax returns.

If you have stock that has diminished in value it would generally be better to sell the stock, take a loss on it, and donate the proceeds. This is a very easy process. Your broker can make the transfer in very little time.

Gifts of appreciated assets can also be made with art work, vintage automobiles, real estate or other assets that have gone up in value. Stocks are generally the easiest since they are valued daily and traded on the various stock exchanges. Other assets may require a specific valuation.

You should always discuss gifts of appreciated securities with your tax advisor. It's easy and it's a wise use of your assets. I recently used this concept to make a life-changing gift to Froedtert & Medical College of Wisconsin. You can do the same.

For more information on how you can use appreciated assets to make a life-changing gift to Froedtert & Medical College of Wisconsin contact Stephen Davis at (414) 805-3308 or [smdavis@mcw.edu](mailto:smdavis@mcw.edu). You can also visit [mcw.edu/legacy](http://mcw.edu/legacy). •

## HONORS AND AWARDS

### Dr. Tina Yen Elected President-Elect of CSA



Tina W.F. Yen, MD, MS, was elected President-Elect of the Central Surgical Association (CSA) at the recent 75th annual CSA meeting in March 2018. She will serve as President-Elect from 2018 to 2019. The following year, she will serve as CSA President and deliver her Presidential Address

at the CSA meeting in 2020 here in Milwaukee (MCW was selected as host for the 2020 meeting). This regional surgical society was founded in 1940 with the purpose to “further the practice of surgery in its various departments, and the study and investigation of surgical problems.” Dr. Yen was the recipient of the CSA’s Best Paper by a New Member Award in 2008 and has served as member and Chair of the Program Committee, a 3-year term as Recorder, and a 6-year term as CSA’s representative to the American College of Surgeons’ Advisory Council for General Surgery, where she served as Vice Chair from 2015-2017.

### Alpha Omega Alpha Honor Medical Society

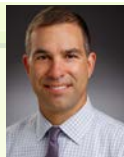


Dr. Amanda Kong and Dr. Andrew Kastenmeier were inducted into the Alpha Omega Alpha Honor Medical Society through the Medical College of Wisconsin in May 2018. They were the only two inductees. Induction into this society



is representative of a lifelong commitment to scholarship, leadership, professionalism, and service. This is an incredible honor for the Department of Surgery, and we congratulate them for all their hard work and dedication!

### Recent ACS Appointment for Dr. Jon Gould



Dr. Gould was recently appointed as the Central Surgical Association’s representative to the American College of Surgeons (ACS) Board of Governors. The ACS is the world’s largest professional scientific and educational association

of surgeons, with more than 80,000 members. Governors represent these 80,000 members and are responsible for communication between the general membership and the Board of Regents.

### Dr. Jon Gould Recipient of the 2018 Thomas L. Smallwood Award for Clinical Excellence

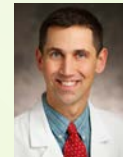


Jon Gould, MD, was recently awarded the highest honor in clinical medicine on this campus in receiving the Smallwood Award. Dr. Gould is currently Vice Chair for Quality, Chief of the Division of General Surgery, and Senior Medical Director of

Clinical Operations at Froedtert Hospital. He is an internationally renowned minimally invasive and foregut surgeon. The Smallwood Award is presented annually by the Froedtert Hospital Board of Directors and Medical Executive Committee to one MCW faculty member in recognition of outstanding contributions to the care of patients at Froedtert Hospital.

### 2018 Eberbach Award Winners

The Eberbach Banquet is held every year to honor Department of Surgery graduating residents and fellows and recognize outstanding faculty and resident educators. At this year’s banquet, held June 23 at the InterContinental Milwaukee hotel,



Brian Lewis, MD (Division of Vascular Surgery), received the Golden Cane Award for the third time. Established in 1987, the Golden Cane Award recognizes an outstanding educator, as chosen by junior and senior medical students.



Jeremy Juern, MD (Division of Trauma/ACS), was selected by current surgery residents as the recipient of this year’s Professionalism Award. This award, established in 2005, is presented to the faculty member who best exemplifies outstanding professionalism.



Established in 1986, the Aprehamian Faculty Teaching Awards are selected by the graduating chief residents, recognizing two outstanding faculty teachers (one from the full-time academic faculty, and one from an affiliated institution). Both of



this year’s winners are first-time recipients of the award: Ashley Cayo-Kappes, MD (Aurora Grafton), and Thomas Carver, MD (Division of Trauma/ACS). Congratulations and thank you to these devoted educators for their dedication and contribution to the education and training of our medical students and residents.

**CONTINUED ON PAGE 14**



# Leading the Way

CONTINUED FROM PAGE 13

## RESIDENTS and PHYSICIAN ASSISTANT HONORED

Multiple resident awards were given throughout the evening. The Barney Becker Award, given to the outstanding resident teacher of the year as chosen by senior medical students, was awarded to **Justin Dux, MD. Tanner Spees, MD**, was the recipient of the Robert E. Condon Golden Scalpel Award. This award, chosen by surgery faculty, is awarded to a graduating resident for outstanding technical ability. Outstanding ability in a junior resident is recognized and chosen by the graduating chief residents with the Junior Resident of the Year Award, nicknamed the Iron Dog. This year's Iron Dog recipient was **Ashley Krepline, MD**. The John Just Award is awarded to a Clinical Third Year Resident to consider Thoracic Surgery by providing funds for an off-campus didactic session. This year's John Just Award recipient is **Michael Cain, MD**. Graduating residents also chose **Dave Herrmann, PharmD**, to receive the Physician Extender Award. Residents who scored the highest on the American Board of Surgery In-Training Exam were also recognized – **K. Hope Wilkinson, MD** (junior resident), and **Charlie Fehring, MD** (senior resident). The James R. Wallace, MD, PhD Award for Minimally Invasive Surgery is given to the chief resident who has achieved the highest level of technical skill in minimally invasive surgery. This award was presented to **Dan Davila, MD**. •

