

SURGERY

Synopsis

UW Medicine
DEPARTMENT OF SURGERY

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Chairman’s Message



Carlos A. Pellegrini, MD, FACS, FRCSI (Hon.)
The Henry N. Harkins Professor & Chair

Friends & Colleagues of the Department of Surgery:

The Fall season is filled with activity. Our campus comes to full life: new students arrive and the new academic year gets under way. Excited crowds of Husky fans flock to the reopened Husky Stadium making traffic snarls part of the equation for those who work in the hospital on game days. Our residents, who spent time in the summer becoming oriented, are now humming through their rotations becoming the skilled surgeons we and they know they can be. Many professional organizations hold their annual meetings in the Fall – including the American College of Surgeons. The University of Washington was well-represented at this year’s Clinical Congress of the College. November is also a time when we remember the men and women who have served in the military. With that in mind we decided to devote this issue to the Department’s surgical work in the **Veterans Administration Puget Sound Health Care System (VAPSHCS)** or as most of us simply call it: “The VA.”

In this issue we discuss how aspects of our tripartite mission are incorporated into our VA’s surgical services. We have excellent *clinical services* at the VA. You will have the opportunity

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The Department of Surgery at the VAPSHCS

Founded in 1923, **Veteran Affairs Puget Sound Health Care System (VAPSHCS)** is one of 152 VA Medical Centers across the country and is one of the VA hospitals affiliated with an academic medical center like the University of Washington. Currently the VAPSHCS serves approximately 80,000 veteran patients. This number has been increasing by approximately 6% per year. VAPSHCS is one of two tertiary-care facilities for Veterans Integrated Service Network 20 (VISN 20). VISN 20 includes the states of Washington, Oregon, Idaho, Alaska, and parts of Montana and California. The official Mission of VAPSHCS is to “honor America’s Veterans by providing exceptional health care that improves their health and well-being” surgical services are a vital component of the mission.

The UW Department of Surgery has four specialty divisions represented at VAPSHCS: General, Cardiothoracic, Plastic and Vascular. Within these four specialties are a total of nine full-time VA faculty and five part-time faculty. Each wears multiple hats in order to care for this population of patients.



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Chairman's Message — Continued from page 1

to read about some of the individuals that make this happen and specialties provided at the VA. We have always had excellent *training for students and residents* at the VA. Read **Dr. Lorrie Langdale's** excellent piece on the evolution of surgical education at the VA, and on the role she is playing in the American College of Surgeons' education pillar. Dr. Langdale's recent appointment to the Board of the ACGME provides her an even broader perspective. The specific *research work* of three of our faculty at the VA: **David Mathes**, Plastic Surgeon; **Leah Backhus**, Cardiothoracic Surgeon and **Dana Lynge**, General Surgeon, are highlighted. **Dr. Mike Sobel**, who is co-Director of the Vascular Surgery Research lab at the VA (along with **Dr. Errol Wijelath**) has written enjoyably about the "five reasons he loves doing research at the VA." We will feature aspects of research of our other VA faculty in a future issue of *Surgery Synopsis*.

Since we last featured the VA, a number of changes in faculty positions have occurred. First, **Dr. Michael Sobel** stepped down from his position as Chief, Surgical Services. We owe a tremendous thank you to Dr. Sobel for the excellent job he did during the ten years of his tenure. For all his efforts over the years, his remarkable research career and his ongoing mentorship of young researchers we are grateful. **Dr. Roger Tatum** has now assumed that position. Roger is doing a great job in the midst of challenging times. Another major change is the planned retirement of **Dr. Don Miller**, Chief of our Cardiothoracic Service at the VA occurring in January 2014. We plan to have a tribute to him in the next issue of *Surgery Synopsis* (Winter 2014) and we thank him for all his years of devoted work at the VA. We have been fortunate to recruit **Dr. Jay Pal** from Texas - who began on November 1, 2013 in order to overlap with Don and make a smooth transition. He will be the new Chief of Cardiothoracic Services at the VA. More information about Dr. Pal (along with his picture) is in the "New Faculty" section of this issue.

Finally, a number of our alumni contributed memories of their time as trainees at the VA. Many of you will remember and resonate with these stories. In particular, I imagine a number of you will remember Dr. "Hub" Radke, who features prominently in the stories.

I hope that you enjoy this issue of *Surgery Synopsis*.

