

The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY



Spring 2016

Newsletter

Volume 17 Issue 1

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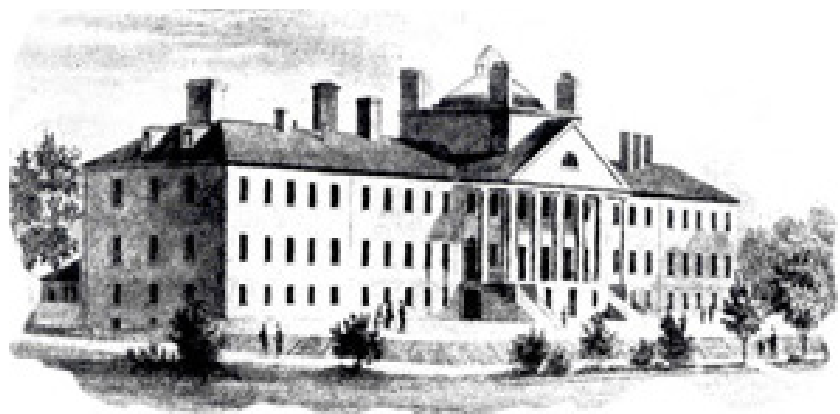
**MGH Surgical Society
ACS Cocktail Reception
Monday, October 17, 2016
6:00 to 8:30 PM
Washington, DC**

Reflections from the Chief

It has been an interesting time since our last newsletter, and I am certain many of you have read the stories that appeared in one of our local newspapers or at least have heard about the issues related to concurrent surgery at the MGH. I am happy to say that the Department of Surgery has been spared from most of these accusations. Furthermore, the Department's Codman Center for Clinical Effectiveness in Surgery has served the institution well by providing a true analysis to reassure ourselves and our patients that the quality of surgery and patient safety remains outstanding and in no way have our patients been harmed. Nevertheless, things have changed dramatically over the last few decades, and the public's perception of how care is delivered at an academic medical institution must be considered. Despite these changes, we continue to offer the best educational experience for our residents, providing both appropriate supervision and the necessary autonomy to prepare them for the next phase in their surgical careers.

The good news is, we have learned much from the scrutiny that has come over the last few months. I believe MGH has set the standard in terms of policies related to OR function and the care delivered by our surgical staff. There is no evidence whatsoever that these changes have hurt the institution with respect to patient referrals or surgical activity. Furthermore, I would like to hope that we have set an example as to how an institution can identify a problem and take steps to solve it—all of which took place before the so-called "investigative reporters" got involved. Certainly, if you have any questions about these activities or the proactive steps we have taken to deal with this problem, please feel free to contact me to discuss. Other than this small "hiccup," it has been a great last six months for the Department and the MGH.

— Keith D. Lillemoe, MD
Surgeon-in-Chief, Massachusetts General Hospital



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Message from the President

It is now five years (!) since I stepped down as MGH Chief of Surgery and retired from clinical practice. I still resist using the “R-word” and prefer to think of my transition (the T-word) to the next phase of life, which in my case has been an amalgam of my new full-time job at the MGH as a Physician Director of Network Development and Medical Director of the International Patient Center. The interstices get filled with various roles and assignments at the American College of Surgeons.

But enough about me. We want to know about you. When I was asked by intern applicants recently what criteria we use for selection, my answer was that there was no one type, that we were looking for individuals who would be really good at whatever they chose to do—be a terrific surgeon, investigator, teacher, leader. What have you been up to since leaving surgical residency? Your lost friends and colleagues want to know. Those coming up behind you want to learn from your experiences. Take time to reconnect!

Tell us about the world outside Boston. Share with us how you are adapting to the changes in the practice of surgery, employment, health care delivery, and regulation by government and insurance systems. What are your views on contentious topics—Obamacare, single-payer systems, MOC, the EHR? Is gun control a public health issue? Has surgical sub-specialization gone too far? Are there any general surgeons left out there? Got any advice for Keith Lillemoe, John Mullen, the Division Chiefs in your specialty? Write an article or editorial or opinion piece for this Newsletter, or at least send a note. You can add it to your CV.



While you are considering this, remember that our next alumni reunion will be in the latter half of 2017, and planning has begun. Take a moment to give your feedback on past reunions so we can make 2017 the best blend of presentations—yours included—and conversations. Communications can be directed to me (awarshaw@partners.org) or Suzanne Williams (swilliams7@partners.org). Complaints to those who may listen, Les Ottinger (lwojso@gmail.com) or Bill Daggett (wmdcardsurg@aol.com).

Don't be shy. We are looking forward to hearing from you.

— Andrew L. Warshaw, MD

President, Massachusetts General Hospital Surgical Society

Article

A Tradition Unlike Any Other

David L. Berger, MD

Excerpts from the presidential address of David Berger to the New England Surgical Society, September 27, 2015. To access the entire address, go to <http://www.massgeneral.org/surgery/surgicalsociety/?display=newsletters>

I would like to thank the New England Surgical Society and its members for the privilege of being your president. It is an honor to stand here and be included on the list of past presidents and officers of this society, many of whom are pioneers and leaders in the field of surgery. I also have to thank my family for being so supportive and putting up with me every time I am late or miss an event. In addition, I should thank all of the surgeons and staff at MGH. The number of people it takes to run a practice and operate is astonishing and everyone invariably is integral to making the day flow properly.

My rotation schedule was pre-determined and the last rotation of my third year (in medical school) was my surgical core. I came home very late that first night and told my wife that I had finally found my home. She listened, nodded appropriately, rolled over, and went back to sleep. I tried to explain and she would have none of it. She had heard it all before. I went back the next morning at 4:00 AM and came back home at 8:00 PM. I carried the suture removal kits and dressings, I went to the lab and got the results, I grabbed the vital signs and did whatever unpalatable job the team would let me do. I watched the senior resident run morning rounds with efficiency and sometimes a bit of brutality, the junior most residents passing on information and the senior resident examining the patient and making the plan for the day, the hierarchy clear and apparent. I went to the OR and stood for operation after operation. I watched and listened to the attending surgeon operate and teach. I listened to the residents tell stories of surgeons and tales of past operations. I was not just enamored with surgery, I was hooked by the system itself. It took less than a day for the world of surgery to suck me in and by the end of a week there was no doubt in my mind that I would become a surgeon.

Surgical residency is an experience unlike any other. It was fantastic. It was several of the best years of my life and I would never want to do it again. It is where the art of



David L. Berger

surgery is passed on from one generation to the next. There are two major milestones in medical training and they occur with the tick of the clock. One day you are a medical student and cannot write orders or function independently, the next day you are a doctor. One day you are a resident who cannot function without supervision and the next you are an attending. There is no other way than a moment for those changes to happen from one day to the next, but when they occur, it is startling. The beginning of residency is the beginning of that process.

There is the first day of orientation, where for some reason there is always a free lunch and all seems rosy. We had great lunches for the first three days of orientation and did not see them again until the applicant interview days six months later. There is the first day on the wards, when you feel completely inept and wonder how you are possibly going to survive the night. Then, of course, there is your first case in the OR. There was another student from my medical school class who was an intern with me. Our residence began on July 1st, which happened to be a Sunday. He started on the anesthesia rotation and I started on a surgical ward rotation. Monday morning, July 2nd, I was assigned to an inguinal hernia repair and he was the anesthesia resident in the room. He and I were in the OR for the first time as MDs. As the operation concluded, I found myself closing the skin and he was above the ether screen monitoring the patient. There was a moment when we looked at each other and laughed. He was giving anesthesia and I was operating, 48 hours before we could essentially only observe. What a difference two days on the calendar meant. Our knowledge base or skill set had not changed, but the odyssey of becoming a surgeon had begun.

Surgery has changed a lot since I was a resident. With surgical simulation, residents are getting a chance to learn and practice outside of an actual operating room and not inside a human being. They are coming to the OR better prepared,

and hopefully, with the rudimentary skills already ingrained. What a significant improvement over my time, when I would sew two pieces of manicotti together at home, over and over again. While the simulations still appear rudimentary, they are improving yearly and any method that allows a resident to have a better base prior to that day in the OR when that particular skill set is needed is a great leap forward. Surgical groups like SAGES have created programs, such as the Fundamentals in Laparoscopic Surgery course, which teaches basic laparoscopic skills that a resident can learn to master. This and other courses and curricula are taught by trainers or labs, allowing residents to improve their hands and work out the kinks before the skills are used in an OR. This process is not limited to technical work. There are multiple resources available that detail the basic knowledge base a resident must acquire. The Surgical Council on Resident Education (SCORE) curriculum provides an excellent and detailed outline of basic material for residents. There is no question that every one of these teaching tools is a valuable and significant improvement over the old days, my days, and the days of other grey-haired or no-haired surgeons.

