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Leading the Way

MEDICAL COLLEGE OF WISCONSIN

DEPARTMENT OF SURGERY

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From the Chair | Douglas B. Evans, MD

For the last few years in late winter/spring, we have devoted a "Word on Medicine" radio show to "coming out of hibernation." This year's show focused on orthopedic injuries with Dr. Anthony LoGiudice and Tori Mayo, your heart with Drs. Jacquelyn Kulinski and Stacey Gardiner, and eating healthy with Dr. Kate Glasenapp and Amy Kulwicki. It was a great show and is available on podcast. In the final segment of the show, I provided a couple thoughts on work-life balance which I have reproduced here as we head into summer, a time when the "life" part of the balance is particularly important to all of us:

Henry Ford usually receives credit for the 40-hour work week after he discovered that his workers were more productive working shorter hours. The 40-hour work week was soon adopted by manufacturing companies around the world. This was a huge change from the Industrial Revolution where it was common to work 60-70 hours each week. In the last few decades, the technology revolution, namely email and then text messaging, has redefined the workday from Dolly Parton's "9 to 5" to an overpowering 24/7. It appears that history is repeating itself once again - almost as though we are returning to the hours of the industrial revolution, just not in a factory for most of us. The term "work-life balance" came into use in the 1980s, as baby boomers attempted to find a balance between career, family and their personal lives. This idea really caught fire with the Gen Xers, and for millennials, work-life balance is a key part of many career decisions. Everyone has their own special formula – some have eliminated all job-related activities on weekends, some disconnect completely on a week or two of vacation, and the list goes on.

In medicine, it is of course potentially more complicated as we all get sick at night and on weekends as well as during the day. I raised this issue with Brewer's manager Craig Counsell last summer at the Central Surgical Association meeting held here in Milwaukee. We had the opportunity to talk with Craig about life, leadership and baseball, and the comparison of medicine to baseball became a topic of discussion. When in season, Craig is connected 24/7 – like many of us in healthcare. I asked him to comment on this, especially with respect to work-life balance and his family. He went on to talk about how baseball was responsible for his career; it has brought so many good things to him and his family, and it is part of their life. He did not view his job in conflict with his other responsibilities as a husband and father. His work was an integral part of his/their life, there was no conflict – an interesting and perhaps healthy perspective that we may want to add to "coming out of hibernation" as we head into summer. Go Brewers, and enjoy the excellent articles in this edition of "Leading the Way."

Figure 1: From left to right: Dr. Douglas B. Evans, Roger Caplinger, Craig Counsell at the Central Surgical Association 79th Annual Meeting.

In this issue:

MCW Surgery
knowledge changing & saving life

Original *Leading the Way* Article

Better Together: Enabling Partnership Between Healthcare Providers and the Community

M. Muska Nataliansyah, PhD, MD, MPH
Assistant Professor, Surgical Oncology
Implementation Scientist, Collaborative for Healthcare Delivery Science

Susan Tsai, MD, MHS
Professor, Surgical Oncology
Director, LaBahn Pancreatic Cancer Program
Chief of Hepatopancreaticobiliary Surgery, Clement J. Zablocki VA Medical Center

Studies have shown that the community can impact the health of individuals.[1] Providers encounter patients at various points in their lives wherein their health may be significantly impacted by current and prior environmental and socioeconomic conditions.[2,3] Social determinants of health (SDH) are insightful proxies that can help healthcare providers to identify health risks and formulate plans to facilitate quality surgical care. There are five domains of SDH that may affect people's health, well-being, and quality of life: (1) Economic stability; (2) Education access and quality; (3) Healthcare access and quality; (4) Neighborhood and built environment; (5) Social and community context.[4] As the healthcare delivery model shifts toward patient-centered care, understanding a patients' community may facilitate the delivery of effective and comprehensive care. Indeed, hospitals can have dual roles as providers of healthcare services and health influencers in their communities.[5]

Enhancing the health of our community can be achieved through community engagement and partnering with public and private organizations. Insights gathered from discussions with community stakeholders may focus efforts to address the relevant health issues. We applied this approach when developing our community health activity last November, the Shawnee Daniels-Sykes' Sharing Insights on Cancer Care (SHINE) event (Figure 1). The late Dr. Daniels-Sykes, a Professor of Theology and Ethics at Mount Mary University, initiated this community event. The purpose is to raise awareness about the five most common cancers affecting Wisconsinites: pancreatic, breast, colon, lung, and prostate cancers. As a person with stage IV pancreatic cancer, her experience with cancer and the complexities of receiving care sparked the idea of creating a community-based cancer awareness event.

We embraced and developed the idea together in collaboration with her faith organization, the Archdiocese of Milwaukee. We also partnered with the MCW Clinical & Translational Science Institute of Southeast Milwaukee (CTSI) and the MCW Cancer Center Community Outreach and Engagement office to leverage their expertise in conducting similar events in the past. The joint efforts and intensive discussions prior to the event enabled us to determine relevant health talk topics for the community and the resources needed to conduct the program.

The daylong event takes a holistic approach, engaging

Topic	Presenter	Department/Division
Cancer Screening Guidelines & Surveillance	Ann Maguire, MD, MPH	Internal Medicine
Pancreatic Cancer	Kathleen Christians, MD	Surgical Oncology
Lung Cancer	Jonathan Thompson, MD, MS	Hematology & Medical Oncology
Colon Cancer: A Gastroenterologist's Perspective	Philip Chisholm, MD	Gastroenterology
Prostate Cancer	Kathryn Bylow, MD	Geriatric Medicine & Medical Oncology
Breast Cancer 101	Adrienne Cobb, MD, MS	Surgical Oncology
Eating Well to Prevent Cancer	Michele Derdzinski, RD, CD	Cancer Center
Eating Well to Prevent Chronic Disease	Andrea Moosreiner, MPH, RD, CD	Clinical & Translational Science Institute
Introduction to Clinical Trials	Ugwuji Maduekwe, MD, MMSc, MPH	Surgical Oncology
All of Us Research Program: Family History, Genetics, Lifestyle, Environment, and Cancer Risk	Jeffrey Whittle, MD, MPH	Internal Medicine
Access to Primary Care Clinic: Saturday Clinic for the Uninsured (SCU)	Rebecca Lundh, MD	Family Medicine
Holistic Health: Mind and Spirituality	Juliette Martin-Thomas, PhD	Psychologist - Community

Table 1. Topics and Presenters, Shawne Daniels-Sykes' Sharing Insights on Cancer Care (SHINE)

Figure 1: Kathleen Christians, MD, speaks at the SHINE event.

Figure 2: Adrienne Cobb, MD, MS, presents at SHINE.

spirit, mind, and body (Table 1). Interactive discussions facilitated by MCW specialists and healthcare professionals provide an overview of preventative screenings to increase awareness and understanding of these cancers. Furthermore, later sessions offer opportunities for attendees to hear about patient experiences and cancer prevention through lifestyle adjustments. With the support of community leaders, the one-day event reached over 70 attendees. We hope this local community engagement and collaboration experience will be the cornerstone of future community events and will cultivate a strong network of health advocates in the community.

The partnership between healthcare providers and the community is not only limited to organizing community events but can also be extended to a partnership in research. These activities can create a feedback loop informing one another – leading to the type of events and research that will be relevant and impactful for the community. The MCW Cancer Disparities Curriculum for Research and Community Scholars provides the opportunity for researchers at MCW to develop partnerships with community members to address complex health issues, such as cancer disparities.[6] It is also an effort to address the misunderstanding and mistrust, which are frequent barriers to effective community and academic partnerships. Through shared learning sessions and interactive discussions, the author has gained diverse and insightful perspectives regarding cancer care in Wisconsin communities. Specifically for the pancreatic cancer population, the author is currently working on a project with a community leader to assess pancreatic cancer care experience in the Milwaukee area. Findings will be applied to the development of a social media campaign toolkit to educate and motivate health behaviors that are relevant to improving pancreatic cancer care. This example shows the potential of community engagement in creating innovative solutions and improving health at the neighborhood level.

