



9 2019 VAM Preview
Vascular Connections provides
the latest details about the
Vascular Annual Meeting.

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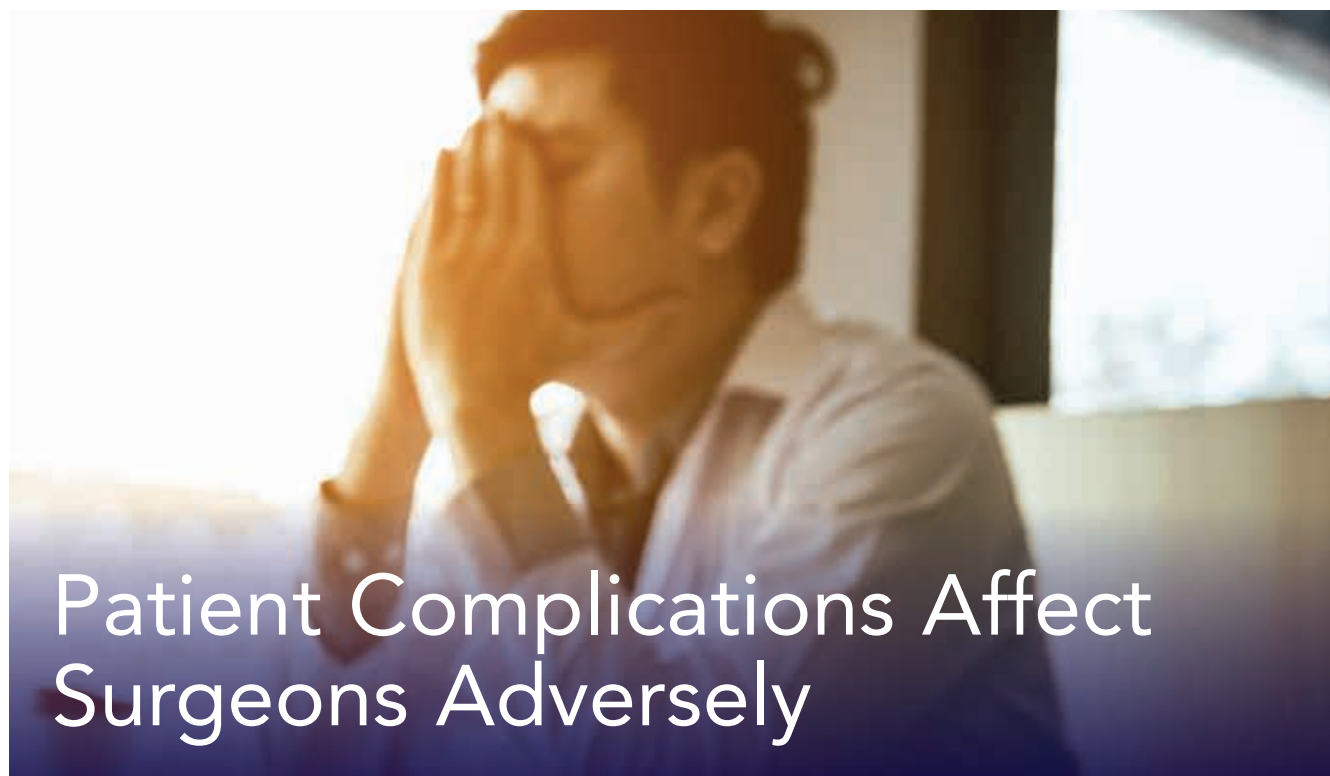
Bias Found Against Female Surgeons

BY RICHARD MARK KIRKNER
MDEdge NEWS
REPORTING FROM SAGES 2019

BALTIMORE – Most male surgeons welcome and support their female colleagues in the workplace, but a survey of male surgeons reports that bias against women in surgery persists, and may be even more acute among younger surgeons, according to a presentation at the annual meeting of the Society of American Gastrointestinal and Endoscopic Surgeons.

“Is there a bias against women in surgery?” asked Michalina Jadick, who presented the results on behalf of AdventHealth Hospital Tampa. “Yes, there is, and understanding this problem is imperative when learning how to fix it.”