However, it is the tradition of surgery that truly makes the surgeon. It is the stories, the practice, the diligence of the senior surgeons that truly form and shape the next generation. That is what takes the basic skills and turns them into what is necessary to be a practicing surgeon, the surgeon who takes pride in his or her actions, and the surgeon who teaches and perpetuates the art. This learning takes place in the halls of the hospital. It takes place in the OR, in the resident call room, and at evening meal. It is also passed on in surgical lore, most of which is based in fact but occasionally told in an exaggerated tale to illustrate a point. It is with the amalgamation of all these sources that surgery is truly mastered. It is surgical finishing school and it begins on the first day of residency and never really ends.

There are many times in a residency when knowledge is conveyed without words. Lessons are taught through assimilation. It is important for residents to keep their eyes and ears open. You never know where the lesson will come from. There are mundane but important lessons, such as the attending that rounds everyday and does a physical exam, a simple but, at times, lost practice in the modern era. There are technical lessons, such as observing how an experienced surgeon uses fixed retraction to improve visualization or trying to figure out why one surgeon can use the same retractor and make the field look so much better than another.

Learning when to operate is as important as learning how to operate. However, the most important lessons usually come at times of duress. I was a third year resident on the cardiac service. For some unknown reason, I was assigned to

first assist the chief of the service to perform a redo CABG on a Saudi Prince. I know there are many Saudi princes, but the patient was a Saudi prince! I also know there are many Cardiac Chiefs but this one had his own special flair. I knew because I had seen him in action and had heard all the stories at 9 o'clock meal.

I prepped the patient without difficulty and the case began well enough. He calmly split the sternum and then sawed directly through the LIMA graft. There was a bit of pulsatile blood and we looked up at the EKG, which was enlarged directly over the ether screen, and saw nicely elevated ST segments. One could call them tombstones. I sat back and waited for the explosion, trying to figure out how this could be blamed on me. Instead, the chief became completely calm and relaxed. He let everyone know what he had done in a level voice. As people in the room started to get agitated, he became calmer. He moved methodically and asked for what he needed in a slow and deliberate fashion. At times, I thought I heard him quietly humming. He quickly got on pump, and ultimately, it was as if nothing had happened. That day, I learned one of the most important lessons I have ever learned from one of the surgeons I feared the most. The behavior of the surgeon at a difficult time in the OR dictates the behavior of everyone else in the room. If there is a sense that you cannot solve the problem because you are losing your cool, then all the people helping you will lose their cool as well. It is a lesson that I teach and use to this day.

Surgery is an incredible field. It is steeped in lore but constantly evolving. We stick to old principles but are forced to re-examine them constantly and abandon them occasionally. The process of learning the art of surgery and evolving into a surgeon is arduous and at times painful, but extremely rewarding. It is the greatest apprenticeship of all. We are lucky to be as part of it. We as surgeons have the highest privilege, that of operating on another human being. However, we are only as good as our last operation and usually are only feeling as well as our sickest patient. Surgery is a tradition unlike any other.

Editor's note: In 2015 David L. Berger joined a rather long series of MGH surgeons who have served as president of the New England Surgical Society. Born in Springfield, Pennsylvania, David graduated from Harvard College with a degree in economics and from the University of Pennsylvania School of Medicine. In 1996 he completed the residency program at the MGH, spent a year as a fellow in vascular surgery at Vanderbilt University, and then returned to the staff of the MGH. Here he is now a Visiting Surgeon and an Associate Professor of Surgery at Harvard. Of particular note, he has served as the general surgeon to three local professional sport teams—the Patriots, the Red Sox, and the Bruins.

Perspectives

The Beginnings of Fetal Surgery at MGH

by Scott Adzik, MD

A Coast to Coast Adventure from the MGH to San Francisco to Toil in the Fetal Surgery Vineyard Alongside Mike Harrison.

In January 1981, I was a second year MGH surgery resident, and I had my heart set on becoming a pediatric surgeon. I had arranged to do a 2-year research fellowship with Judah Folkman at Boston Children's Hospital beginning in July 1982, and I was very excited about it. However, in early 1981, Les Ottinger pulled me away from the West Surgical Service to fill in for some more "cardiac surgery junior resident time" because a resident had dropped out. This was very fortuitous for two reasons: first and most important, I met my future wife, Sandy Ray, who had just started as a cardiac surgery nurse in the MGH SICU; and second, Gus Vlahakes had just returned from a 3-year research fellowship at the Cardiovascular Research Institute at the University of California, San Francisco (UCSF), where he had worked with Julian Hoffman on fetal cardiac physiology in sheep. Gus was assigned a senior resident spot on the Cardiac Surgical Service, so he and I shared every other night call. Gus told me that Mike Harrison was developing fetal surgery at UCSF, and I knew **instantly** this was something I wanted to do—work at the nexus of the pediatric surgery of the future.

I called Mike out of the blue, and asked if I could work with him. After he made some calls and checked me out to make sure that I wasn't a psychopath, he told me that his very first research fellow (Don Nakayama) was starting in July 1981, another UCSF resident was booked to start in July 1982 (he dropped out but Phil Glick filled in), but I could come in July 1983 as fellow #3 (more than two years in the future!), if I could come up with research salary funding.

After getting the blessing from Hardy Hendren and Judah Folkman, who both held Mike in high regard, I worked feverishly on grant support and was lucky to get research funding from the MGH Marshall K. Bartlett Fellowship, ACS Resident Research Fellowship, NIH NRSA, and the American Kidney Foundation.

Sandy and I got married on June 4, 1983 and took off for San Francisco after a short honeymoon in Bermuda. As a



Scott Adzik

newly married resident, I was very grateful that Jerry Austen offered to generously take care of our medical benefits through the MGH Surgery practice plan. We were off to the races! A peak life experience was about to begin with mentor and then colleague, Mike Harrison. It was a miracle and a privilege to participate directly in the fetal surgery work—from experimental models to initial clinical application—a story that Mike describes beautifully.

Editor's note: Scott Adzick graduated from Harvard College and Medical School. He completed the MGH Residency in 1986 following a break as a Postdoctoral Scholar in the Department of Surgery at the University of California, San Francisco. There followed a Pediatric Surgical Fellowship at the Children's Hospital, Boston. Then, after nine years back in San Francisco, he became and remains the C. Everett Koop Professor of Pediatric Surgery at the University of Pennsylvania School of Medicine.

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It All Began at the MGH

by Michael R. Harrison, MD

I came to UCSF straight from a pediatric surgery fellowship in January 1978, because at that time I thought it offered the best opportunity of any place in the world to develop fetal surgery. But it all started 9 years earlier at the MGH. I had been nourishing a crazy idea about fixing surgical defects before birth since the first month of surgical internship. In July 1969, as a green and clueless surgical intern, I assisted the god-like Dr. Hardy Hendren in an emergency operation on a newborn baby with congenital diaphragmatic hernia (CDH). Despite the amazing surgery, and my all-night vigil trying to keep the baby alive, the baby died of respiratory failure. Why? I was so green and so naive it seemed obvious to me that the baby had died because the lungs were too small, and the lungs were too small because they were not able to grow adequately before birth, and that the only way to save babies with severe CDH was to fix the anatomic defect before birth so the lung would be adequate at birth. In that first month of internship, I wrote a short protocol for an animal experiment that would test this hypothesis by creating and repairing diaphragmatic hernias in fetal dogs (most surgical research was done in dogs in those days). I never got to do the experiment, but held on to the idea through seven years of surgical training.

But there were many experiences dragging me toward the first fetal surgery. I had two wonderfully productive years of research at the Laboratory of Immunology at NIH, where I became fascinated by fetal immunology and the problem of why the mother doesn't reject the foreign fetus, a question that remains unanswered to this day. I also had a brief six-month interlude of pediatric surgery training in Oslo, Norway, thanks to Hardy Hendren's intercession with his friend Ola Knutrud. My determination to pursue fetal intervention was reinforced by studying the mortality of my old nemesis, CDH, in a medical care system that allowed me to document that many babies with diaphragmatic hernia died before they ever reached the tertiary center, a phenomenon I dubbed the hidden mortality. This work suggested that the natural history of a disease discovered before birth may not be the same as when the same problem is encountered after birth simply because the most severe cases do not survive to be studied. This phenomenon turned out to apply to many fetal diseases.