These promising avenues to improve patient care and community health need to be strategically explored. However, as an organization, our actions are shaped by multiple factors and the availability of resources. The organization and implementation science may provide some insights into explaining the complex dynamics and factors to consider moving forward.[7,8] Contingency theories explain how an organization's actions are contingent upon internal and external conditions, which shape the organization's development and structure.[9] Engaging the community we serve will provide us with the knowledge needed to provide comprehensive care for our patients. It will allow us to design a care delivery system that can connect patients in need with socioeconomic resources available in the community. Furthermore, the resource dependency theory explains how organizations network and associate with each other to acquire and maintain the autonomy and resources necessary to sustain themselves.[10] Our community will always look to us for medical expertise, and we need their insights to strategically expand our service and organization. Nurturing this reciprocal relationship may become the bedrock of a healthier community and a lasting organization.

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Nataliansyah at mnataliansyah@mcw.edu.

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Original *Leading the Way* Article

Thoracoscopy versus Thoracotomy for Esophageal Atresia and Tracheoesophageal Fistula: Outcomes from the Midwest Pediatric Surgery Consortium

John P. Marquart, MD
General Surgery Resident
Pediatric Surgery Research Fellow

Christina M. Bence, MD
Pediatric Surgery Fellow

Alexis N. Bowder, MD, MPH
General Surgery Resident

Dave R. Lal, MD, MPH
Professor, Pediatric Surgery

Esophageal Atresia (EA) with or without Tracheoesophageal Fistula (TEF) is a congenital anomaly historically repaired via thoracotomy. Over the past two decades, thoracoscopic repair of EA/TEF has increased, along with controversy surrounding its safety and efficacy.[1-3] Despite numerous studies, the optimal approach for repair of infants with EA/TEF remains ill-defined.[3-5] Therefore, we aimed to define the characteristics of infants undergoing thoracoscopy versus thoracotomy for repair of Type C EA/TEF (proximal EA with distal TEF), as a secondary analysis of two large multicenter studies.

We performed a secondary analysis of two multicenter databases of patients with Type C esophageal atresia/tracheoesophageal fistula (EA/TEF) undergoing repair.[6,7] Data from the combined cohorts yielded 504 patients who underwent Type C EA/TEF repair. Thoracotomy was utilized in 448 (89%) and thoracoscopy in 56 (11%). Patients undergoing thoracoscopic repair were more likely to be full term (P<0.001), have a greater weight (p<0.001), and significantly less likely to have complex congenital heart disease (p<0.001) than those undergoing thoracotomy.

The most common postoperative complication was the development of an anastomotic stricture within 1 year of EA repair. Strictures developed in 198 (44%) patients after thoracotomy and 29 (52%) after thoracoscopy (p=0.421). There was no difference in time from surgical repair to the development of the first anastomotic stricture by surgical approach (p=0.256) (Figure 1).

Regression analysis incorporating propensity score-based overlap weights showed no significant difference in the odds of vocal cord paresis/paralysis (OR 1.087 p=0.885), odds of anastomotic leak (1.683 p=0.123), the time to anastomotic stricture (HR 1.204 p=0.378),

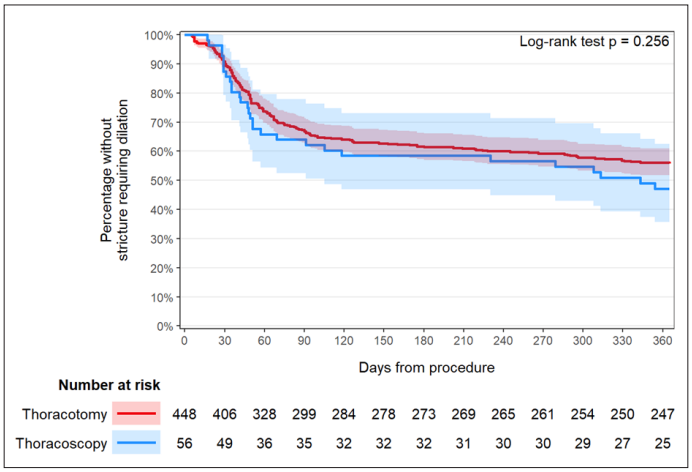

Figure 1: Time to first stricture

	Estimate	CI/Division	P value
Anastomotic Leak	OR 1.683	[0.869, 3.260]	0.123
Vocal Cord Paralysis	OR 1.087	[0.348, 3.395]	0.885
Time to Anastomotic Stricture	HR 1.204	[0.797, 1.820]	0.378
Number of Dilations in 1 year	IRR 1.182	[0.711, 1.965]	0.519

OR = Odds ratio, HR = Hazard ratio, IRR = Incidence rate ratio

Table 1: Propensity Score Overlap Weighted Analysis for Thoracoscopy vs Thoracotomy

or the number of dilations (IRR 1.182 p=0.519) between thoracoscopy and thoracotomy (Table 1).

Previous studies examining outcomes of thoracoscopy and thoracotomy for EA/TEF repair have been limited by their single institution and retrospective design.[3-5] There has been one randomized controlled trial involving 10 total patients with EA/TEF that demonstrated no differ-

ence in postoperative outcomes by surgical approach.[8] A recent systematic review with meta-analysis similarly found no difference in total complications (p=0.97) by surgical technique in infants with Type C EA/TEF.[4] However, there was a similar trend toward increased anastomotic strictures in the thoracoscopic cohort as compared to the thoracotomy group (OR 1.92 [0.93, 3.98], p=0.08) as demonstrated in our study. Additionally, there continue to be individual reports with worrisome results for a thoracoscopic approach.[1,2]

Our study found that surgeon selection bias influenced the approach offered for repair of infants with Type C EA/TEF. Infants undergoing thoracoscopic repair of Type C EA/TEF, tend to be healthier and with a lower rate of congenital heart disease as compared to those undergoing repair via thoracotomy. Adjusting for differences in measured covariates, we found equivalent rates of complications including anastomotic strictures, vocal cord paresis/paralysis, and leaks for repairs performed via thoracoscopy versus thoracotomy. However, our study may be underpowered to detect such outcome differences due to the small number of infants undergoing thoracoscopic repair.

The Division of Pediatric Surgery has a major interest in the management of infants with EA and TEF. Our decades of experience combined with our commitment to innovation and discovery will ensure that our patients of today and those of tomorrow receive the best possible operative repair.

For additional information on this topic, read the full study[9], visit mcw.edu/surgery, or contact Dr. Marquart at jmarquart@mcw.edu.

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MCW's Outstanding Medical Student Teachers for 2021-2022

M3 Surgery Clerkship Awardees

Faculty Awardees

Jed Calata, MD
Matthew Goldbatt, MD
Lyle Joyce, MD, PhD
Anai Kothari, MD, MS
Brian Lewis, MD

Resident & Fellow Awardees

Adhitya Ramamurthi, MD
Benjamin Seadler, MD
Wen Hui Tan, MD

M4 Surgical Rotation Awardees

Faculty Awardees

Thomas Carver, MD
Patrick Murphy, MD, MPH, MSc

Resident Awardee

Santiago Rolon, MD

Other Educational Achievements

Clinical Apprenticeship M1

Sophie Dream, MD

Ambulatory Community Oncology

Caitlin Patten, MD

Clincial & Translational Research Pathway

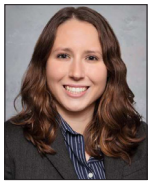
Timothy Ridolfi, MD, MS

Urban & Community Health Pathway

Jose Salazar Osuna, MD, PhD

Original *Leading the Way* Article

Allyship in Academic Surgery



Christina Georgeades, MD
General Surgery Research Resident

Chandler S. Cortina, MD, MS
Assistant Professor, Surgical Oncology

Callisia N. Clarke, MD, MS
Associate Professor, Surgical Oncology

Susan Tsai, MD, MHS
Professor, Surgical Oncology
Director, LaBahn Pancreatic Cancer Program
Chief of Hepatopancreaticobiliary Surgery,
Clement J. Zablocki VA Medical Center

Tracy S. Wang, MD, MPH
Professor, Surgical Oncology
Chief, Section of Endocrine Surgery
Vice-Chair of Strategic and Professional Development

Introduction

The word ally was first recorded in the mid-to-late 13th century, derived from the Latin term alligāre, 'to bind together, combine, unite'. Allyship is a more recent term, coined in the mid-1800s and first utilized in the context of social justice in the 1940s. Defined as "the status or role of a person who advocates and actively works for the inclusion of a marginalized or politicized group in all areas of society, not as a member of that group but in solidarity with its struggle and point of view and under its leadership," its use in the English language has increased by over 700% in published texts over the past decade, particularly since 2020.