A freshman at Boston University
See **Bias** · page 15



Patient Complications Affect Surgeons Adversely

BY MARK S. LESNEY
MDEdge NEWS
FROM JAMA SURGERY

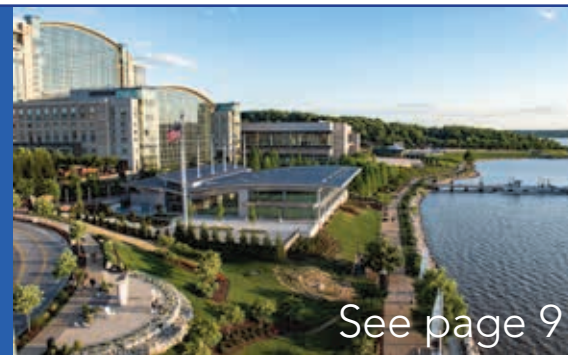
P sychological consequences of patient complications seem to be an important occupational health issue for surgeons, according to the results of an extensive literature review published in JAMA Surgery.

Sanket Srinivasa, PhD, of North Shore Hospital, Auckland, New Zealand, and colleagues assessed studies from MEDLINE, Embase, PubMed, Web of Science,

and Google Scholar that examined the consequences of complications, adverse events, or error for surgeons published up to the search date of May 1, 2018. Studies pertaining to burnout alone, studies not conducted on surgeons or surgical trainees, and review articles with no original data were excluded. This final review of consisted of nine studies (10,702 unique participants) that explored the occurrence of patient complications and their affect on surgeons’ psychological well-being and their professional and personal lives.

See **Complications** · page 15

Check out the
Preview Issue of
Vascular Connections
for highlights of the
June 2019 VAM in
National Harbor.



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Guest Editorial: A Thousand Cuts

BY BHAGWAN SATIANI, MD
ASSOCIATE MEDICAL EDITOR, VASCULAR SPECIALIST

Historians have written about “lingchi” or slow slicing, which was a form of torture and death practiced in ancient China in the 10th century. Another reference to the term “a thousand cuts” is in a political sense, in which one side has decided to “bleed by a thousand cuts” the other side as a means of slowly wearing them down. In my mind, this is akin to a vascular surgeon suffering a thousand cuts (major postoperative complications) during a career dealing with an elderly atherosclerotic population with multiple comorbidities. The difference between vascular surgery and most other surgical specialties is in the magnitude and consequence of vascular surgery complications to critical organs, which often result in death and/or significant disability.

One of my earliest complications was a stroke after an uneventful carotid endarterectomy. As I recall, the procedure was carefully done as I tried to establish my reputation as a solo private practitioner. The call from the recovery room within an hour was brief, telling me that the patient was somnolent, aphasic, and unable to move the contralateral side. I still remember that sinking physical feeling to this day. Over the years, this feeling was to recur after an operation followed by a transient ischemic attack or stroke, graft occlusion, or rarely, a ruptured carotid patch when we were still learning not to use ankle great saphenous veins. I dealt with these episodes calmly on the outside but inside the cumulation of these episodes was building.

Twenty years later, with cervical arthritis pain a constant companion even after neck fusion, the climax came one night at 2 a.m. when I received a call from the emergency department to come in for a



Dr. Satiani is a professor of clinical surgery in the division of vascular diseases and surgery at The Ohio State University, Columbus. He blogs at savvy-medicine.com. Reach him on Twitter @savvycutter.

ruptured aneurysm after a long operating day. I put the phone down and started cursing.

My wife heard this but stayed quiet. She knew this was unlike me. The next day she asked, “So, tell me again, why you are still doing this?” She forced me to deal with something I was wrestling with. How do I “slow down,” operate less, work less, and take a pay cut? Would this help? What will my peers think? What about the financial hit to our income and retirement plans? What about the academic progress I’d planned? How will my patients deal with this? Will I miss my patients and my passion? How do I tell my partners, and come up with some formula for compensation? How do I plan an alternative future?

I certainly survived the “thousand cuts,” but my guess is that these events had a cumulative effect. My wife, a counselor, said that this was unsustainable. The term “burnout” had been defined but was not in common use at the time. With this and progressing cervical arthritis, I ended up walking away from arterial procedures at a much earlier age than I had planned, partly from fear of causing harm to my patients.

Have I had some regrets? Yes, some. The financial piece does not bother me as much and only

when I calculate how much I left on the table. Our spending habits allowed us to live comfortably, save a lot, and my investments presumably were safe. I did miss my patients, although I switched to the venous side exclusively for another 7 years to try to assuage the stress until my body could not handle that either. To this day, there is not a week that goes by that I do not dream I am operating with blood all around me! My academic future, despite moving to a full-time academic institution, did get derailed to a moderate degree. When colleagues hear you are no longer full time and hear the word retirement (even though that was not accurate), you are no longer part of the club. At least, that is what I perceived. This occurred even though my academic production had ramped up significantly, almost doubling over the past 15 years. This reaction has been disappointing.