With these embryonic concepts about fetal treatment bubbling in my head, I was thrilled to learn about the exciting work in fetal physiology going on at UCSF using the fetal lamb model. Al deLorimier, the first and, at that time, only UCSF pediatric surgeon, had used the fetal lamb model



Mike Harrison

to study the physiologic consequence of a surgically created diaphragmatic defect. I took the job in San Francisco (my first and only faculty position) specifically because I thought I could tap into this exciting experimental animal research and use it to see whether fetal intervention made physiologic sense (i.e., if correcting a defect would have the desired effect) and to develop the techniques that would make fetal surgery safe and feasible. This proved to be the case.

Experimental Models: Physiology in lambs, feasibility in monkeys

Within months of arriving at UCSF in January 1978, we embarked on a series of experiments to create and correct diaphragmatic hernia, then urinary tract obstruction, and finally hydrocephalus—the first three in a long series of diseases which I thought might be fixable in human fetuses. In each case, we simulated the disease by surgical intervention, studied the consequences of the intervention on the development of the target organ system, then corrected the lesion and studied the developmental consequences of correction. This pattern of investigation formed the basis of the fetal intervention enterprise for the next two decades and helped establish the fetal lamb model as the most widely used and accepted method of testing the physiologic rationale for fetal intervention in a host of diseases.

But the fetal lamb model had one grave deficiency, it was simply too easy to get away with fetal intervention in the lamb because (as we used to say) the sheep uterus was too dumb to contract in response to a surgical incision. This property made it ideal for testing fetal pathophysiology, but completely inadequate for testing the safety of intervention

for both mother and fetus and for developing techniques that would allow access to the fetus without precipitating preterm labor. We decided early on that success in the fetal lamb model would not be enough to justify human intervention; instead we would have to prove that a proposed procedure was safe for mother and fetus in the non-human primate model before we could offer it clinically. For that reason, we went right on to fetal surgery experiments in rhesus monkeys, first at UCSF and then at the primate colony at the University of California, Davis, where we could follow the operated mothers for years and study the effect of intervention on maternal morbidity and reproductive potential. Availability of the facilities both at UCSF and at Davis for sheep and monkey work played a crucial role in the development of fetal surgery. To get a feel for the magnitude of this enterprise and its role in launching fetal surgery, in the 1980s we operated on more than 2,000 fetal lambs and 500 fetal monkeys. A very considerable part of the effort and cost of launching fetal surgery was the many millions of dollars invested in this research, all of which had to be raised through almost continuous (and painful) grant writing.

However, the most important element in launching the enterprise of fetal surgery in the 1980s was the investment of talent and time by a small group of bright, ambitious, and resourceful research fellows. The effort expended was prodigious. For example, every procedure done in Davis required a full day, including hours commuting back and forth, and many more hours to arrange the veterinary aspects of the intervention as well as the hours devoted to the surgery, itself, and the many, many hours devoted to follow-up of the animals. The bottom line: clinical fetal surgery was made possible by a huge volume of translational research done in our laboratory by the Fetal Treatment Center research fellows. The fellows provided an indispensable pool of talent, enthusiasm, and good humor. Needless to say, they contributed a fabulous amount of hard work in doing the experiments, writing them up, and presenting the results at meetings. They have made immense contributions to the field over many years. Many of them have gone on to successful careers for which I am immensely proud. There is no way to recognize all the talents and personalities in this short piece, but the MGH surgery program provided some of the most talented and productive fellows. Scott Adzick made amazing contributions both as a research fellow in the middle of his MGH training and as my first Pediatric Surgery faculty recruit. He has gone on to world renown as founder and leader of the Center for Fetal Diagnosis and Treatment at the Children's Hospital of Philadelphia. Thanks to Scott's enthusiasm, we attracted 3 more talented MGH surgery residents who made important contributions to the devel-

opment of fetal surgery: Brian Duncan, Tom MacGillivray, and David Gibbs. On a personal note, I view the research fellows as my most important (and certainly most enjoyable) contribution to the enterprise of fetal surgery.

Editor's note: Mike Harrison graduated from Yale University and Harvard Medical School. He completed the MGH Residency in 1975 following a break as a Research Associate at the NIH. He then had a fellowship at the Rikshospitalet in Oslo, Norway and spent two years as a Pediatric Surgery Fellow at Children's Hospital of Los Angeles. His subsequent career has been at the University of California in San Francisco where he became the Professor of Surgery, Pediatrics, and Ob/Gyn. He is now Professor Emeritus there.

W a n d e r j a h r

The Education of a Few MGH Surgeons Abroad

John T. Mullen, MD, Cristina Ferrone MD, and Matthew M. Hutter, MD, MPH

Most of you will recognize that word, *Wanderjahr* (from German for “wander year”), as this was the title of Dr. Edward Churchill's account of his Moseley Traveling Fellowship from 1926 – 1927, taken from his diaries and interviews conducted some 30 years after the event. It is a wonderful account, providing valuable insight into the world of surgery at the beginning of the twentieth century. It was, of course, common for promising young surgeons of that generation to spend time abroad, principally in Europe, to meet and observe the pioneers in surgery. This was a transformative experience for Churchill, as it provided him with the vision and confidence to become a pioneer in the new field of thoracic surgery and a master surgical educator who rejected Halsted's pyramidal training system and designed instead the “rectangular” residency training program, which has clearly stood the test of time.

Sadly, it is uncommon for young surgeons of our generation to take time out of their busy schedules to conduct their own *wanderjahr* – or even a “wander month.” However, in the past year or so, all three of us (CF, JM, MH) relatively ‘young’ surgeons had the unique honor and privilege to travel abroad to learn from our surgical colleagues in Europe, Asia, and Australia. Each of us believed that the knowledge and perspective gained as a result of these fellowships would enable us to offer better care to our patients, and that the professional relationships we made would hopefully translate into exciting new collaborations in the years to come.

Dr. Ferrone traveled to Germany to visit the masters in hepatopancreatobiliary surgery; Dr. Hutter traveled to Europe, Asia, and Australia to learn how surgeons around the world ensure high-quality care; and I (JM) traveled to Japan to learn from the masters in gastric cancer surgery. Each of us was awarded a competitive traveling fellowship, which not only provided a bit of structure to the experience but also defrayed the costs of travel and lodging. For those considering a traveling fellowship, we cannot emphasize enough how valuable such a trip abroad can be to one's personal and professional development. Indeed, we have much to learn from our surgical colleagues around the world, and establishing both personal and professional connections with them is an honor and a joy. What follows are highlights of our experiences abroad.

Report of the 2015 American College of Surgeons' Traveling Fellow to Germany

by Cristina Ferrone, MD
(General and Gastrointestinal Surgery)

The primary focus of my ACS Germany traveling fellowship was to learn about the care of hepatobiliary patients, the training and education of surgical residents (especially female surgeons), translational research, and clinical trial infrastructure in the various clinical centers of the three Universities I visited in Germany. My hosts in Heidelberg were Professor Dr. med. Dr. h.c. Markus W. Büchler and Dr. Oliver Strobel. Professor Dr. med. MBA Tobias Keck was my host in Lübeck, and my hosts in Dresden were Professor Dr. med. Jürgen Weitz, MSc and Professor Dr. med. Robert Grützmann.

Unlike the United States, where most surgeons have their own individual practices within the University Hospital, the German Departments of Surgery function as group practices. The group practice is most similar to the way the Acute Care Surgeons at MGH run their practice, in that patients may be cared for by any surgeon in the group. Since most patients are seen preoperatively by the Chairman of the Department, or *Leitender Oberarzt*, which roughly translates to "lead attending," the Chairman is the point of reference for the patient. In the departments I visited, the cases are distributed by the *Leitender Oberarzt* to the *Oberarzt*. This allows for a very broad variety of cases for the attending surgeons. Most of the surgeons I spoke with would, as a routine, perform very diverse operations, from a breast cancer case, to an esophagectomy, to a liver transplant, sometimes even in one day. This approach allowed for a very diverse operative experience and a very efficient use of the operating rooms.