Sincerely,

Carlos A. Pellegrini, MD, FACS, FRCSI (Hon.)
The Henry N. Harkins Professor & Chair
Department of Surgery
University of Washington

DoS at the VAPSHCS — Continued from page 1

General Surgery: Faculty are **Drs. Edgar Figueredo** (Assistant Professor), **Lorrie Langdale** (Professor and Section Chief), **Dana Lynge** (Associate Professor), **Roger Tatum** (Associate Professor and Chief of Surgery at the VA), **Peter Wu** (Associate Professor), and **Deborah Lane Marquardt** (Assistant Professor) who joined the group in late summer 2013. *Please read more about Dr. Marquardt in the "New Faculty" portion of Surgery Synopsis.*



Figueredo



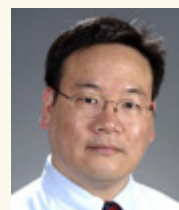
Langdale



Lynge



Tatum



Wu



Marquardt

These faculty provide the full spectrum of general surgery for the VAPSHCS's population and each has their unique clinical interests as well. Drs. Figueredo and Tatum have both trained extensively in laparoscopic techniques. Both have special interests in foregut surgery. Drs. Langdale, Figueredo and Marquardt are trained critical care surgeons, and also serve as the surgical critical care staff for the VA SICU. Dr. Wu specializes in Surgical Oncology. Their collective expertise covers the range of general surgical needs within this broad population of patients.

Cardiothoracic Surgery: **Dr. Donald Miller** (Professor) has been a surgeon for over 40 years and an outstanding Chief of Cardiothoracic Surgery at the VA for 10 years. Dr. Miller is preparing to retire in January 2014. In addition to his clinical excellence, he has been a highly valued teacher and mentor to the cardiothoracic residents who rotate through the VA. *(Please be sure to read a longer tribute to Dr. Miller and his career in the upcoming winter edition of Surgery Synopsis).*

On November 1, we welcomed the arrival of **Dr. Jay Pal, MD, PhD** from the University of Texas Health Science Center in San Antonio. He will lead our cardiac surgical

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program at the VA. He brings a wealth of experience in advanced heart failure therapy and ventricular assist devices. We are delighted to welcome him to the team. *(Please read more about him in the “New Faculty” section of this edition of Surgery Synopsis).* He joins **Dr. Leah Backhus (Assistant Professor)** who is Section Chief of Thoracic surgery at the VA. The remainder of the Cardiothoracic Division of the Department of Surgery attends and provides back-up and call coverage at the VA, delivering the full complement of cardiothoracic surgical services to our Veterans.



Miller



Pal



Backhus

Plastic Surgery: Dr. David Mathes (Associate Professor) leads the Plastic Surgery section at the VA. Like the other VA plastic surgery faculty, he is part-time at the VA and part time in the UW hospitals. **Dr. Kari Keys (Assistant Professor)** is in her second year with the Department and is predominately practicing at the VA, but also practices at HMC. **Dr. Nicholas Vedder (Professor and Chief of Plastic Surgery)** regularly rotates to the VA. Other members of the Plastic Surgery Division provide coverage as needed, rounding out this important service for the VA.



Mathes



Keys



Vedder

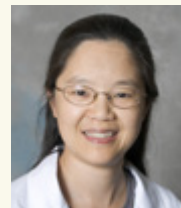
Vascular Surgery has a robust presence at the VA. **Dr. Ted Kohler (Professor)** is the Section Chief for Vascular Surgery. **Drs. Michael Sobel (Professor)** and **Gale Tang (Assistant Professor)** are both fully employed at the VA and have busy clinical practices as well as strong and mature research activities. **Errol Wijelath, PhD (Research Associate Professor)** co-leads the Vascular Research Lab at the VA with Dr. Sobel.



Kohler



Sobel



Tang

VA faculty in Cardiothoracic, Plastic and Vascular Surgery are fully integrated into their specialty divisions at UW Medicine, ensuring the full spectrum of care and coverage can be offered at the VA as well as forging and maintaining strong academic and collegial ties.

Following is a more in-depth look at the other two legs of our mission: teaching and research, as well as a new program to better serve the broader VISN 20 network. Finally, we have included some interesting (and humorous) vignettes from our trainees – past and present – that give a flavor of what it is like to be a surgeon at the VA. For all of you that have contributed at any time to the mission of VA Puget Sound and the thousands of veterans that we are proud to serve, thank you!

VAPSHCS Education – A Change of Focus

Lorrie Langdale, MD

The VA has played essential role in resident and medical student education since the Department of Surgery was founded in the mid-1950's. Dr. Langdale (pictured on page 3) is a past surgical clerkship director for the Department of Surgery. Though she passed this responsibility to Dr. Roger Tatum in 2006, she provides us with a larger view of the changing face of medical education. Dr. Dana Lyngne continues to direct residency education for the VA and the rest of the faculty are active educators for both students and residents. Enjoy Dr. Langdale's perspective on medical education past, present and future.