As outlined in our 2022 Annual Report, the Department of Surgery's faculty, fellows, residents, and clinical and administrative staff are individuals with varied backgrounds and experiences and, equally importantly, serve a diverse patient population spanning the entire upper Midwest region. The provision of healthcare to such a diverse patient population is optimized not only with the presence of a representative workforce, but also with the support provided by proactive allyship.

Effective Allyship

An ally is an individual that endeavors to advance an inclusive culture through intentional efforts to benefit underrepresented minorities.[1,2] Being an ally starts with self-reflection but is then manifested by positive action to address barriers to equality and well-being (Figure 1). Importantly, allyship is not defined by the individual seeking to be an ally, but rather bestowed upon an individual from the underrepresented minority in acknowledgement of their advocacy. Every individual has the ability to be an ally in the workforce,[2] including in the field of surgery. However, it is crucial that words of support be backed by action to truly be helpful. Being an effective and proactive ally can take many forms, ranging from personal development to advocacy for organizational and systemic changes (Table 1).

The first step to becoming a better ally starts with personal reflection and education.[3] Taking the time to deepen one's understanding of the experience of underrepresented minorities through reading and listening is important for transforming one's perspective, and thus better recognizing disparities, microaggressions, and systematic biases.[2] Self-reflection on one's own privilege is a key exercise. Privilege is having an advantage over others in various aspects of life, such as - but not limited to - socially, physically, and financially. Having privilege does not mean that one's life experiences have not been challenging, rather that there may be unique opportunities that one has benefited from that others have not experienced. Conscious acknowledgement of privilege provides a means of using one's position to intentionally consider implicit biases and correct systemic inequalities.

On an interpersonal level, becoming a trusted confidant to individuals in underrepresented minorities by

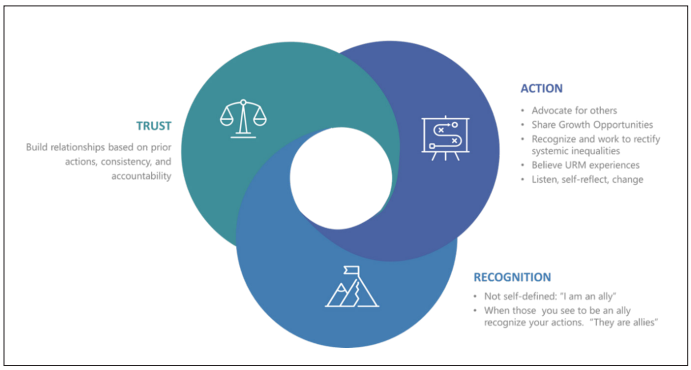


Figure 1: Allyship is a verb - key elements of being a proactive ally

Allyship Domains	Examples
Personal	Educate oneself Accept feedback Recognize own privilege
Interpersonal	Become a trusted confidant Do not be a bystander Support development and promotion
Organizational	Create an inclusive workplace Encourage diversity in hiring and recruitment practices Build a community of allies

Table 1. Methods of engaging in effective allyship[3]

listening, being empathetic, and believing their lived experiences can foster a relationship built on safety and empowerment.[3] Additionally, it is critically important to speak up and intervene when discriminatory behavior towards underrepresented minorities is witnessed.[2] Furthermore, intentional mentorship, coaching, and sponsorship of people from underrepresented minorities is another significant way to be an ally.[3]

On an organizational level, creating an inclusive department may require a systematic approach which starts with reflection of organizational goals and values and the development of a comprehensive strategy to recruit, retain, and promote underrepresented minorities. Intentional efforts to evaluate workforce diversity, promote an inclusive and supportive environment, and dismantle biased organizational policies are key elements. Oftentimes, individuals from underrepresented minorities carry a heavier burden for organizational responsibilities that do not directly result in academic productivity. The so-called "minority tax" may involve increased commitments for committee work and mentorship. One strategy to promote diversity, equity, and inclusion (DEI) without overburdening a few individuals within the organization is to support an external identity organization which can provide young faculty and trainees access to additional mentorship, coaching, and sponsorship.[2,3] Encouraging participation in surgical societies may be an important resource for underrepresented faculty and trainees. Building a community of allies to generate a stronger voice to advocate for people from minority backgrounds is another way to demonstrate allyship.[3]

Diversity, Equity and Inclusion Opportunities

A growing number of surgical societies have been established that aim to mentor and sponsor historically underrepresented populations in surgery or surgical leadership. Membership or service to one or more of these organizations offers a significant opportunity for allyship. These societies include the Association of Out Surgeons and Allies (AOSA), the Association of Women Surgeons (AWS), the Latina Surgical Society (LSS), the Society of Asian Academic Surgeons (SAAS), and the Society of Black Academic Surgeons (SBAS). While these organizations exist to promote their respective affinity groups, membership is open to all surgeons and surgical trainees regardless of race, ethnicity, sexual orientation, or gender. Allies can support these organizations by becoming members, donating to the societies' foundation, or actively sponsoring student, trainee and faculty membership, as well as attendance at their annual meetings. Other opportunities exist with specialty-specific surgical societies as well. Acknowledgement of the lack of DEI throughout the house of surgery has seen a dramatic increase in the number of surgical societies with a dedicated DEI committee aimed at addressing underrepresentation within their respective fields. These DEI initiatives offer unique opportunities for involvement, mentorship and sponsorship throughout the pipeline to surgical training, along with opportunities for individual and/or organizational efforts.

Perhaps the most significant opportunity for allyship exists in our day-to-day work environments and can be exemplified by actively promoting and advocating for others, speaking out and acting against discrimination and bias. Serving as an active DEI champion should be incorporated into every interaction and is especially important in the optimal care of patients.

As enthusiasm increases to address deficits in surgical DEI for our patients and colleagues, there has been a significant increase in funding and resources for this work. DEI science is now a respected and powerful space to accomplish timely clinical and academic work with broad impact. However, these opportunities should also serve to build collaborative and diverse partnerships and ensure that team members from underrepresented backgrounds in surgery are championed in this space.

The Department of Surgery at the Medical College of Wisconsin is proud to be institutional members of the following societies:

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Georgeades at cgeorgeades@mcw.edu.

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Original *Leading the Way* Article

Multidisciplinary Follow-up Care after Firearm Injury Survival: The Trauma Quality of Life Clinic

Colleen Trevino NP, PhD
Assistant Professor, Trauma and Acute Care Surgery

Milwaukee experienced 877 nonfatal shootings in 2022, nearly doubling since 2019 (Figure 1). As the only Level I Trauma Center in the city, the Division of Trauma and Acute Care Surgery providers have directly experienced the influx of gun violence victims. The timing of the start of the Trauma Quality of Life Clinic (TQOL) could not have been better. It has been two years since the inception of this multidisciplinary, comprehensive post-discharge follow-up clinic and over 300 patients who were victims of gun violence have been treated — mothers, fathers, children, grandmothers, grandfathers, aunts, uncles, cousins, best friends.