From left: Dr. Ulrich Wellner, Dr. Kim Honselmann, Prof. Dr. med. MBA Tobias Keck, Dr. Cristina Ferrone, and Dr. Dirk Bausch at the old restaurant Schiffergesellschaft in Lübeck.

The operative management of hepatobiliary patients in Germany is quite similar to what I have experienced at the Massachusetts General Hospital (MGH) with a few notable differences. Some of these differences include the "artery first approach" when performing Whipple procedures, slightly different liver parenchyma transection techniques, and depending on the center, the management of patients with intraductal papillary mucinous neoplasms is also quite different from what we teach at the MGH. They tend to be operatively more aggressive with smaller lesions.

The role of the Chief of Surgery in Germany is very different from the United States. The Chiefs in Germany have an incredible amount of involvement with the members of their Division. These differences include not only operative case distribution, but also participation of the Division in clinical trials or research efforts. The group effort of the Department allows for fast patient accrual in clinical trials, as well as large tissue banking and research efforts.

During the time I spent at all of the centers, the teaching of medical students and residents is what impressed me most. While the residents do not operate as much as they do in this country, the theory and reasoning behind the operations, as well as the anatomy, are always very elegantly explained.

I would like to express my utmost gratitude to the American College of Surgeons and to the Deutsche Gesellschaft für Chirurgie for this incredible opportunity. I would also like to thank my Chairman, Professor Keith Lillemoe, and my colleague, Professor Carlos Fernández-del Castillo, for supporting my trip and taking care of my patients in my absence. I would like to thank my husband and parents for caring for our three children. Last, a sincere thank you to my hosts and their teams in Dresden, Heidelberg, and Lübeck.



From left: Dr. Christian Krautz and family, Prof. Christian Pilarsky, Dr. Anne Sturm, Prof. Robert Grützmann, Dr. Cristina Ferrone, and Dr. Georg Weber and family at the home of Prof. Robert Grützmann in Dresden.

Report of the 2014 American College of Surgeons' Traveling Fellow to Japan

by John T. Mullen, MD (Surgical Oncology)

As a surgical oncologist specializing in the surgical treatment of gastric cancer, I have long been interested in traveling to Japan to observe and to learn from the leading gastric cancer surgeons in the world. As soon as I became aware of this unique fellowship opportunity in Japan sponsored by the *College*, I immediately applied and was grateful to have been chosen as the 2014 ACS Traveling Fellow to Japan. With the invaluable assistance of my mentors at MGH and of my hosts in Japan, I was able to assemble an efficient and educational itinerary organized to coincide with the 114th Annual Congress of the Japan Surgical Society in Kyoto.

My first stop was Kyoto University Hospital, where I met Dr. Shigeru Tsunoda, MD, PhD, assistant professor of surgery and a colleague of Dr. Hiroshi Okabe, MD, PhD, associate professor of surgery. We attended a meeting during which all clinic patients to be seen that day were discussed in detail, including a review of the imaging studies with a radiologist. I did not go to clinic but rather went to the OR to observe a laparoscopic distal gastrectomy, which was specifically planned for me this day and which was performed by Dr. Okabe and assisted by Dr. Tsunoda. Unfortunately, international visitors are not allowed to scrub on cases, but observing the cases was still incredibly educational. Professor Okabe is widely regarded as a very accomplished laparoscopic gastric surgeon in Japan. His group performs approximately 90 gastrectomies and 25 minimally invasive esophagectomies each year. It was a real pleasure to watch Professor Okabe and his team perform a meticulous, effortless distal gastrectomy and D2 lymphadenectomy. I immediately understood why the outcomes with this procedure

in Japan are so fantastic—the procedure is so carefully and systematically performed.

As this was my very first opportunity to be in an operating room outside of the United States, several things struck me as notable: (1) OR cases tend to start quite late in Japan, such as at 9:30 or 10:00 AM; (2) surgeons at the major university hospitals specialize in only one field (e.g., esophago-gastric cancer) and typically do only one major OR case per day; (3) there are far fewer operating rooms in the major university hospitals in Japan than in the US—perhaps only 15-20 for a 1000-bed hospital; (4) Japanese surgeons perform a time-out procedure just as we do in the US, and in fact the checklist is posted in large format on the walls of the OR at some centers; (5) surgeons use similar linear and circular staplers and energy devices as we do in the US, and at least at the hospitals I visited, there seemed to be no financial pressure to limit the use of disposable instruments; (6) OR cases are almost always done by two faculty members—typically a full or associate professor together with an assistant professor, and the surgical residents typically only hold the camera and help close the wounds; and (7) once the gastrectomy specimen is retrieved, an army of residents will come to the OR to open the specimen, show it to the operating surgeons, and harvest the regional lymph nodes, node by node, placing them in formalin-filled jars, a practice which no doubt accounts for their amazing nodal yields.

At the time of my stay in Kyoto, the Annual Congress of the Japan Surgical Society was held at the Kyoto International Conference Center. This Congress is very similar to our ACS Clinical Congress, in that it is the largest and best attended surgical meeting in Japan each year, with more than 14,000 attendees. I was joined by 15-20 other traveling fellows from around the world, including fellows from Germany, India, China, Korea, and Spain. There I attended the International Session on Upper Gastrointestinal Tract



From left: John Mullen with a maiko (apprentice geiko), Dr. Matt Katz from the University of Texas M.D. Anderson Cancer Center, and a local surgeon viewing the cherry blossoms (sakura) at night along the streets of Kyoto.

Surgery and gave a presentation on “Predictors of Lymph Node Involvement in T1 Gastric Carcinoma.”

My next stop was Nagoya University, where I was hosted by Professor Yasuhiro Kodera, MD, PhD, FACS, Chairman of the Department of Surgery (II). Dr. Kodera is a famous surgeon and thought leader throughout the world in the field of gastric cancer. He arranged several minimally invasive esophageal and gastric cancer operations for me to observe, and I also had the opportunity to watch Professor Nagino, MD, PhD, Chairman of the Department of Surgery (I), do an extended hepatectomy for a Klatskin tumor. I was particularly impressed by the advance preparation of the surgeons in Japan for their major surgical procedures. Beautiful hand-drawn diagrams of the planned resection with all of the portal venous, arterial, and biliary anatomy carefully detailed were posted on the operating room wall, accompanied by three-dimensional CT scans of the liver with the functional liver remnants outlined for the various possible resections.

During my stay in Nagoya, I also had several long discussions with Professor Kodera about neoadjuvant and adjuvant therapy approaches to gastric cancer and about the rationale and status of multiple clinical trials concerning gastric cancer being conducted in Japan. Last, I had the unique opportunity to attend a meeting one evening at a local hotel ballroom at which many of the young surgeons from the community hospitals in Dr. Kodera’s network assembled together to present some of their more challenging cases. This meeting occurs at least every few months and allows Dr. Kodera to learn about the surgical care that is being delivered at the community hospitals in his ‘network’ in and around Nagoya as well as the opportunity to

spot a young surgeon with promise to recruit back to the academic hospital.

The final stop on my itinerary was Keio University in Tokyo, where Professor Yuko Kitagawa, MD, PhD, FACS, was my host. Professor Kitagawa is the Chairman of the Department of Surgery at Keio University and is a world famous surgeon specializing in esophagogastric cancers. He is particularly noted for his work in sentinel lymph node (SLN) mapping for early gastric cancers, and on the first morning of my visit he gave me a wonderful tour of the hospital and of his new research facility, including a large animal lab for his translational research program. Professor Kitagawa and his very capable junior partner, Dr. Hiroya Takeuchi, MD, PhD, associate professor of surgery, organized several consecutive OR days of complex upper GI cases for me to observe, including combined laparo-endoscopic resections of GISTs near the gastroesophageal junction, SLN mapping of early gastric cancers, and laparoscopic distal gastrectomies with D2 lymphadenectomies. I was again impressed by the facility with which they performed these rather complex procedures using three-dimensional laparoscopy.

While in Tokyo, I was joined by my wife and two children, and we made it a point to visit several famous sights in Tokyo, including the Tsukiji Fish Market, the Imperial Palace, Asakusa, and the Hama Rikyu Gardens. We also took an extended weekend trip on the Skinkansen out to Kyoto, where we visited Arashiyama and took a boat cruise down the Hozugawa River, and then on to Hiroshima and Miyajima, an island off the coast of Hiroshima. We visited the Peace Memorial Park, the Peace Museum, and the Atomic Dome in Hiroshima. This was an expectedly somber visit, but it was an eye-opening, educational experience, especially for my children.