From the beginning, a core value for the Department of Surgery has been its educational program. While it is easy to get immersed in the day-to-day workings of resident and student training, sometimes it is important to take a step back and look beyond the immediacy of teaching styles, evaluations and feedback to appreciate what we are really trying to accomplish: preparing physicians and surgeons to care for patients and maybe influencing the process for the better.

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Beginning in 1993, I managed the medical student program for the Department of Surgery for thirteen years. From that position, I had the opportunity to influence the School of Medicine through expansion of the clerkship within WWAMI and the addition of 4th year clerkship requirements to the curriculum. The broadening of student exposure to surgery was originally aimed at those choosing primary care, hopefully honing their skills at recognizing potential surgical illness. I rarely admit my role in this curriculum requirement to our medical students as I am never confident that my tires will still have air pressure at the end of any rotation! However, the changes must not have been all bad. Under Roger Tatum's leadership, surgical educational opportunities continue to expand through our region and more and more students are choosing to pursue a surgical career. Some of the best have chosen to stay and train with us.



Foy

An Evolving Curriculum: While the current curriculum has served us well, medical education at the University of Washington will soon enter a new phase. This last year Hugh Foy and I had the opportunity to contribute to a reassessment and potential revamping of the curriculum as a whole, with particular emphasis on the clinical experience. Various models from across the US and Canada were reviewed, critiqued, and debated. The proposed next curriculum iteration will involve a more integrated approach to the medical student experience; coupling surgery with anesthesia and even formulating block rotations with medicine for care continuity. These are important changes. The expectation is they will facilitate understanding between disciplines and teach the art of team management and global patient care in an evolving practice environment. The importance of this last aspect has been driven home to me as I have assumed two additional roles in the last year.

Service on the American College of Surgeons (ACS), Board of Governors:

The ACS Board of Governors represents the surgeon in practice (sort of a House of Representatives). I have been honored to represent the Washington State ACS Chapter for the last four years. In an effort to expand its



sphere of influence and better serve ACS fellows, the Board of Governors has reorganized into "Pillars" aligned with the major ACS Divisions: 1) Member Services; 2) Education; 3) Advocacy and Health Policy; 4) Quality/Research/Optimal Patient Care; and, 5) Communication and Fiscal Affairs.

The inclusion of an "Education Pillar" was sparked by responses on the annual Governor's survey, identifying the status of surgical education and preparedness of trainees to enter practice as major concerns. As a member of the Board's Executive Committee, I have been tasked with facilitating a new partnership between the ACS Education Division and an enthusiastic cadre of Governors interested in the spectrum of education as it affects current surgical practice across the country. The many aspects of surgical training, the challenges of continuing education while in practice, and the importance of patient education by surgeons will form the basis of three major workgroups, each with new Governor representation on established ACS committees. The expectation is that these workgroups will bring added value to both ongoing projects and the direction of new ventures within ACS through the voices of surgeons in the trenches.

Service on the Board of Directors of the Accreditation Council on Graduate Medical Education (ACGME):

Surgical education does not evolve in isolation. ACGME sets the national and, to an extent international, tone for graduate medical training by establishing the requirements for resident and fellowship eligibility then approving, accrediting and monitoring compliance of Resident Review Committee (RRC) governed programs. I was recently selected as a member of the Board of Directors for ACGME, nominated by the AAMC. This new role has offered the opportunity to see medical education as a whole (not just surgery) and from a variety of viewpoints. Certainly some of the more controversial aspects of our current system have been driven by ACGME decisions (no, I was not on the Board for the duty hours decisions but will be actively involved with their reassessment!). So far, the experience has been extraordinary and I can attest that the essence of this group is rooted in a sense of responsibility to the public. As educators, we are entrusted with guaranteeing that our trainees are capable and prepared to provide quality care.



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This is not a simple task and makes herding cats look pretty easy. There are significant challenges on the horizon but I think it will be worth any effort.

Clinical care today may seem complicated but is actually very simple – we want the best for our patients and the health of our country as a whole. Accomplishing this takes dedication and passion, but as is the case for most major issues, the answers often lie in education.

Research at the VAPSHC

Roger Tatum, MD

A great number of research projects are being carried out by our surgical faculty. Several projects are summarized here; others will undoubtedly be shared in future issues of *Surgery Synopsis*. In addition, our highlighted research in this issue is **Dr. David Mathes** (pictured on page 3). (Please read more about his research endeavors in the “Researcher Profile” section of this issue of *Surgery Synopsis*.)