The lack of mental health and social resources for traumatically injured patients was identified over a decade ago within the care provided by the Division of Trauma and Acute Care Surgery. Many times, these issues superseded the physical hardships caused by injuries. Rates of post- trauma chronic pain are 63% to 73%, [1-3] depression are 30% to 40%, [4,5] posttraumatic stress disorder (PTSD) are 20% to 30% [6] and long-term functional disability rates are as high as 69%. [7]

An overall lack of standardized, multidisciplinary follow-up across the US in trauma centers was identified.[8] The TQOL clinic structure was developed and piloted in 2018, cutting the clinic no-show rate from 40% to 22%. [9] Reducing no-show rates improved patient engagement

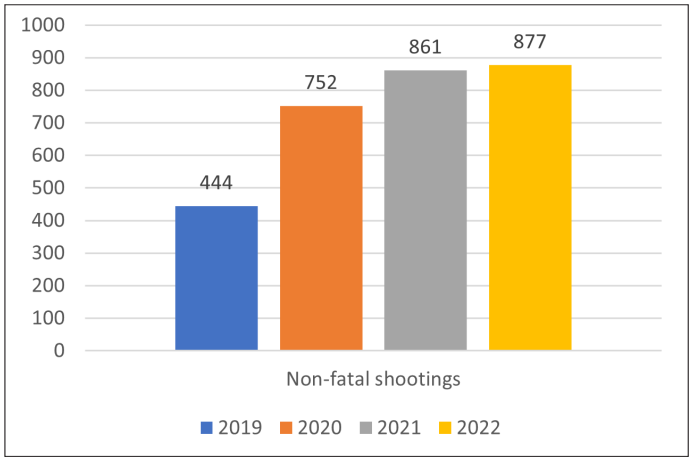

Figure 1: Non-fatal shootings per year in Milwaukee based upon City of Milwaukee Crime Statistics.

in their health care, and efforts were then focused on their recovery needs in a trauma-informed patient-centered holistic manner.

Due to the complex biopsychosocial needs of gun violence survivors, TQOL was developed specifically as a hospital-based, multidisciplinary post-discharge clinic that aims to address all medical, psychological, and social needs of this population. In the clinic, the patient sees a trauma nurse practitioner, a psychologist, a physical therapist, a social worker, and a hospital-based violence interventionist all at the same appointment within the same clinic room. The goal of TQOL Clinic is to improve functional recovery, psychological and social wellbeing, and reduce violence recidivism and re-injury.

The vast majority of the TQOL participants were Black (80%) and male (82%) with the average age of 32 years (SD 11.79; range 15-88 years). The average Injury Severity Score was 15.27 or moderately injured (SD 10.15; range 1-75; 31% missing data). Following their initial presentation, most patients went home (52.9%), 5% left Against Medical Advice, and 7.8% went to correctional facilities (33% missing data). The average length of stay was 1.84 days (SD 9; range 0-68 days) and average intensive care days were 1.84 days (SD 4.22; range 0-31 days).

The overall no-show rate for TQOL over the first two years dropped to 12% (Figure 2). Ninety-two percent of those who did not attend their first appointment were rescheduled and 89.5% of these patients no-showed to their rescheduled appointment. Unfortunately, at the time of the TQOL clinic appointment, only 19.3% of patients had outpatient appointments scheduled with the other specialists they saw while in the hospital (i.e., orthopedics, otolaryngology, physical medicine and rehabilitation, vascular surgery, urology). In these cases, referrals were made within clinic to request appointments to ensure the patients were getting the necessary care for their injuries not managed by the Trauma team. At least 61% had one other specialist to follow-up with after discharge and 35% had two or three required post-discharge specialist appointments.

The original goal was to have the patient attend the next available clinic after discharge, within 3 to 10 days. Due to the high numbers of nonfatal shootings over the first two years of TQOL, the time from discharge to first clinic appointment was prolonged. Excluding extreme outliers, the average time to clinic appointment was 15 days with a range of 3-30 days. In this cohort, 17% of

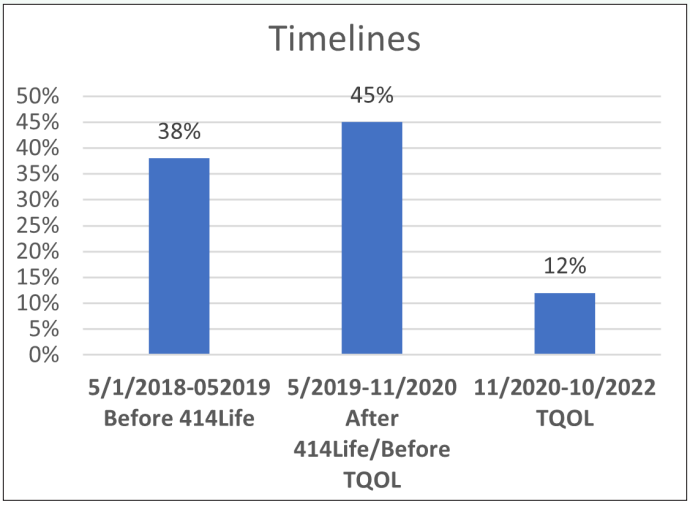

Figure 2: Clinic No-show Rates for Gun Violence Survivors

Figure 3: Froedtert and Medical College of Wisconsin TQOL Providers

patients had a visit to the emergency department before their TQOL appointment with 92% of those visits related to the index firearm injuries. The readmission rate before the TQOL appointment was 8.2% with 92% of those visits related to the index firearm injuries. The overall readmission rate in 2022 for all trauma patients was 8.3%. The prolonged time to the first TQOL clinic may have contributed to increased emergency department visits and readmissions.

The top resources provided by the nurse practitioner were medication refills, physical therapy referrals, primary care referrals, and referrals to specialists. Twenty percent of patients were scheduled for additional psychology appointments. The hospital-based violence interventionist's primary support included retaliation interventions, addressing financial issues, and providing family support.

Screenings in TQOL clinic found that 78% were risk positive for PTSD, 48% were risk positive for depression, and 78% were risk positive for chronic pain that moderately interfered with daily living. These rates are all significantly higher than all other mechanisms of injuries from trauma populations in the literature.

With this comprehensive multidisciplinary follow-up clinic, gun violence survivors had high engagement in follow-up care in a population at extreme risk for the development of poor long-term mental health outcomes, physical disability, and chronic pain. The Medical College of Wisconsin's Division of Trauma and Acute Care Surgery continues to lead the way in developing innovative care unlike any other program nationally or internationally (Figure 3).

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Trevino at ctrevino@mcw.edu.

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Original *Leading the Way* Article

Olympic Pursuits in Exchange for The Pursuit of Becoming a Surgeon: Reflections of a Fifth Year General Surgery Resident

Paul Dyrud, MD
General Surgery Chief Resident

My earliest memory of skating was at three years old. My sisters started figure skating and so I was signed up for lessons, too. Ultimately, I played the part of a clown for the figure skating show. Growing up in Minnesota, the natural thing for my parents to do would have been to sign me up for hockey, but hockey was too rough, too political, and too expensive in their minds. Her mother was a first-generation immigrant; her father immigrated from Eastern Europe and worked a factory job. My dad was a missionary kid and grew up in Madagascar (the fourth largest island, and one of the poorest countries in the world, where presently, the majority of the population lives on less than one dollar per day). They met at a Colorado hospital where my dad was a general surgery resident and my mom worked as a nurse. My oldest sister was born in Madagascar when my dad did two years of medical mission work in between his general surgery training and cardiothoracic surgery fellowship. After fellowship in Seattle, my parents moved to Minneapolis, Minnesota where I was born.

Four years after my figure skating clown debut and several failed attempts at persuading my parents to let me play hockey, I went to a festival on a hometown lake where a Speedskating club practiced. Though skeptical at first, I gave it a try. Over time, I started winning local and then national age group races. By the time I was 15 years old, I was one of the top junior skaters (19 and under) in the country and subsequently earned berths on the US Junior World Championship teams as a 17-, 18-, and 19- year-old. The Junior World Championship is held annually; the top three skaters aged 19 and under from each represented country are selected to compete in four individual distance races and one team event. As a junior, I earned two Junior World Championship medals and set US Junior National records in four of the five distances. I later competed on the international World Cup circuit from 2006 to 2010 and again in 2013. I missed qualifying for the 2010 Olympic team by one second in the 1500-meter race. I quit skating for two years to finish college and start a family. I didn't intend to ever race again, but at my wife's insistence, I returned to skating in 2012 with the goal of making the 2014 Olympic team. I again fell just short of making the team. While ultimately disappointed with not realizing a childhood dream of competing in the Olympics, my other long-term goal, largely inspired by my dad's modeling of the profession, was to become a physician. If given the opportunity to only realize one of my dreams, I would choose becoming a physician every time. The arduous road to becoming a physician and surgeon shares some similarities with the challenges faced as an athlete. Here are some of the lessons I learned and honed in sports that that I have applied to residency:

Work hard every day. Sports and residency are both physically and mentally demanding. As a junior resident, one of my main goals was to make the advanced practice providers (APPs) happy. I volunteered to offload tasks and was thorough with orders, instructions, and documentation. There were many days, especially as an intern, where we walked several miles around the hospital, and I knew if I could do a 100-mile training bike ride, I could certainly make my way to a patient on the other side of the hospital to help the APPs. The work of a senior resident is different in that we are now responsible for more administrative tasks, knowing consults and inpatients in greater detail, formulating plans, and operating more. In this role, communicating takes a significant amount of time and effort, but it is important to keep the APPs and residents informed. And as a senior, when the juniors are inundated, I try to help with orders and notes when I can, just as all my seniors did for me.