The Mullen family (from left) (John, Ryan, Madison, and Melissa) in front of the famed Torii gate on Miyajima Island.

In closing, I believe that the knowledge and perspective I gained as a result of this fellowship will enable me to offer better care to my patients with gastric cancer, and the research collaborations that I made and that I plan to foster in the years to come will hopefully translate into exciting new treatments for this disease. For those considering this or another such traveling fellowship, I cannot emphasize enough how valuable such a trip abroad can be to one's personal and professional development. Indeed, we have much to learn from our surgical colleagues around the world, and establishing both personal and professional connections with them is an honor and a joy.

Report of the James IV Traveling Fellowship 2014-2015

by Matthew M. Hutter, MD, MPH
(General and Gastrointestinal Surgery)

I am most thankful for the experiences I had as the James IV Association of Surgeons Traveling Fellow from the US for 2014-2015. The James IV Association of Surgeons was founded in 1957. Its sole purpose is to sponsor visiting fellowship opportunities for young surgeons. The goal is not only to promote the exchange of surgical knowledge, but also to foster the kind of lasting friendships that have meant so much to the founders of this Association and to those who have subsequently joined. Each year, one surgeon from "the British Isles" (England, Scotland, Ireland, Hong Kong, or Australia), one surgeon from Canada, and one or two surgeons from the US are given the opportunity to spend six weeks on an international traveling fellowship to countries of their own choosing. Travelers are encouraged to bring their family members. Joe Fischer, the only other MGH surgeon to have received this fellowship, was a traveler in 1975. I encourage all trainees and young faculty to consider this amazing opportunity (www.jamesivassociationsurgeons.com).

For my fellowship, I chose to travel to Europe and Asia. In July 2014, I traveled to Europe, where I visited Amsterdam, London, Scotland, and Paris. In February of the following year, I traveled to Hong Kong, mainland China, and Australia. This allowed me not only to align the trips with my kids' school calendars and to divide my time away over two fiscal years, but also, serendipitously, I was able to enjoy an Australian summer during a record-setting snowfall in Boston!

My primary goal was to observe first-hand how surgeons from different countries, who have different health systems and face different cultural and political challenges, assess the quality of surgical care and promote and incentivize high

quality care. I also wanted to learn how other health systems safely introduce novel techniques and technologies. What I learned was so much more. My experiences ranged from a one-on-one meeting with the recent CEO of health care for all of England, to hiking with a private practice surgeon and her dog in an Australian park. The opportunity to share this experience with my family, who accompanied me for the majority of the trip, was an experience we will never forget. It would be impossible to describe all the remarkable people I met, including the 16 other James IV Travelers I became acquainted with, or to describe all the experiences I had in the 18 hospitals and seven countries I visited over six weeks, but here are a few of the highlights.

Europe – July 2014

Amsterdam

My first stop was Amsterdam, where I was hosted by Professor Jaap Bonjer, who is Head of the Department of Surgery and Chairman of the Vrije Universiteit Medical Center (VUMC). Jaap leads his department with unbounded energy and enthusiasm, and has created a stellar *esprit de corps* amongst the professional staff.

During my time at VUMC, whether in the OR or meeting with research fellows and staff, I became enamored of the Dutch people, their health system, as well as the city of Amsterdam. First, their culture of safety is unparalleled. When I think of all the challenges I have encountered here in the US, instituting checklists, SCIP compliance, or other



From left: The Lord Ara Darzi, Chair of Surgery at Imperial College in London, with Hutter family in the inner chambers of Parliament after High Tea with members of the House of Lords.

QI projects, it was a pleasure to see a faculty that was genuinely invested in their health system. From the responses I got to my probing questions, I soon realized they truly believed in it, too. Take, for example, their initiative to decrease infections by minimizing OR traffic. By design, all of the doors in the ORs at the VUMC are pocket doors that slide into the wall to avoid swinging particulate matter and infection about the room. The amount of time the doors remain open during a case is tracked electronically, and every effort is made to minimize the number and duration of door openings. Nurses use cell phones to speak with other nurses while looking at each other through the window in the closed door, rather than opening the door to have a discussion. Once when I wandered out a door, the anesthetist hustled through with me—he had been waiting for a bathroom break but was not going to leave until someone else could share the door opening with him. This is very different from our ORs, where the OR door swings practically onto the Mayo stand in some of our operating rooms, and where the OR at times seems more like a thoroughfare than a sterile sanctuary.

I was also amazed at how well the Dutch work together to perform nationwide clinical trials. With very limited budgets, similar to what one might get to perform a pilot study in the US, they are able to pull off world class nationwide clinical trials, such as the COlon Cancer Laparoscopic or Open Resection (COLOR) trial. Surgeons across the country feel it is their duty and pleasure to be involved in this work. They willingly hire study staff and enroll patients on their own dime and time in order to advance surgical knowledge. Their work ethic is amazing. It is part of their social fabric and re-engages surgeons across the country, who have worked or trained together in years past. With charismatic leadership and a culture where everyone works towards a common goal, the Dutch have made amazing strides in quality and safety and academic output such as clinical trials.

London

Our next stop was London. Here my host was Professor the Lord Ara Darzi, from the Imperial College. As the Chair of Surgery at Imperial College, Ara Darzi has created a world class surgical research department, the breadth and depth of which I have never before seen. He has also been able to navigate the political and policy fields as demonstrated by his numerous accomplishments, including being knighted in 2002, raised to the peerage in the House of Lords in 2007, and being appointed both as the Parliament Under-Secretary of State in the Department of Public Health and the Global Ambassador of Health in the UK. Truly an impressive man.

I met one-on-one with Sir David Nicholson. Sir Nicholson

was the Chief Executive of the National Health Services (NHS) in England from 2006 to 2014. He had just retired from that post three months prior to my visit. He spoke freely and thoughtfully on the lessons learned in the NHS over those years, and provided deep insight into those experiences as well as the challenges facing the US in the coming years. I was also privileged to attend an extended, one-on-one luncheon with Sir Liam Donaldson, who had held a 12 year post as the Chief Medical Officer of England—the US equivalent to the Surgeon General. The discussions we had about his experiences and the lessons he learned while at the helm of the UK health care system were remarkable, as were our discussions about his current focus on incident reporting and the status of data in the NHS. I toured all the different surgical research programs that Ara Darzi has spawned and spent two days in the “theatre” at the Queen Mary Hospital and Royal Marsden Hospital.

Ara Darzi graciously enough invited me and my family to High Tea at the Parliament, a custom reserved solely for the members of the House of Lords and their guests. He personally led us on a tour of Parliament, including the inner chambers that are otherwise inaccessible. This experience was a highlight of our travels.

Scotland

From London, I traveled to Edinburgh, Scotland to meet our host, Professor O. James Garden. Professor Garden is a hepatobiliary surgeon and the Chair of the Royal Infirmary of Edinburgh. He had just returned from a meeting with the Royal medical staff, as he is the “Surgeon to the Queen in Scotland.” He was a tremendous host and crafted a visit that included Edinburgh, Dundee, and Glasgow. In Edinburgh, I met with surgeons and residents at the Royal Infirmary and spent time in their theatres.

Next, I traveled to Ninewells Hospital in Dundee where Bob Steele, a James IV member, was my host. I met with their surgical researchers, and I visited the Sir Alfred Cuschieri Skill Center, as well as the Medical Science and



With Professor James Garden (center) and former James IV traveler, Rowan Parks (right), in Edinburgh Scotland.

Technology Institute where clinicians work with industrial engineers to create prototype surgical instrumentation and equipment right at the hospital.

In Glasgow, I met with the Head of Health Protection Scotland, which is the Scottish version of our CDC. I spoke with their quality improvement teams and epidemiologists about similarities and differences between our healthcare systems for measuring and improving the quality of care, and especially the challenges of implementing change. I also met with their Health Services Research group, which analyzes the outcomes of surgical care.

After learning so much about the British NHS, it was fascinating to juxtapose that experience with the Scottish NHS and to see how seemingly small differences in the way their systems work can have such a large impact on health care delivery.