What about the positives? Huge. I already had consciously prioritized time over money after my first 4 years in solo practice hiring my first – and subsequently three more – partners before the surgical volume may have required it. This was before terms such as “time poverty” were talked about. Later, I ended up spending a lot of time with my grandchildren: being a part of their birth, baby-sitting, watching their activities, and teaching them about life.

I have traveled with my wife and our close friends to places I would not have otherwise until I was much older, when I may not have physically been able to travel. I have read tons of books, taken classes in fiction writing, written six books, volunteered on boards for domestic violence as well as the Ohio Commission on Minority Health. I started a band as a percussionist, which is still active and performing 20 years later. More of my

Satiani continued on following page



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Satiani

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time at work has been spent on mentoring our “junior faculty,” fellows, and residents. I am proud of my contributions to the growth of our junior faculty members by teeing up clinical research projects for them: coming up with ideas, helping write, and giving them first or senior authorship leading to promotions.

The free time also has enabled me to act on my passion, which is developing physician leaders. Under my directorship our Faculty Leadership Institute has graduated 166 faculty leaders over the past 7 years. I also have had the time to teach surgical residents all about the business of medicine for the last 13 years so they can prepare for life after graduation.

What I have not forgotten is that sinking feeling in the pit of my stomach. It is likely that the “thousand cuts” resulted in what we recognize as burnout today. I empathize and identify with younger surgeons when they go through devastating complications, which have nothing to do with their cognitive or technical skills.

I advise them to keep a long-term perspective, which in the short term is often hard to do. For one, I would suggest keeping all notes and thank-

you cards from patients in a folder in your desk from day one, which I leaned on periodically. A few years ago, I started thinning the folder and came across a half-opened envelope, which I probably hurriedly glanced inside. Fully opened, from 25 years ago, with the thank-you card was a \$50 bill! We need these reminders on bad days, which all of us will encounter.

The other advice is to take enough time off to recharge, pick up recreational habits, and learn to meditate to calm yourself. Take every vacation day due you. From a work perspective, track your complications, not only for the registries but also for yourself. This builds a long-term perspective. As founder of our private-practice group, I gave my colleagues their own outcomes for index procedures and cumulative outcomes each January, from 1989 to 2002. This not only created a competitive spirit to review indications and complications and to improve results, but it also gave each of us a long-term view, giving us confidence that our results matched the best of outcomes reported.

There is an advantage to being in a group practice in which you can share outcomes freely. Take advantage of it. Ask for assistance in complex cases by discussing strategy preoperatively and for help during surgery. Lean on

senior associates liberally. They have been through it. It was a practice in our group to scrub with new partners routinely in their first few cases, all complicated cases, and to come in on weekends for cases for the first month or more, if needed.

The concept of part-time surgeons is foreign to the surgical culture. And yet, later in a career, we take long periods of time off, work less, even share a job and have associates cover for our patients. While it may

aggravate the shortage of surgeons if enough people do it, I suspect it may be a net even proposition because it will keep us healthier and, in the workforce, longer.

It should be acceptable for some of us to admit we cannot stay healthy absorbing the thousand cuts and step back from “full-time” work before real consequences of burnout such as depression and suicidal thoughts result. Machismo is overrated and so 1970s.

NEWS Briefs

FDA approves new indication for alirocumab

Alirocumab has received an updated indication from FDA for reducing the overall risk of major adverse cardiovascular events in patients with a recent acute coronary syndrome, such as a heart attack. The drug was previously approved as an adjunct treatment to help lower LDL cholesterol in adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease.

Upcoming Meetings

The 33rd annual meeting of the European Society for Vascular Surgery will be held September 4-7, 2019, in Hamburg, Germany.

The Eastern Vascular Society 33rd Annual Meeting will be held at the Omni William Penn Hotel, Pittsburgh, September 5-7, 2019.

SAVE THE DATE!

2019 SVS Coding & Reimbursement Workshop

SEPT. 20–21, 2019

Hyatt Rosemont, Rosemont, IL
(Near O'Hare Airport)

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SAVE THE DATE!

Toronto, Canada
June 17–20, 2020
Toronto Convention Center

2020
VASCULAR
ANNUAL MEETING
TORONTO, CANADA

Scientific Sessions:
June 18–20
Exhibits: June 18–19

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Passports and/or travel documents will be required for most attendees. Be sure to update your passport early. Visit vsweb.org/CanadaDocuments.