Dr. Michael Sobel, (pictured on page 3) a prolific researcher and Co-Leader of the Vascular Surgery Lab at the VA for many years, succinctly captures some of the reasons for being excited about research at the VA.

Five Great Things about VA Research: Although everyone loves to complain about the red tape and administrative hassles associated with VA research, there are substantial advantages that keep us doing research at the VA. Here are my top five reasons:

1. **The Patients.** Veterans are very supportive of clinical research. Even when participation may not benefit them directly, their altruism and commitment to advancing medical science is strong.
2. **A Unified Health Care System.** The VA has excellent continuity of care. Patients stick with the VA, and through the electronic medical record, one can obtain data from clinic visits, labs, and imaging – even if they occur in Florida or Arizona. The VA also has large regional and national databases that can be queried for population-based studies.

3. **Funding.** The VA has its own system of research support that closely parallels the different types of NIH awards: mentored career development awards, investigator-initiated research projects, and small scale clinical trials. If you commit at least a 5/8 effort to the VA, you can compete for these awards. In addition, the VA has a national Cooperative Studies program for large-scale multi-center clinical trials, supported by regional centers like our own Northwest Health Services Research and Development Center of Excellence.

4. **Research Infrastructure.** It’s easier for an investigator to get started at the VA. You’re not on your own, because we have an umbrella organization that is responsible for the overall research enterprise. The R&D Department provides space, access to a wide array of common equipment, and animal facilities. There’s an Imaging Core that includes

flow cytometry, confocal imaging, histology, microPET and CT scanning. There is also a Clinical Research Unit whose staff can help with IRB applications, study procedures and patient follow-up.

5. **Colleagues.** VA researchers are generous, and collegial. We share techniques, equipment and materials. It’s a diverse group, but feels more like a family.

“As educators, we are entrusted with guaranteeing that our trainees are capable and prepared to provide quality care. This is not a simple task and makes herding cats look pretty easy. There are significant challenges on the horizon but I think it will be worth any effort.”

—Lorrie Langdale, MD

Communicating Adverse Patient Events in Surgery: The CAPES Study at the VA

Dana Lynge, MD

Dr. Lynge (pictured on page 2) is a general surgeon at the VA and also the residency education director for surgery at the VA. He has a strong interest in patient communication. The CAPES study he is engaged in is a demonstration of this interest.

Disclosure, Apology and Offer (DA&O) programs are becoming widespread in modern medical centers. The VA Administration issued a revised “Disclosure of Adverse Events to Patients” policy statement and protocol in October of 2012 to “ensure consistent practice in disclosing to patients the occurrence of adverse events related to the patients’ care.”

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These programs have developed for several reasons. First, they are an effort to guarantee that the “right thing” is done after an “adverse” event occurs during surgery or the perioperative period. Second, there is evidence that routine disclosure of such events improves patient satisfaction.

Despite the spread of such programs and directives, little research has been done on them. For instance, we do not know how surgeons disclose “adverse events” to patients; we do not know what constitutes “adequate disclosure”; we do not know what impact disclosure has on the patient and surgeon; and we do not know what the effects – if any – may be on litigation. The CAPES study involves the VAPSHCS, the Boston VA and the West Haven VA and examines two specific questions:

- methods surgeons use to communicate adverse events to patients
- effects of these methods of communication on the patient and the surgeon

Designed as a prospective study, it has been fully funded by a VA Health Services Research and Development grant. 65 surgeons at the three VA medical centers are participating in the CAPES study. (A related study is being conducted at the UW by Drs. Gallagher and the Department of Surgery’s Drs. Flum and Wright examining what impact training may have on the quality of adverse event disclosure.) It is expected that the findings from the CAPES study as well as others such as the UW study will help to improve the disclosure methods and process – and, most importantly, communication between surgeon and patient surrounding these difficult events.

Leah Backhus, MD, Thoracic Surgeon, VAPSHCS

Dr. Backhus (pictured on page 3) is the recipient of an Institute of Translational Health Sciences (ITHS) career-development award (KL2). The ITHS career development awards are highly competitive (with only 2-5 scholars selected each cycle). The ITHS KL2 awards offer institutional support to provide mentored research career

development to clinical investigators who have recently completed professional training and are beginning basic, translational and/or clinical research. KL2 scholars are given an intensive career development experience in a multidisciplinary setting. Scholars supported through the KL2 mechanism are expected to be engaged in translational research.

Her research both for this award and in other research she has conducted focuses on coordinating transitions of care. Her KL-2 research specifically focuses on following the care transitions in early stage lung cancer patients’ post-surgical resection. An earlier research study funded by the VA National Cancer Collaborative is highlighted below:

Dr. Backhus’ work with the VA National Cancer Care Collaboratives was to examine and improve the system processes for lung and head and neck cancer patients

requiring care coordination between a hub (referral) and spoke (tertiary) facility rather than care through a single institution.