Have a good attitude and be a team player. This concept was (literally) driven home by my quintessential third grade teacher Miss H, whose license plate read "ati2de". Your attitude is reflected in your written, verbal and non-verbal communication. I was fortunate as an athlete that during the years of competing on the World Cup circuit, even when my performances weren't where I thought they should be, I was always extended an invite to train on the national team and attend training camps. I attributed this support to my attitude; I was always pleasant and respectful to coaches and teammates. In team sports, if your attitude is poor then doors close quickly. The best junior residents to work with always respond with a pleasant attitude, even when the patient census is high. They also respond enthusiastically to case assignments, even when they are not the biggest and most desirable case. Successful residents don't pout when asked to do a debridement. In fact, they do the opposite; they have a good "ati2de" about it.

Things will get better over time. More truthfully stated, with hard work and a positive attitude, things will get better over time. Pushing my body to work hard as an athlete came easily until the fall of 2005. However, when preparing for the 2006 Olympic trials, I moved to Park City, Utah to train on the US National team. Inexplicably, by late fall, my legs felt constantly fatigued. Having only made huge improvements until this point in my life, the thought of not getting better was unfathomable and yet I somehow became slower. I went two full years without a personal best time, and pushing my body to its limits was a much more difficult task when improvement wasn't guaranteed. Recovering from that crisis of confidence was a very slow process. Learning to move forward and keep working hard in less-than-optimal settings is perhaps the single biggest lesson I took with me into residency. Residency is hard; there is always more to do and more to learn. As an intern it seems insurmountable, but it does get better if you push through and stay positive. There are aspects that become more difficult as your responsibilities increase, but there is equally as much satisfaction as you gain more clinical independence and more confidence in the operating room.

Be humble and treat others well. "Pride comes before a fall." We've probably all seen that proverb come to truth when an athlete showboats right before the finish line or a touchdown. Even the best athletes experience their fair share of humbling moments in sport. There are even more humbling circumstances in medicine and surgery. Even the best surgeons have complications. In residency, when the consult pager doesn't stop beeping, being humble translates to being gracious when calling back the page. Remember that it is a privilege to be in a position to help patients. At a large academic institution such as ours, we often interact with staff we've never worked with before. Moreover, when we rotate at outside institutions, we arrive not knowing any of the OR personnel. Unfortunately, it's not uncommon for OR nurses or techs to be condescending or rude to residents, as we are outsiders at a new hospital. Avoid the urge to be rude in return. As a resident, remember they don't know you and have never worked with you, be humble and gracious and treat them well and you'll win them over quickly.

Make time and sacrifices for family. My senior year of high school, my family planned a three-week trip to Madagascar. I was not happy about missing weeks of training and compromising my skating season. I threatened to run away the morning of the flight. Thanks to my mom, the model of tough love who was referred to by my friends as "Judge Judy", I went to Madagascar, and it was eye-opening. My skate season was not ruined; in fact, I won a silver medal at the Junior World Championships, finishing ahead of Sven Kramer, who is considered by many as the greatest speedskater of all time (Sven went on to become a 3-time Olympic gold medalist in the 5000-meter and 9-time Olympic medalist). Throughout medical school and residency, it is tempting to get bogged down with endlessly preparing for tests, cases, etc. Although the preparation process is obviously critical, it's important to be flexible and make time for friends and family. Even when there are deviations from the "perfect plan of attack", the result often exceeds our expectations, if we have remained diligent and hard working. I have four kids and time is fleeting. I'm grateful that my wife challenges the aspect of my personality that wants to wholly focus on the next challenge or goal. Without her, I would have missed many small but important events in our kids' lives. The perfect residency rotation schedule probably does not exist, so don't sweat the details outside of your control, work hard, be diligent, make time for friends and family and things will work out!

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Dyrud at pdyrud@mcw.edu.

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Reproduced from the F&MCW *Better Together - Periop Pulse* newsletter

Delivering Bad News: Never Easy, Especially During the Holidays

Karen E. Kersting, PhD
Assistant Professor, Surgical Oncology

Interview by Douglas B. Evans, MD

(DBE): I operated on a patient with pancreatic cancer last week who had received many months of chemotherapy and radiation, only to have us find that the cancer had spread at the time of operation. Because of this, we did not remove the primary tumor, and of course, needed to convey this information to the patient and his family that afternoon. Some of the PACU nurses are present when we convey such difficult news to patients who are just waking up and asking the obvious questions – and those wonderful nurses then spend the next one to two hours with the patient – not easy! While all patients and families are sad to learn that the cancer was not removed, the holiday season is particularly difficult, and patients often get depressed and dejected when bad news is delivered. In oncology, we often avoid having routine cancer follow-ups in December (and put them off until January). So, I am taking this opportunity to ask Dr. Karen Kersting, a psychologist in the Division of Surgical Oncology, how best to deal with this – Karen, what are your recommendations (to doctors, APPs, nurses and every member of the health care team) for delivering bad news to patients, when the news has to be delivered right before the biggest holidays of the year?

(KEK): The most important thing is to go into the experience of delivering bad news with a realistic expectation of how the patient will react. I think we often walk into these conversations with a vague sense that it is our responsibility to help the patient "feel ok." But that is not realistic. It is appropriate for the patient and their family to react with despair, disbelief, anger, and/or hopelessness. There is no point or benefit to encouraging the patient to "be positive" or "look on the bright side" when they are acutely experiencing these emotions – even though the discomfort of the moment makes us feel like that's our job. The best we can do in these moments is to have a genuine human interaction with the patient; witness their pain and fear, and validate their disappointment. Simple words like "I see how much this news hurts," "it makes sense that you feel angry and overwhelmed", and "I am sad too" are most helpful because they convey that you are on the same page as the patient, even in the hardest moment. Patients want to know that they are fully seen, even when they are not cured. I think that doctors, APPs and nurses sometimes fear connecting with patients like this and acknowledging their despair. There are many reasons including their own emotional exhaustion and the inability to spend the necessary time with the patient. But in my experience, a moment of deep connection and profound empathy helps the difficult conversation to move forward and leaves the doctor, APP, or nurse with fewer feelings of guilt. So, when bad news is delivered around the holidays, we can add that to the ways in which we see our patients suffering and acknowledge it as such. "It makes sense that this is extra hard right before Christmas, I hate that this is happening to you at all."

(DBE): December is always very busy for all of us in health care delivery; especially in the Operating Room, which means that it is busy for everyone involved in the perioperative care of patients. This is also a time when there may be additional responsibilities at home and outside of work. How can doctors, nurses, APPs, techs and everyone involved in the care of patients maintain the patient as the focus of their day – and remain energized and focused on being the best we can be?