Paris

In Paris, my host was Professor Brice Guyet. Brice is a hepatobiliary surgeon and laparoscopic innovator who works at L'Institut Mutualiste Montsouris, a private non-profit hospital that participates in the public hospital service. It was fascinating to see how he has developed novel techniques for laparoscopic liver resection using new technologies. Perched on a stool, with sock feet on the Bovie foot pedal, he used the "French Touch" with bipolar cautery to stop bleeders right on the IVC. 3D imaging and an Aesop driving the laparoscope further helped him execute with precision. With passion and conviction he has been an innovator and pioneer in his field. As luck would have it, we were in Paris for their Bastille Day celebration, saw the Tour de France come through town, and saw all the sites that the kids had studied in school.

Asia and Australia – February 2015

The second leg of my traveling fellowship commenced in February 2015 and spanned two continents. In Asia, we visited Hong Kong and Shenzhen, China, while in Australia we traveled to Sydney, Cairns, and Melbourne.

Hong Kong

Our hosts in Hong Kong were Professors John Wong and C.M. Lau, the past and current chairs of surgery, respectively, at Queen Mary Hospital. Hong Kong has two systems of healthcare—private and public. The economics of this situation drives many accomplished academic surgeons to the private side eventually. I found Hong Kong and its culture to be fascinating, as well as its hospitals and their leaders. I spent time on the wards and in theatre, had meetings with their research and quality teams, and had brunches, lunches, and dinners during which I met with numerous members of



With Professor John Wong (left) at Queen Mary Hospital at the University of Hong Kong. Note, the James IV traveler is expected to wear the traveler's tie, which, as you can see, I dutifully wore.

the department, from junior trainees to professors emeritus. Professor John Wong had been their chair for 20 years, and he shared his reflections and thoughts about mentoring, career development, and building a modern surgical department with the financial challenges of competing public/academic and private models.

Shenzhen, China

Next, I traveled to Shenzhen in mainland China, to visit the brand new 2,000 bed Shenzhen Medical Center, which boasts 10,000 outpatient visits a day. China is building out its medical expertise with state-of-the-art medical centers. In addition, they are working with partners from overseas to import a modern management style, including staff and leadership. I was fascinated to learn of their challenges with the merging of cultures, and the adoption of new models for patient care, leadership, and management.

Australia

The final leg of my fellowship began in Sydney, Australia. Michael Solomon, my host at the University of Sydney, arranged for me to visit two hospitals, the Queen Victoria Hospital and the Prince Alfred Hospital. I met with his team at the Surgical Outcomes Resource Centre (SOuRCe) where we discussed differences in measuring quality between Australia and the US. I also met with Cliff Hughes, a surgeon who runs the Clinical Excellence Commission which is the governmental body that leads quality and safety in the Province of New South Wales. The Minister of Health from New South Wales also requested to meet with me, so he could learn more about EHRs and their challenges with regard to implementation and quality and safety in the US.



Visiting the Shenzhen Hospital in China and viewing their state-of-the-art operating room.

I met with the surgical leaders of the Agency for Clinical Innovation on behalf of the American College of Surgeons, as they had just implemented the NSQIP at five hospitals there. We discussed lessons learned in the US with leveraging the NSQIP to drive quality improvement, and I learned about the carrot and stick approach they use in Sydney to drive quality improvement.

My family joined me in Sydney to see the sights. We climbed the Sydney Bridge, watched the Australian Open of surfing, did some surfing ourselves, and met with plenty of kangaroos and koalas. We then headed to Cairns and snorkeled on the Great Barrier Reef. After Sydney, my family headed home, while I continued on to Melbourne.

Melbourne

Bruce Mann and Julie Miller hosted my visit to Melbourne. They were kind enough to put me up in their home. They are both surgeons, and they have three charming children. I felt like I really got a true taste of what life was like at home and at work for an Australian surgeon. I visited the Royal Melbourne Hospital, the Royal Women's Hospital, the Peter MacCallum Cancer Center, and the Alfred Hospital. I met with their Surgical Outcomes group—the Melbourne EpiCentre. I spoke at the Melbourne Bariatric Surgery Society Meeting. I met with Paul O'Brien, who wrote the landmark studies on outcomes of the laparoscopic adjustable band. Those discussions were so interesting he invited me to his house where we figured it all out over a bottle of champagne. I met with the leaders of the academic medical centers, and we discussed the fiscal and political challenges of building an academic medical center.

A common theme from all these visits is that *All politics is local* and indeed for all of these countries, where there is significant government involvement, I would add that *All health care is political*. We in the US seem to be venturing further into this realm with the Affordable Care Act. Whether in Amsterdam, Scotland, Hong Kong, or Australia, politics plays a significant role in how health care is delivered. We as surgeons in the US need to continue to do what is right in the face of political challenges and changes in health care, and to advocate for our patients to fight the surgical diseases that afflict them.

I would like to thank my wife, Amy, and my kids, Max, Will, and Anna (ages 12, 10, and 8), who made this trip so special. Amy organized everything—a truly stupendous feat. Max, Will, and Anna each carried their own weight—with a carry on suitcase and backpack—and trekked with us across miles of underground tube, metro and train stations, and quaint cobblestone roads to our flats. My daughter still asks for malt vinegar for her French Fries. While I was in the hospital, they would be out seeing the sights and then over dinner would tell me everything they had done that day. I could share with them the highlights of the day as I was processing them. Of course, we had weekends and the occasional day when we could see the sights and explore the cities together.

I want to thank the James IV Association of Surgeons for what has certainly been one of the highlights of my surgical career to date. I am grateful to my hosts who created amazing itineraries at each hospital, and really rolled out the red carpet for me and my family. They dined with us, entertained us, put us up in housing or in their homes; they even pretended to be interested in my talks! I would like to thank my chairman, Keith Lillemoe, for sponsoring me, my chief, David Rattner, and my colleagues in General and GI Surgery for allowing me the time away, and especially Denise Gee, Janey Pratt, and Oz Meireles who cared for my patients during my extended absences.

My mind and my world have been opened and enriched by meeting so many fascinating and kind people, and experiencing how surgery is performed in many different countries. My family will cherish this experience as well. Thank you for this remarkable opportunity.

Editor's note: Cristina Ferrone graduated from the University of Pennsylvania and The Washington School of Medicine, St. Louis; Matthew Hutter from Harvard University and Harvard Medical School; and John Mullen from the University of California, Berkeley and the UC Davis School of Medicine. All three completed the MGH residency program in surgery, had additional fellowships in various aspects of general surgery and public health, and are now active members of the clinical staff of the MGH Department of Surgery.

Announcements

W. Gerald Austen, MD ('59) was awarded the 2016 National Physician of the Year Award for Lifetime Achievement from Castle Connolly at a dinner held on March 21, 2016 at the historic Pierre Hotel in New York City. The National Physician of the Year Awards recognizes both physicians and leaders in health care whose dedication, talents, and skills have improved the lives of countless thousands of people throughout the world.

Branko Bojovic, MD joined the Plastic & Reconstructive Surgery faculty in October 2015 and also joined the faculty at the Shriners Hospitals for Children—Boston. Dr. Bojovic is returning to the MGH where he completed part of his Plastic Surgery residency in the Harvard Combined Plastic Surgery Program. After completing his residency, he did a fellowship at the Johns Hopkins and remained as a member of their faculty for some years. Dr. Bojovic specializes in craniofacial surgery and microsurgery.



Susan M. Briggs, MD, MPH, FACS ('80) (Trauma, Emergency Surgery, and Surgical Critical Care). In December 2015, as outgoing president of the Boston Surgical Society, Dr. Briggs gave the 2015 Presidential Address on “Surgeons as Leaders in Disaster Response” at the Harvard Club of Boston. Dr. Briggs was also selected to be the 2016 American

College of Surgeons “Scudder Orator.” This annual lecture was created in memory of Charles Lock Scudder, an attending surgeon at MGH from 1903-1943.

David Tom Cooke, MD ('06) Associate Professor of Surgery and Head of the Section of General Thoracic Surgery at the University of California Davis School of Medicine, was elected to the American Association for Thoracic Surgery. In addition, he was elected chair of the Cardiothoracic Surgery Advisory Council for the American College of Surgeons.