The Pacific Northwest provides unique geographic challenges to coordination of patient care in that VISN 20 covers portions of six states (Washington, Alaska, Oregon, Idaho, and parts of Montana and California) and spans

over 800,000 square miles. An average of 100-120 unique lung cancer cases are treated annually at the VAPSHCS. Approximately 20-25% of lung cancer cases treated in Seattle are diagnosed at VA facilities within VISN 20 and referred to VAPSHCS for definitive care. Seattle’s largest referral facility is the Spokane VA Medical Center. Abundant challenges with development and execution of care management plans were in evidence given the distance between the two facilities. Complex treatment is further challenged by communication, logistics, and timely completion of necessary procedures.

We determined to improve care transition between these two institutions. Our collaboration was selected as one of 11 sites to participate in the VA National Cancer Care Collaborative.

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DoS at the VAPSHCS

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The most significant issue observation data showed was the *discrepancy in time from clinical suspicion to diagnosis of lung cancer between the two facilities*. We hypothesized that much of the delay might be due to the inconsistent way in which patients navigate the process from suspicion to diagnosis. This was the basis for our specific improvement aims. The four aims below were tackled using Lean principles, Six Sigma, and systems engineering techniques to examine patient flow and processes of care. The Plan, Do, Study, Act (PDSA) model was adopted for testing ideas for change in rapid cycles.

- AIM 1: Decrease time from clinical suspicion to diagnosis from 77 days to 35 days;
- AIM 2: Reduce time for the Thoracic Surgery Inter-facility consult process from 21 days to 14 days;
- AIM 3: Implement hand-off/treatment summary notes for patients returning to Spokane;
- AIM 4: Improve quality of care/patient satisfaction for lung cancer patients referred from Spokane to Seattle

We were aided in our work by System Redesign and Industrial Engineering coaches provided by the VA Office of Systems Redesign and the Veterans Engineering Resource Center (VERC). Training was provided at three national face-to-face learning sessions introducing the core techniques of VA process improvement.

Team goals were met; however, the more compelling impact was that we established a working collaborative between Seattle and Spokane. This collaborative was able to hardwire processes that continue to result in improved efficiency and patient satisfaction.

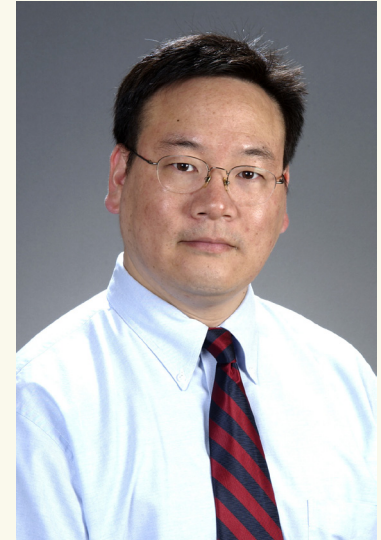
Telehealth and the VA: Surgery's Role in this Emerging Modality

The VA health care system has prioritized the incorporation of telehealth services for patient care. The Surgery Service Line has taken a lead role in promoting this national initiative for clinical care, research and education.

Optimal management of cancer patients requires an efficient and coordinated effort between referring physicians, surgeons, medical and radiation oncologists, and staff of specialized health care professionals. One of the main challenges for delivering cancer care in the VA is providing comprehensive multidisciplinary evaluation, treatment, and follow-up to veterans distributed over a wide network of regional VA facilities covering a fifth of the U.S. land mass (VISN 20 Region).

The VAPSHCS serves as a regional cancer center and tertiary referral center for veterans and has received national recognition for creating the first cancer telemedicine program between regional affiliates in the Pacific Northwest. For the past 10 years, the program has been led by the Director, **Peter C. Wu, MD**, a dual fellowship-trained surgical oncologist with major clinical and research interests in the multimodality treatment of advanced malignancies. He currently serves as the chairperson of the VAPSHCS Cancer Committee and is the clinical chair of the VA Telehealth Committee.

The cancer telemedicine outreach program is used for over 100 patients each year and is designed to provide regional caretakers an opportunity to present cancer patients to a multidisciplinary tumor board staffed by a dedicated team of cancer specialists. The ability to incorporate real-time audio and video exchange between caretakers at distant facilities preserves the personal



Peter Wu, MD

The VAPSHCS serves as a regional cancer center and tertiary referral center for veterans and has received national recognition for creating the first cancer telemedicine program between regional affiliates in the Pacific Northwest.

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