(KEK): Believe it or not, my answer to this question actually shares DNA with my answer to how to deliver bad news. It is important to validate to yourself and others how bad it can feel to be overwhelmed with holiday expectations when your focus on patient care must remain your number one concern. "This. Is. Hard." Make a point of seeing what you and your coworkers are going through and naming it. Getting through difficult times requires tapping into all of your tried-and-true coping mechanisms – which can also be difficult during the holidays! But let's review what those are: healthy eating, movement, rest, sleep, relaxation, and connection. Making time for these healthy habits, even if they need to be abbreviated during the season, is an important first step:

- Prioritize sleep and exercise.
- Balance your favorite holiday foods with your healthy mainstays.
- Keep going with your relaxation and spiritual practices like meditation, prayer, and breathing

Next, when you look at all of the holiday experiences you want to engage in, prioritize the ones that create feelings of connection and will linger in your memory. For example, if the big family dinner isn't your favorite event,

make that the one you skip and, instead, create the opportunity to go shopping with a beloved family member. Finally, tap into the specialness of being there for your patients, especially during the holidays. Use the season to magnify and appreciate just how much you and your team do for your patients all year long. Celebrate each other when you can and know that you embody the spirit of the holidays.

Dr. Karen Kersting (https://www.mcw.edu/find-a-doctor/kersting-karen-e-phd) has a special interest in the care of patients with cancer and assisting people deal with stressful, life-changing events. She has been a frequent contributor to WISN's The Word on Medicine (Saturday at 4PM) as well as The Latest Word on Medicine (Friday at 2PM). She can be reached at kkersting@mcw.edu.

Save the Date!

2023 Midwest Regional Trauma/ Acute Care Surgery Symposium

June 5-7, 2023

Register now for the combined conference hosted by MCW Surgery and the Comprehensive Injury Center. Online registration is required to attend the pre-symposium skills courses or symposium. Please visit ocpe.mcw.edu/surgery or scan the QR code to register.

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THE *latest* WORD ON MEDICINE

Since the first episode on October 5, 2018, the LWOM has brought you the latest news on current medical issues directly from our MCW faculty experts. Catch the Latest Word on Medicine Fridays at 2:00 p.m. CDT on iHeartRadio.

iHeart RADIO

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Better Together: Enabling Partnership Between Healthcare Providers and the Community

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Research Roundtable

The MCW Surgery Research Roundtable is a monthly meeting of research residents, fellows, and other research trainees. The roundtable provides an opportunity for discussion of active research projects and for educational presentations of research-related topics. For more information, contact Kelly Birmingham at kebirmingham@mcw.edu.

Reproduced from the F&MCW *Better Together - Periop Pulse* newsletter

Thoughts at the Scrub Sink: Surgical Quality

Jon Gould, MD, MBA
Walker Endowed Chair of General Surgery; Chief, Division of Minimally Invasive and Gastrointestinal Surgery; Vice Chair for Surgical Quality; Professor of Surgery

I've been a surgeon in training or a surgeon for over a quarter-century now. I never thought of it that way until I sat down to write this, and I don't feel as old as that sounds. I'm also reflecting at my desk and not at the scrub sink, but that's beside the point. The point is that what we know and how we think about surgical quality has evolved dramatically in the past 25 years. When I was a surgery resident in the late 1990s, we didn't talk or think too much about quality – but we knew good and bad quality when we saw it… or so we thought. My impression of quality improvement back then was that someone just had to take a pound of flesh from whichever resident could be blamed for a bad outcome, and that was how we would improve. In my Department of Surgery, hospital, and enterprise roles as a surgical quality leader, I have come to understand quite a lot about what quality is, how difficult it is to measure, and how many opportunities there are to fall short. Take surgical site infections (SSI) following a colectomy for example. SSIs following a colectomy occur about 4% of the time. Patients who develop an SSI stay in the hospital on average 8 days longer, and the cost of their care is more than $20,000 greater than patients who don't develop SSIs. And that's just the tip of the iceberg – SSIs are no fun for anybody, but especially the patient. Lots of research tells us that there are things we can and should do to minimize our SSI rates. These are things like giving the right antibiotic every time and on time, keeping the patient warm, smoking cessation in advance of surgery and more. We have a standard colon SSI bundle, and we do pretty good most of the time hitting the mark. The problem is that health care is complex. There is an infinite combination of providers who might be involved in an episode of care. Patients are unique with infinite possible combinations of technical challenges, health issues, social determinants of health and more. We are inundated with administrative tasks and requirements (JCAHO is here as I write this), other patients' concerns, work, home, and everything else that makes it amazing to me that we get it all right as often as we do. But we can do better…. the most important word in this sentence is 'we' (Figure 1).

Surgery (and medicine in general) is a team sport. We must collaborate, communicate, empower, appreciate, respect, and value each other. This is more important in the high-stakes, high-pace (sometimes), high-stress operating room. I would argue that those of us who get to spend a good part of our professional lives in the operating room are the luckiest in all of health care. The highs can be high. The lows can be managed when we come together, support each other, and look for opportunities to improve the system so we can do better next time. When we are good at this, there are way more highs than lows. Now more than ever with staffing challenges, increasing complexity and acuity of our patients, and growing workloads, it is essential that we rely on each other, manage each other up, and support each other. All disciplines, all departments, all platforms, all service lines… you get the point. Yes, this column is still about surgical quality – it's still difficult to measure… but you will know it when you are a part of it.

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Gould at jgould@mcw.edu.

CONGRATULATIONS

JON C. GOULD, MD, MBA

Secretary,
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

THE WORD ON MEDICINE

The Word on Medicine celebrated its 5th anniversary in November 2022! For over half a decade, the WOM has brought together medical experts and patients to discuss the latest in medical innovation and discovery. The Word on Medicine (WOM) airs live on News/Talk 1130 WISN every Saturday at 4 PM CDT. Missed an episode? Browse our library of past episodes by scanning the QR code.

NEWS/TALK 1130 WISN

Reproduced from the F&MCW *Better Together - Periop Pulse* newsletter

Thoughts at the Scrub Sink: The Landing

Katie Iverson, MD
Assistant Professor, Trauma and Acute Care Surgery

The leap from trainee to attending feels like more of a catapult. Suddenly, you are flung away from that safety net of guidance and reassurance. Floating through the air of uncertainty. Questioning every small decision. There is something very different about finally having that ultimate responsibility as a first-year attending. The doubt is palpable and consuming. When I tell my patients I'll be performing their operation, the word performing seems very fitting. Getting through a tough operation can seem very much like an act. Recreating the steps of surgery, you are emulating your attendings and their chosen techniques. But can you embody these mentors fully enough for the optimal outcome, an award-winning performance? A million questions come up. *How did this attending do this again? Why did it look so much easier when they did it? Why is this exposure so bad? Why am I struggling so much? Could I make this look any more difficult? Can everyone tell I have no idea what I'm doing?* As one who has taken the scenic route through education and training, I have had the privilege of witnessing many of my friends and colleagues undergo this transition before me. I've seen the soul-crushing defeat of the bad outcome. How embarrassing it feels to have to ask the "stupid" questions to your new partners. Finding the fine balance between humility and confidence. And somehow, despite walking alongside these journeys, nothing can quite prepare you for this painful, personal catapult into attending-hood. Having been at Froedtert and the Medical College of Wisconsin for almost a year now, I feel fortunate to be in a place where I have had so much support during this transition. One of the most amazing things about our institution is the willingness of everyone to help. My partners are not only quick to jump in and assist in an operation, fixing a bleeding iliac or portal vein, but seem to do so with a smile. Surgeons in other divisions are happy to look at that injured pancreas or aorta. The scrub techs and circulating nurses often know what instrument I need, even before I know it. The residents who are working tirelessly with so many great surgeons routinely teach me different ways of doing things. Our APPs notice those overlooked details and miraculously drive our patients' care forward when it would otherwise lie stagnant. While I still have my personal doubts, I am reassured in knowing that my patients are cared for by a competent, hard-working, and selfless team. What I have learned over the past year is that there is always help. Asking those stupid questions is not always a sign of weakness, but rather a sign of thoughtful consideration and prioritization of patient care. It is important to be cognizant and transparent about the limits of our own knowledge and skills. It is a lesson not only for us, but for the learners around us. Patient outcomes depend on so much more than just one person, but rather a whole team, hospital, and health ecosystem. One of the most vital things I've learned this year is the value of good partners and I do believe at F&MCW I have found them. I am immensely grateful to be in a place where there is a soft landing at the end of that catapult.