David A. D'Alessandro, Jr., MD joined the Division of Cardiac Surgery in September 2015 as the Surgical Director of Heart Transplant & VAD. Dr. D'Alessandro is a 1997 graduate of Columbia University College of Physicians & Surgeons. He completed his residency in General Surgery in 2000, followed by a fellowship in Renal Transplant in 2002 and a residency in Thoracic Surgery in 2004, all at the New York Presbyterian Hospital/Columbia University Medical Center in New York City. Before coming to MGH Dr. D'Alessandro's most recent appointment was Surgical Director for Cardiac Transplant at Montefiore Medical Center located in Bronx, NY. His clinical focus has been sur-

gical treatments for end-stage heart failure, including mechanical assistance and heart transplantation. He has a broad experience in all aspects of adult cardiothoracic surgery, including on and off pump coronary artery bypass surgery, valve repair and replacement, and the treatment of thoracic aneurysms.

Daniel Doody, MD (Division of Pediatric Surgery) was named Associate Program Director of the General Surgical Residency in January 2016.

Mary E. Fallat, MD, FACS, FAAP Chief of Pediatric Surgery



and Hirikati S. Nagaraj Professor of Surgery at the University of Louisville School of Medicine, and Chief of Surgery at Kosair Children's Hospital, was the featured speaker for the inaugural **Dr. Patricia K. Donahoe Pediatric Surgery Lecture** on March 3, 2016. Dr. Donahoe is pictured in the accompanying portrait. This named lecture honors Dr. Donahoe's many accom-

plishments throughout her years of dedicated service to the Department of Surgery. Dr. Fallat was a surgical research fellow under Dr. Donahoe and has since become the recipient of many honors and awards in her own right.

Heather R. Faulkner, MD, MPH joined the Plastic & Reconstructive Surgery faculty in August 2015. Dr. Faulkner was previously the Adult Reconstructive and Aesthetic Breast Surgery Fellow in the MGH Division of Plastic Surgery. She will be practicing in Danvers, Massachusetts.

Carlos Fernández-del Castillo, MD will be awarded the Andrew L. Warshaw Master Educator Award at the Annual



Meeting of the Society for Surgery of the Alimentary Tract at Digestive Disease Week to be held in May 2016 in San Diego. The SSAT established the Andrew Warshaw Master Educator Award in 2011 to recognize outstanding surgical educators and mentors. The award is presented annually to a member of the SSAT who exemplifies excellence as a mentor, teacher, and educator. Dr. Fernández-del Castillo, who is Director of the

Pancreas and Biliary Surgery Program and Co-Director of the GI Cancer Center, was also installed on April 11, 2016 as the inaugural incumbent of the Jorge and Darlene Pérez Endowed Chair in Surgery. A widely recognized expert in pancreatic and biliary surgery, he was awarded this chair in recognition of his commitment to advancing the field of pancreatic cancer treatment.

Robert E. Hillman, MD (Center for Laryngeal Surgery and Voice Rehabilitation) received the 2015 John T. Potts Jr., MD Faculty Mentoring Award from the Center for Faculty Development in recognition of his outstanding mentorship of academic trainees.

Matthew M. Hutter, MD, MPH, FACS ('02) Associate Professor of Surgery and Medical Director of the Codman Center for Clinical Effectiveness in Surgery, was honored as the inaugural incumbent of the



Codman-Warshaw Endowed Chair in Surgery. Under Dr. Hutter's leadership, the Codman Center reduced re-admission rates in the Department of Surgery by 20 percent and he also received the Bowditch Prize in 2013. This chair will allow Dr. Hutter, shown here with Dr. Andrew L. Warshaw (left) and Dr. Keith D. Lillemoe (right), to pursue further research on surgical outcomes and quality of treatment to advance the safety and efficacy of surgical care.

Hiroko Kunitake, MD ('12) joined the staff of the General and Gastrointestinal Surgery Division at the MGH in January 2016. Dr. Kunitake received her MD from the David Geffen School of Medicine at the University of California, Los Angeles and is a 2012 graduate of the MGH General Surgical Residency Program. She completed her training with a Colon and Rectal Surgery Fellowship at the University of Minnesota.

Christopher Kwolek, MD has been appointed Chairman of the Department of Surgery at Newton-Wellesley Hospital. Dr. Kwolek will remain in his role as Chief of Vascular Surgery at NWH, a position he has held since 2005.

Rajshri Mainthia, MD (PGY3) is the first Quality and Safety Fellow from the Department of Surgery to be appointed by the Hospital Quality and Safety Committee and will start her fellowship in September 2016.

Junaid Malek, MD joined the staff of the Community Surgery Division at the North Shore in February 2016. Dr. Malek received his MD from the Rosalind Franklin University of Medicine/The Chicago Medical School in 2004 and completed his general surgery residency at the Beth Israel Deaconess Medical Center. He completed his training with a vascular surgery fellowship at the MGH.

James F. Markmann, MD Chief of Transplant Surgery, was elected to membership in the prestigious Southern Surgical Association at the December 2015 annual meeting. When an individual outside the geographic region of a professional association is selected for membership, it is considered especially noteworthy and speaks most highly of the member's credentials and contribution to his field.

Jarrold Predina, MD (PGY4) has been awarded a Daland Fellowship from the American Philosophical Society. The APS

awards a limited number of Daland Fellowships in Clinical Investigation for research in the several branches of clinical medicine, including internal medicine, neurology, pediatrics, psychiatry, and surgery. The committee emphasizes patient-oriented research. Dr. Predina is spending his research years in Dr. Sunil Singhal's laboratory at the University of Pennsylvania.

Ronald G. Tompkins, MD, ScD ('85) Director of the Center for Surgery, Science and Bioengineering, was awarded the eminent F lance-Karl Award at the 2016 Meeting of the American Surgical Association in April. This award recognizes seminal contributions in clinical or laboratory research which have application to clinical surgery. Dr. Tompkins joins other MGH residents and faculty members, including M. Judah Folkman, Francis D. Moore, Sr., Patricia Donahoe, and Jay Vacanti, as recipients of this distinguished award.

On October 26, 2016, the Division of Cardiac Surgery celebrated the establishment of the Stanford Calderwood Chair and the appointment of its inaugural incumbent, **Gus J. Vlahakes, MD ('78)**. Celebrated at the Paul S. Russell MD Museum, the program featured remarks from Dr. Keith Lillemoe, Chair of the Department of Surgery; Dr. Thor Sundt, Chief of the Division of Cardiac Surgery; and Dr. Gus Vlahakes. More than 50 guests were in attendance.



Pictured from left: Drs. Keith Lillemoe, Thor Sundt, Jerry Austen, Gus Vlahakes, and Mr. Williams Lowell, Co-Trustee of the Calderwood Charitable Foundation.

Mauricio Villavicencio-Theoduloz, MD joined the Division of Cardiac Surgery in September 2015 as the Surgical Director of Lung Transplant & ECMO. He finished a general/cardiac surgery residency in Chile and received additional training in cardiovascular surgery and thoracic transplantation at the Mayo Clinic in Rochester, Minnesota. He then did further training in Heart & Lung Transplantation with a focus on Lung Transplant at the Freeman Hospital in the United Kingdom for Professor John Dark. Mauricio returned to Chile in 2007 where he founded and directed two cardiopulmonary transplant programs.

John Wain, MD ('85) has accepted a new position as the Chief of Thoracic Surgery at the St. Elizabeth's Hospital in Brighton, Massachusetts. Dr. Wain, a graduate of Jefferson Medical College, completed his general surgical residency at the MGH and went on to a Residency in Thoracic Surgery at the Toronto General Hospital. In 1986, Dr. Wain returned to the MGH for a cardiotho-

racic surgery fellowship. Upon completion of this training in 1988 Dr. Wain joined the faculty in the Division of Thoracic Surgery where for many years he led the Lung Transplant Program.



Michael T. Watkins, MD (see accompanying photo), was designated President-Elect of the New England Society for Vascular Surgery at the Annual Meeting held in Newport, Rhode Island in October 2015.

At the 2016 Meeting of the American Surgical Association, **Tatsuo Kawai, MD** of the Transplant Division was inducted into membership of the organization.

In addition, **Robert Sheridan, MD, Sareh Parangi, MD** and **Matthew Hutter, MD, MPH** were elected to membership. Finally, **Keith D. Lillemoe, MD**, Surgeon-in-Chief and Chair Department of Surgery, began his term as President of the ASA.