## NEW FACULTY

### TRANSPLANT SURGERY



**Motaz A. Selim, MBBCh, MSc, MD**, was recently appointed Assistant Professor of Surgery upon completing fellowship training in abdominal organ

transplant surgery and research in the Division of Transplant Surgery. Prior to joining MCW, Dr. Selim was a Lecturer in Vascular and General Surgery with the Kasr Al Ainy Faculty of Medicine at Cairo University in Egypt. He also did a clinical abdominal organ transplant surgery fellowship at Mount Sinai Medical Center in New York and a clinical fellowship in vascular surgery at the Texas Heart Institute at Baylor College of Medicine in Houston. Dr. Selim completed medical school and surgery residency training at Kasr Al Ainy Medical School in Cairo. He will provide clinical care of patients on the transplant surgery service at Froedtert Hospital and Children's Hospital of Wisconsin, including liver, kidney and pancreas transplantation and vascular access for hemodialysis.

### RESEARCH



**Angela J. Mathison, PhD**, Assistant Professor of Surgery, joined the MCW Department of Surgery in August from the MCW Genomic Sciences

and Precision Medicine Center where she is the Technology Development Director. Prior to joining MCW in 2017, Dr. Mathison was a Research Scientist in the Epigenetics and Chromatin Dynamics Lab at the Mayo Clinic in Rochester. She obtained her PhD degree in Cellular and Molecular Biology at the University of Wisconsin in Madison with a thesis focused on the host response to the intracellular pathogen *Brucella*. Other research experience was acquired during her time as an undergraduate in the Department of Chemistry at the University of Minnesota-Twin Cities and at the University of Wisconsin-River

Falls. Dr. Mathison's research focuses on the role epigenetics in the development and progression of pancreatic cancer and the potential to target these cellular mechanisms for novel therapies.



### TRAUMA AND ACUTE CARE SURGERY

**Jill R. Streams, MD**, Assistant Professor of Surgery, joined us in September after completing

a Trauma Surgery and Surgical Critical Care fellowship at Vanderbilt University Medical Center. She earned her medical degree at Vanderbilt University School of Medicine and completed general surgery residency training at Northwestern University McGaw Medical Center, including a two-year research fellowship in the NIH T32 Vascular Surgery Scientist Training Program. Dr. Streams will provide clinical care of patients on the Trauma, Acute Care Surgery, and Critical Care services.



**Colleen Trevino, MSN, FNP, PhD**, was recently appointed Assistant Professor in the Department of Surgery. Dr.

Trevino received her PhD in Nursing from the University of Wisconsin – Milwaukee, where she also completed a Master of Science in the Nursing Family Practitioner Track and an undergraduate degree in nursing. She recently completed a two-year term as Assistant Director of Advanced Practice Providers for the Medical College Physicians. Dr. Trevino has conducted extensive research in the area of pain management in traumatically injured patients. She is currently investigating the transition of acute traumatic pain to chronic pain and the prescribing practices of trauma providers in relation to opioid misuse and validation of an opioid abuse risk screening tool. In addition to her research, Dr. Trevino provides clinical care of patients on the Trauma and Acute Care Surgery services, in both the inpatient and outpatient settings. •



# THE MEDICAL COLLEGE OF WISCONSIN DEPARTMENT OF SURGERY

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### **Bariatric and Minimally Invasive Surgery**

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### **Chief Surgical Residents**

(2018–2019)  
Justin Dux, MD  
Nathan Kugler, MD  
Gregory Larrieux, MD  
Rachel Landisch, MD  
Stephen Masnyj, MD  
Robert McMillan, MD

\* Participates in Community Surgery/Off-campus locations.

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## MARK YOUR CALENDARS

### Upcoming Events

**NOVEMBER 9: Breast Care 101: What You Need To Know** – Four Points by Sheraton Milwaukee North Shore, Milwaukee

**DECEMBER 1: Updates in General Surgery Symposium** – MCW-Green Bay Campus

**JANUARY 25, 2019: MCW Pancreatic Cancer Clinical Symposium**  
—Harley-Davidson Museum, Milwaukee

**MARCH 13, 2019: Peter Allen, MD, Ellison Visiting Professor**

**MAY 15, 2019: Ronald Dahlman, MD, FACS, FAHA, Towne Visiting Professor**

**JUNE 3-5, 2019: Acute Care Surgery Symposium/Lunda Visiting Professor, Hasan Alam, MD**

We now offer ABMS MOC Part 2 Self-Assessment credit for our Grand Rounds Lectures. Email [surgeryevents@mcw.edu](mailto:surgeryevents@mcw.edu) for more info. Please contact Heidi Brittnacher ([surgeryevents@mcw.edu](mailto:surgeryevents@mcw.edu)) for more information on any of these events.

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- Transplant Surgery
- Trauma/ACS
- Vascular Surgery

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Editors:

*Rana Higgins, MD*

*Heidi Brittnacher, 414-955-1831 or  
[hbrittna@mcw.edu](mailto:hbrittna@mcw.edu)*

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**To refer a patient or request a transfer/consultation, please use the references below:**

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##### All non-cancer requests

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Transfers/Consultations:

877-804-4700

[mcw.edu/surgery](http://mcw.edu/surgery)

##### Clinical Cancer Center

Referrals: 866-680-0505

Transfers/Consultations:

877-804-4700

#### PEDIATRIC PATIENTS

Referrals/Transfers/

Consultations: 800-266-0366

Acute Care Surgery:

414-266-7858