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Iverson at kiverson@mcw.edu.

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

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Referrals: 800-272-3666
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Transfers/Consultations:
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Acute Care Surgery:
414-266-7858

Adapted from *News from the American College of Surgeons*

Alexis Bowder, MD, Receives Resident Surgical Volunteerism Award

Alexis Bowder, MD, General Surgery Chief Resident, was awarded the American College of Surgeons (ACS)/ Pfizer Resident Surgical Volunteerism Award for her 10 years of volunteer work in practice, education, and research, primarily in Haiti. The award was presented October 18 during the ACS Clinical Congress (ACSCC) 2022 in San Diego.

Figure 1: Alexis Bowder, MD

The ACS/Pfizer Surgical Humanitarian and Volunteerism Awards recognize ACS Fellows and members who are committed to giving back to society through significant contributions to surgical care as volunteers. Dr. Bowder was one of five recipients at the 2022 ACSCC. The awardees are determined by the ACS Board of Governors Surgical Volunteerism and Humanitarian Awards Workgroup, and the awards are administered through the ACS Operation Giving Back program.

Dr. Bowder has been involved in global volunteer work since 2012 when she spent six weeks as an interpreter at a primary care clinic in Honduras between her first and second years of medical school. Between her third and fourth years of medical school, she worked for one year at Hopital Universitaire Mirebalais in Haiti, working as a research associate with Harvard Medical School's Program in Global Surgery and Social Change. As a subintern, Dr. Bowder recorded vitals for all surgical patients and removed dressings before rounds. In the operating room, she filled various roles, ranging from circulating to first assisting. Patients seen in the surgical clinic or around the hospital received her phone number and could contact her for perioperative issues. In addition to working with the Haitian team, she was the liaison for any visiting surgical teams from the United States or internationally. She helped visitors reach the hospital, locate patients to evaluate, and schedule procedures.

As a resident, even with ongoing political strife primarily in the capital of Port-au-Prince, she continued regular trips to Haiti where she shifted the focus of her clinical and education efforts to also include St. Boniface Hospital in Fond-des-Blancs. While continuing to participate in daily rounds and postoperative care of patients, Dr. Bowder began dedicating more time to developing the surgical research skills of the Haitian medical students, residents, and faculty, and supported their clinical research (Figure 2).

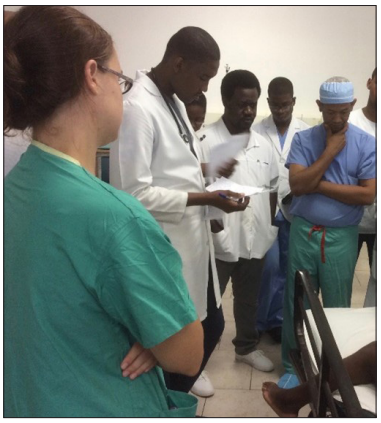


Figure 2: Dr. Bowder on daily morning rounds in Haiti.

Her work supporting surgical research at St. Boniface Hospital has led to the development of a sustainable database of surgical cases and their postoperative outcomes, including the design of an electronic database to be implemented in the coming years. In collaboration with Haitian colleagues, she helped to establish a non-profit organization, the Haiti Surgical Research Consortium, which seeks to strengthen the Haitian surgical system by promoting Haitian-led surgical research training and capacity building to better inform efforts and provide universal access to timely and affordable surgical care. Dr. Bowder has been integral in collaborating with several Haitian organizations and Info-CHIR, Haiti's only peer-reviewed journal of surgery and anesthesiology, to implement an annual clinical research curriculum aimed at teaching Haitian clinicians the skillsets needed to design, conduct, and disseminate their own clinical research.

Even early in her career, Dr. Bowder has been a strong advocate on the global stage for improving care in Haiti. In the last two years, she attended the United Nations General Assembly to advocate for surgical care and attended grassroots meetings on the importance of developing a National Surgical, Anesthesia, and Obstetric Plans (NSOAP) in the country. Additionally, she worked with the Global Surgery Foundation and the United Nations Institute for Training and Research to perform a situational analysis of obstetric and cervical cancer care in Rwanda and Zambia to inform future interventions to decrease maternal mortality by improving access to c-sections and surgical care for cervical cancer.

In addition, she has personally raised more than $5,000 to support Haitian faculty and trainees in their research efforts - assisting with publication and international presentation of their work and developing a Haitian research education platform.

For additional information on this topic, visit mcw.edu/surgery or contact Dr. Bowder at abowder@mcw.edu.

Original *Leading the Way* Feature Article

International Collaboration at F&MCW

During the first week of February 2023, members of the Froedtert & the Medical College of Wisconsin Cardiothoracic Surgery team were honored to host a renowned multidisciplinary team comprised of cardiac surgeon Dr. Alfonso Agnino, electrophysiologist Dr. Edoardo Celentano, and anesthesiologist Dr. Matteo Parriniello. The physicians visited from the Division of Minimally Invasive and Robotic Cardiac Surgery Service of the Humanitas Gavazzeni Hospital in Bergamo, Italy (Figure 1).

During the visit, Froedtert & MCW Cardiothoracic Surgery and Electrophysiology specialists (Drs. Mario Gasparri, Stefano Schena and James Oujiri) and staff shared their knowledge on performing a unique and cutting-edge surgery for treatment of atrial fibrillation. The visitors were able to watch the team perform a robotic epicardial ablation with left atrial appendage exclusion as part of the hybrid convergent procedure for the treatment of long-standing atrial fibrillation (Figure 2). Such procedure, in combination with endocardial catheter ablation performed by electrophysiology colleagues, allows effective treatment of atrial fibrillation in people failing medical therapy, cardioversion, isolated catheter ablation or even lack of concomitant treatment during other cardiac surgery procedures with excellent outcomes approaching those of current gold standards.

This was a unique opportunity for the team from Humanitas Gavazzeni Hospital as Froedtert Hospital is the only site in the US currently performing this procedure with robotic technology (Figure 3).

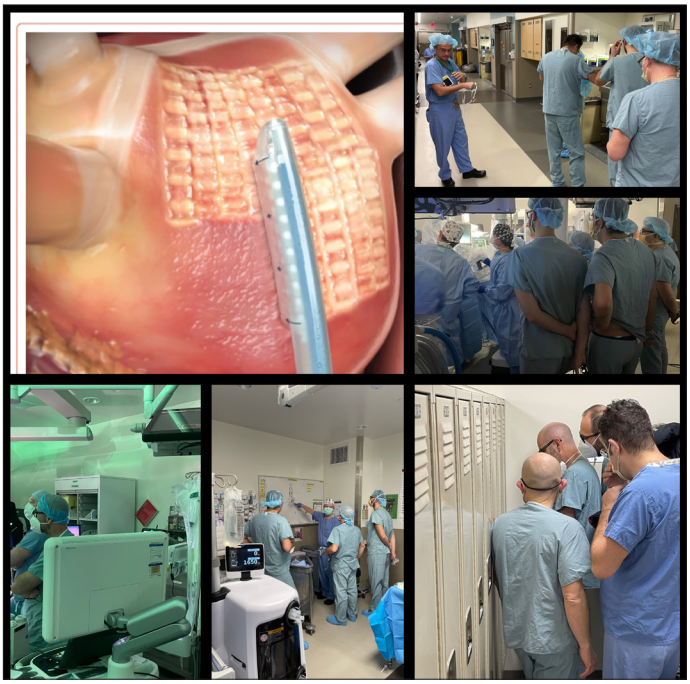


Figure 2: Visitors observe a robotic procedure at F&MCW.

Figure 1: Collaboration commences at F&MCW.

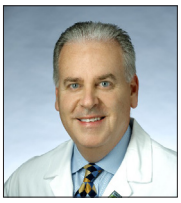
Figure 3: International teamwork makes the dream work.