On May 24, 2016, the MGH Cancer Center will celebrate the 9th annual “the one hundred,” which each year honors 100 individuals and groups whose commitment to the fight against cancer creates hope and inspires action. Among this year’s one hundred are **W. Gerald (Jay) Austen Jr., MD** Chief, Division of Plastic and Reconstructive Surgery and Burn Surgery; **Kevin Hughes, MD** (Surgical Oncology); **William Kastrinakis, MD** (Community Surgery); and **Paul Shellito, MD** (General and GI Surgery).

Promotions

To Professor of Surgery:

Robert L. Sheridan, MD, *Burn Surgery*

To Associate Professor of Surgery:

Liliana Bordeianou, MD, *General and Gastrointestinal Surgery*

David Chang, PhD, *Codman Center for Clinical Effectiveness in Surgery*

David Clouse, MD, *Vascular Surgery*

Marc de Moya, MD, *Trauma, Emergency Surgery, and Surgical Critical Care*

Cristina Ferrone, MD, *General and Gastrointestinal Surgery*

Eric Liao, MD, PhD, *Plastic and Reconstructive Surgery*

Thomas MacGillivray, MD, *Cardiac Surgery*

Peter Masiakos, MD, *Pediatric Surgery*

John T. Mullen, MD, *Surgical Oncology*

To Assistant Professor of Surgery:

Genevieve Boland, MD, PhD, *Surgical Oncology*

Curtis Cetrulo, MD, *Plastic and Reconstructive Surgery*

Suzanne Coopey, MD, *Surgical Oncology*

Kyle Eberlin, MD, *Plastic and Reconstructive Surgery*

Cassandra Kelleher, MD, *Pediatric Surgery*

Robert T. Lancaster, MD, *Vascular Surgery*

Oznan Meireles, MD, *General and Gastrointestinal Surgery*

George Tolis, MD, *Cardiac Surgery*

Daniel Yeh, MD, *Trauma, Emergency Surgery and Surgical Critical Care*

In Memoriam

Dr. Eugene Appel passed away in March 2015. Gene graduated from Cornell University with a degree in engineering as well as a bachelor of arts before matriculating at the Harvard Medical School, class of 1966. He completed his surgery residency at the MGH in 1971. Gene moved to La Jolla in 1976 and spent almost all of his surgical career in San Diego where he practiced general surgery at Sharp Memorial Hospital for 40 years and served as the chief of surgery at that hospital. Gene was one of the first trauma surgeons at Sharp Memorial and helped that unit flourish over the years. He was very active in community affairs in La Jolla and was an avid marathoner. All his life, Gene remained famous for his sense of humor and outsized personality. He is survived by his wife, Barbara, his three children, Deborah, Karen, and Brian, and two grandchildren.

Dr. Giles Toll, a third generation Coloradan with a fierce regard for the outdoors, died at age 88 on January 29, 2015 at home with his family. Born in Denver, Giles attended Williams College and then Harvard Medical School (1951-1957), following which he trained in surgery at the MGH under Dr. Edward Churchill. He served two years in the US Navy Medical Corps. Thereafter, Giles trained in clinical pathology under Dr. Benjamin Castleman at the MGH (1957-1961) and returned to Denver to practice pathology at St. Lukes Hospital and to admire the state he loved by mountaineering, skiing, and travelling. He was appointed Assistant Professor of Pathology at the University of Colorado Health Science Center. “He was happiest in the mountains,” said daughter Marcia Toll. Working with family members, Giles worked to transfer family property around South Boulder Creek and Indian Peaks Wilderness area into the public domain. A long time member of the Colorado Mountain Club, Giles served on the board of its foundation. He climbed all of the “Fourteeners” at least twice, once with his wife Connie and once with his son, Chris. “He loved being with his wife in the outdoors,” Chris said. “They were really soul mates.” Family history was important to Giles. His grandparents came to Colorado in 1870. His grandfather served as attorney general of Colorado. Giles, who lived in Golden, is survived by his wife, Connie Hauver; her daughter Sian Hauver; his sons, Darwin Toll and Chris Toll; his daughter, Marcia Toll; his sister, Marcia Toll Saunders; and nine grandchildren.

Dr. Clifford John Strachley, age 92, passed away on February 20, 2015 at his home in Walnut Creek, California. Born in Cincinnati, Ohio, in 1922, he attended the University of Michigan for three years, before accepting an early admittance to Harvard Medical School, where he graduated with honors. He then completed his residency in general and vascular surgery at Massachusetts General Hospital (1946 – 1953). Cliff served in the US Army during medical school and residency (ASTP), as well as in Germany for two years following World War II. He then practiced surgery in Syracuse, New York for nine years, following which he moved to Honolulu, Hawaii where he served as Chief of Surgery at the Kaiser Foundation Hospital until 1980, when

he was appointed Professor of Surgery (1980) and Vice Chairman of the Department of Surgery at the University of Hawaii Medical School (1986 – 1991). He retired in 1991 after practicing surgery for over 40 years. Cliff and his wife, Marnie, of 71 years, divided their time between California and Colorado before settling full time in California over the last decade. Cliff, with an insatiable appetite for learning, in his late seventies, resumed his education at St. Mary’s College, receiving his bachelor’s degree at age 81. He was asked by his graduating class to deliver the commencement address. In retirement Cliff enjoyed spending time with his wife, reading to his three grandchildren, as well as hiking, skiing, and playing golf and tennis. He is survived by his wife, three children, and three grandchildren.

Dr. Robert West Hopkins, Professor Emeritus of Medical Science at Brown University and former surgeon and Chief-of-Surgery at Miriam Hospital in Providence, Rhode Island, passed away on February 22, 2016, in his home in Milton, Massachusetts.

Bob grew up in Longmeadow, Massachusetts, graduated from Harvard College and Medical School, and completed the internship and residency in Surgery at the MGH. After service in the USN in Korea, and then the Pennsylvania Hospital, he spent the years from 1959 to 1970 at Case Western Reserve in Cleveland, Ohio. He was then recruited to Providence, Rhode Island, by Fiorindo Simeone. There he had an important role in developing Brown University’s new medical school. Like his grandfather and father, he was an active clinical surgeon, performing in 1973 the first kidney transplant in Rhode Island. An admired teacher and colleague, he was an active member of many medical and surgical societies, and served as president of the Rhode Island Division of the American Cancer Society, the New England Society for Vascular Surgery, and the Society of Medical Consultants to the Armed Forces. He continued to attend, with great interest, conferences and meetings well into his 90s. He is survived by his wife of 56 years, Ann, and his two daughters.

Senior Class Destinations 2016



<i>Top (l to r):</i>	<p>Craig Jarrett Stephen Waterford Jonathan Greer</p>	<p>Cardiothoracic Surgery Fellowship, Brigham and Women’s Hospital Cardiothoracic Surgery Fellowship, Washington University–St. Louis Surgical Oncology Fellowship, University of Pittsburgh</p>
<i>Bottom (l to r):</i>	<p>Danielle Deperalta Tiffany Chao Amy Fiedler Laura Rosenberg Lillias Maguire</p>	<p>Surgical Oncology Fellowship, H. Lee Moffitt Cancer Center Global Surgery, Medtech Startup, and General Surgery Cardiothoracic Surgery Fellowship, Massachusetts General Hospital Masters in Public Health, Harvard School of Public Health Colorectal Surgery Fellowship, University of Minnesota</p>

Incoming Interns



Taylor Coe
University of California,
San Diego, School of Medicine



Margaret Connolly
University of Maryland
School of Medicine



Claire de Crescenzo
University of California,
Davis, School of Medicine



Richard Guyer
Vanderbilt University
School of Medicine



Jon Harrison
Sidney Kimmel Medical College
at Thomas Jefferson University



Antonia Kreso
University of Toronto
Faculty of Medicine



Lydia Maurer
Stanford University
School of Medicine



Jordan Secor
University of Illinois at
Chicago College of Medicine



Thomas Ward
University of Virginia
School of Medicine

ACS Scenes Chicago 2015



Top (l to r): (Photo) Greg Veillette, Chad Wilson, David Lawlor, Janey Pratt and Brian George.

Middle (l to r): (Photo 1) Fred Jarrett and Wesley Adams; (Photo 2) Greg Veillette and David Berger; (Photo 3) Nic Melo and Scott Regenbogen.

Bottom (l to r): (Photo 1) Patrick Jackson, Gretchen Schwarze and Ketanji Brown Jackson; (Photo 2) Chan Raut, Allan Goldstein and Tracy Grikscheit; (Photo 3) Nic Melo, Melissa Hull and John Mullen.