VASCULAR CONNECTIONS

The Official Newspaper of the Vascular Annual Meeting



PREVIEW EDITION

SOCIETY FOR VASCULAR SURGERY • VASCULAR AND ENDOVASCULAR SURGERY SOCIETY • JUNE 12-15, 2019 • GAYLORD NATIONAL RESORT & CONVENTION CENTER

VASCULAR ANNUAL MEETING

Hope to See You All at VAM

I'm looking forward to this year's Vascular Annual Meeting and hope that all of you are as well.

We will be gathering from June 12 to 15 at the Gaylord National Resort & Convention Center in National Harbor, Md., just outside of Washington, D.C. Our scientific sessions are June 13 to 15 and the Exhibit Hall — filled with vendors showcasing not only the latest and greatest but also the tried and true — is open June 13 to 14. We even plan an Office Vascular Care Pavilion to showcase equipment for outpatient and office-based facilities, in recognition of the growth in such facilities.

I am also anticipating our "Vascular Spectacular" gala, which will bring us all together to celebrate

As always, organizers have spent long hours on the VAM program and how it can best meet the needs of a diverse membership.

each other, and our specialty. The Spectacular kicks off at 6:30 p.m. Friday, June 14, late enough so that anyone participating in late-afternoon meeting events has time to change and get ready for a complete change of pace.

As always, organizers have spent long hours on the VAM program and how it can best meet the needs of a diverse membership. Some highlights:

- Vascular residents and fellows get their own programming this year, geared specifically to those who are nearly finished with their training.
- We have non-abstracted-based



Dr. Michel S. Makaroun

sessions on a wide range of topics, including:

- » Gender differences in leadership
 - » Experts discussing issues such as filter complications, thoracic outlet syndrome and complex open aortic surgery
 - » The intricacies of working in office-based settings
 - » The important topic of vascular surgeon wellness
 - » Alternative career paths
 - Industry-sponsored sessions will cover important developments
 - Six other societies are lending their members' voices, experience and expertise: the American Venous Forum, the American Podiatric Medical Association, the Outpatient Endovascular and Interventional Society, the Society for Vascular Medicine, the Society for Vascular Ultrasound and The Society of Thoracic Surgeons.
- And once again the Vascular Quality Initiative and the Society for Vascular Nursing will hold their annual meetings in conjunction with VAM.
- Please join me for education, camaraderie, networking and much more. I'll see you in National Harbor. **VC**
— SVS President Michel S. Makaroun, MD



COURTESY GAYLORD NATIONAL RESORT & CONVENTION CENTER

The 2019 Vascular Annual Meeting will once again take place at the Gaylord National Resort & Convention Center in National Harbor, Md. The hotel includes a 19-story glass atrium and sweeping views of the Potomac River. The 300-acre National Harbor features plenty of shopping, dining and recreation and is just south of Washington, D.C.

VASCULAR ANNUAL MEETING

Crawford Critical Issues Forum Focuses on Improving Outcomes

Each year at the Vascular Annual Meeting, the Society for Vascular Surgery holds a special session organized by the incoming SVS President and devoted to the discussion of new developments and new challenges. The topic of the 2019 E. Stanley Crawford Critical Issues Forum is one that's weighing on the minds of vascular surgeons: With increasing scrutiny over how healthcare dollars are being spent, how can we use evidence-based medicine to improve outcomes, reduce costs, and ensure appropriate utilization of resources?

"For the last decade, the SVS has been developing a number of programs that address different aspects of quality. Now, we find ourselves

at a point in time when our portfolio of programs has matured and uniquely positions us to lead in outcomes analysis, quality improvement, and the development of evidence-based guidelines and appropriate use criteria," said session moderator and organizer Kim J. Hodgson, MD, SVS president-elect and chair of the division of vascular surgery at Southern Illinois University Medicine. "We'll show how these components will help us do a better job of providing the right intervention, in the right patient, at the right time."

The session will be held from 10:30 a.m.-noon on Thursday, June 13, 2019.

Crawford continued on page 10

SVN Conference: It's All About Teamwork

Vascular nurses are an integral part of the vascular team and of primary importance in vascular patient care.

Teamwork, in fact, is the overall theme for the Society for Vascular Nursing's 37th Annual Conference, held again in 2019 in collaboration

The two-day conference will present a wide array of topics 'to present the full picture of patient care,' said SVN President Cindi Christensen.

with the SVS Vascular Annual Meeting. SVN makes its management home at the SVS. The conference is June 12 and 13, the two opening days of VAM, at the Gaylord National Resort & Convention Center in National Harbor, Md.