Leading the Way

Division of Minimally Invasive & Gastrointestinal Surgery

Amir A. Ghaferi, MD, MSc, MBA, joined the Department of Surgery faculty in December 2022 as a Professor of Surgery with Tenure. Dr. Ghaferi is also the President and CEO of the Physician Enterprise, and Senior Associate Dean for Clinical Affairs at Froedtert & Medical College of Wisconsin. Dr. Ghaferi received his medical degree from the Johns Hopkins University School of Medicine. He completed his surgical training at the University of Michigan, where he would go on to obtain a Master's degree in Health and Healthcare Research, and an Executive MBA from the Ross School of Business. Dr. Ghaferi was previously the Moses Gunn, M.D. Professor of Surgery and the Chief Clinical Officer of the University of Michigan Medical Group. In his leadership role, he leads the enterprise strategy for establishing and advancing a regionally integrated and aligned medical practice. Dr. Ghaferi's research focuses on understanding the relationship of organizational systems and design to achieve quality and efficiency.

Division of Transplant Surgery



Matthew Cooper, MD, joined the Department of Surgery faculty in March 2023 as the Mark B. Adams Chair in Transplant Surgery and Professor and Chief of the Division of Transplant Surgery. Dr. Cooper also serves as the Director of the Joint Solid Organ Transplantation Program at Froedtert Health and Children's Wisconsin. Dr. Cooper received his medical degree from Georgetown University School of Medicine, completed general surgery residency at the Medical College of Wisconsin, and a fellowship in transplant surgery at Johns Hopkins. Dr. Cooper and his wife, Alicia, are thrilled to return to Milwaukee. Their three children are following the family tradition in medicine; their oldest daughter, Julia, is a pediatric ICU nurse at Georgetown, their son, Matthew, is a current student at Marquette University, and their daughter, Emily, will be a first-year medical student at MCW this fall. Dr. Cooper previously served as Director of Kidney and Pancreas Transplantation and Medical Director of Transplant Quality at the Medstar Georgetown Transplant Institute. He is the immediate past president of the United Network for Organ Sharing (UNOS).

Kondragunta Rajendra (Raj) Prasad, MS, MCh, joined the Department of Surgery faculty in May 2023 as Professor of Surgery and the Section Chief of Liver Transplant Surgery. In addition, he will serve as the United Network for Organ Sharing (UNOS) Primary Surgical Director for Liver Transplant within Froedtert Hospital and Associate Medical Director for Pediatric Liver Transplant at Children's Wisconsin. Dr. Prasad completed his medical degree at Nagarjuna University in Guntur, India followed by postgraduate training in general surgery and a fellowship in GI surgery. He was a visiting fellow at the Thomas Starzl Transplantation Institute and completed a fellowship in liver transplantation and hepatobiliary surgery at St. James University Hospital, Leeds, UK. Dr. Prasad previously served as Consultant in Transplant and Hepatobiliary Surgery and as Director of Surgery at Leeds Teaching Hospitals in England. Dr. Prasad is accompanied by his wife, Dr. Phaedra Tachtatzis, who is a Transplant Hepatologist at Froedtert, and their three children - Elli and Ariadne (twin girls) and Adonis - who are very excited about their new adventure in the USA.

Division of Trauma & Acute Care Surgery

Robb A. Edwards, MD, joined the Department of Surgery faculty as an Assistant Professor of Trauma and Acute Care Surgery in March 2023. We are excited to welcome Dr. Edwards back to the Department of Surgery, where he completed his general surgery residency in 2011. Prior to joining MCW, Dr. Edwards practiced at Franklin Hospital and St. Francis Hospital. Dr. Edwards will primarily practice at the Froedtert Menomonee Falls Hospital on the trauma service.

Faculty by Specialty

The Medical College of Wisconsin **Department of Surgery**

Bariatric & Minimally Invasive Gastrointestinal Surgery

Amir A. Ghaferi, MD, MSc, MBA (12/1)
Matthew I. Goldblatt, MD
Jon C. Gould, MD, MBA
Rana M. Higgins, MD
Andrew S. Kastenmeier, MD
Tammy L. Kindel, MD, PhD
Kathleen Lak, MD
Philip N. Redlich, MD, PhD
Wen Hui Tan, MD

Cardiac Surgery

G. Hossein Almassi, MD
Nilto C. De Oliveira, MD
Lucian A. Durham III, MD, PhD
Tracy R. Geoffrion, MD, MPH
Viktor Hraska, MD, PhD
Lyle D. Joyce, MD, PhD
Takushi Kohmoto, MD, PhD, MBA
James E. Mace, Jr., MD
Michael E. Mitchell, MD*
Paul J. Pearson, MD, PhD
Stefano Schena, MD, PhD
H. Adam Ubert, MD
Ronald K. Woods, MD, PhD*

Colorectal Surgery

Jed F. Calata, MD
Kirk A. Ludwig, MD
Mary F. Otterson, MD, MS
Carrie Y. Peterson, MD, MS*
Timothy J. Ridolfi, MD, MS

Community Surgery

Marc de Moya, MD
Robb Edwards, MD (3/1)
John W. Haeberlin, MD
Kaizad Machhi, MD
Eric A. Soneson, MD
Mark A. Timm, MD

Pediatric General & Thoracic Surgery

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Mohammed Aldakkak, MD
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Young-In Chi, PhD
Christian J. Kastrup, PhD
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Angela J. Mathison, PhD
Aoy Tomita Mitchell, PhD
M. Muska Nataliansyah, MD, PhD, MPH
Kirkwood Pritchard, Jr., PhD
Raul A. Urrutia, MD

Surgical Oncology – Breast Surgery

Adrienne N. Cobb, MD, MS*
Chandler S. Cortina, MD, MS*
Amanda L. Kong, MD, MS*
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Tina W.F. Yen, MD, MS

Surgical Oncology – Endocrine Surgery

Sophie Y. Dream, MD*
Douglas B. Evans, MD*
Jennifer L. Rabaglia, MD, MSc
Tracy S. Wang, MD, MPH*
Tina W.F. Yen, MD, MS

Surgical Oncology – Hepatobiliary & Pancreas Surgery

Kathleen K. Christians, MD
Callisia N. Clarke, MD, MS
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T. Clark Gamblin, MD, MS, MBA
Karen E. Kersting, PhD, LCP
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Surgical Oncology – Regional Therapies

Callisia N. Clarke, MD, MS
T. Clark Gamblin, MD, MS, MBA
Alexandra Istl, MD, MPH
Anai N. Kothari, MD, MS
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Thoracic Surgery

Mario G. Gasparri, MD*
David W. Johnstone, MD*
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Transplant Surgery

Matthew Cooper, MD (3/1)
Francisco A. Durazo, MD
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Joohyun Kim, MD, PhD
Terra R. Pearson, MD
Kondragunta Rajendra Prasad, MS, MCh (4/18)
Jenessa S. Price, PhD
Stephanie Zanowski, PhD

Trauma/ACS

Marshall A. Beckman, MD, MA*
Thomas Carver, MD*
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Marc A. de Moya, MD*
Terri A. deRoon-Cassini, PhD, MS
Christopher M. Dodgion, MD, MSPH, MBA*
Robb Edwards, MD* (3/1)
Anuoluwapo F. Elegbede, MD, MS*
Timothy J. Geier, PhD, LP
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Katie Iverson, MD, MPH*
Christina L. Megal, DNP, APNP, FNP-C, CWON-AP, CFCN
David J. Milia, MD*
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Todd A. Neideen, MD*
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Libby Schroeder, MD*
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Vascular & Endovascular Surgery

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Joseph P. Hart, MD, MHL
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Chief Advance Practice Providers

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Cynthia L. Schulzetenberg, PA-C, *Inpatient Chief*

Chief Surgical Residents (2022-2023)

Alexis Bowder, MD, MPH
Erin Buchanan, MD
Paul Dyrud, MD
Kyla Fredrickson, MD
Ashley Krepline, MD
Nathan Smith, MD

Administrative Chief Residents (2022-2023)

Erin Buchanan, MD
Paul Dyrud, MD

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Department of Surgery
8701 Watertown Plank Road
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Editors:
Rana Higgins, MD
Theresa Neitzel, tneitzel@mcw.edu
Wendy Behrs
Haley Hendricks

Designer:
Elizabeth Chen, EC Design