The teamwork theme – as well as resilience – will be front and center for the keynote address, by Virginia R. Beeson, BSN, MSN, NEA-BC, a retired captain in the United States Navy Nurse Corps. "Teamwork: It's All About Teamwork!" is from 8:15 to 9:30 a.m. June 12.

Capt. Beeson will discuss how, though good teamwork has never been more important in healthcare than today, team behavior is nonetheless very poor. She will focus on the key elements for successful team

practices and give tips, tools and activities for enhancing team performance.

The two-day conference will present a wide array of topics encompassing a wide range of experiences and perspectives "to present the full picture of patient care," said SVN President Cindi Christensen.

Vascular nurses provide care that runs the gamut from medical and research to diagnostic, to surgical and post-op care, to preventative care, she said, and meeting topics do as well.

Speakers include both nurses and physicians.

Physicians can discuss surgical procedures and care unfamiliar to some SVN members. "We're not all in the OR," Christensen said. "Having a surgeon discuss the surgical perspective and what the patient is experiencing during surgery gives everyone an opportunity to learn about, and understand, some of the surgical aspects of care."

Attendees gave positive feedback to last year's meeting, the first held in collaboration with VAM, said Christensen. "We've spent the last year working together so planning for this year has been even more collaborative," she said. "We're excited to have this partnership enhance our conference."

Visit vsweb.org/VAM19 for a full schedule of the SVN Conference. **VC**

Dear VESS Members and Attendees

Welcome to the 2019 annual spring meeting for the Vascular and Endovascular Surgery Society (VESS), which convenes in conjunction with the

Vascular Annual Meeting on June 12th at the Gaylord Convention Center in National Harbor, Md. The collaboration of our VESS spring program committee and the SVS VAM program committee has produced a comprehensive program that should provide

for the diverse interests of vascular surgery. The topics cover aortic, cerebrovascular, lower extremity, venous disease, hemodialysis, physician wellness/burnout, academic issues, and the medical management of vascular disease. Matthew Smeds and the rest of the program committee have put in the hard work to assemble a thoughtful and engaging lineup for this year's spring meeting! I would also encourage you to visit our industry sponsors for this event, which will be open for exhibit perusal June 13-14 within the convention center. Thanks also to the Society for Vascular Surgery for hosting this meeting within the VAM venue and for the ongoing col-

laboration we have enjoyed between our societies.

VESS remains focused on engaging and mentoring vascular trainees and vascular surgeons

within a framework of collegial academic exchange, and many of the invited discussants for our program may be "first-timers" at the microphone. So come support our sessions and their participants as they strive for learning and experience! VESS continues to support

research through grant funding at both the trainee and young investigator levels, and our presenters at both the spring VESS/VAM and the VESS Winter Annual Meetings enjoy a very high acceptance rate for publication of their findings. For more information about VESS, just visit vesurgery.org. The leadership of this society is proud of what it stands for and equally proud of its program offerings. We hope this year's spring meeting enhances your understanding and practice of vascular surgery and makes you an even better surgeon. See you June 12th!

James H. Black, III, MD
VESS President, 2019-2020



DR. BLACK

Crawford

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First, Dr. Hodgson will speak about the topic of "Why Good Outcomes Are No Longer Good Enough." Then he'll give the stage to Arlene Seid, MD, MPH, medical director of the quality assurance office within the Pennsylvania Department of Health.

According to Dr. Hodgson, the department recently became concerned about an increase in the volume of endovascular procedures, and complications thereof, mainly in outpatient settings. It raised questions about the procedures and discussed whether reimbursement via programs such as Medicaid should be ceased.

SVS responded by meeting with Dr. Seid and helping her develop guidelines with criteria for appropriate vascular procedures. She will discuss "The Government's Perspective on When & Where Endovascular Interventions Should Be Performed."

Meanwhile, SVS is working with the American College of Surgeons to develop certification for vascular surgery centers. "We are well underway and expect certification to be operational within the year," Dr. Hodgson said.

This will be addressed by another speaker, Anton Sidawy, MD, MPH, FACS, professor and chair of the Department of Surgery at the George Washington University Medical Center. He will discuss his work with the certification program and outline its potential to improve appropriateness and outcomes. Then Fred A. Weaver, MD, chair of the SVS Patient Safety Organization and professor of surgery and chief of the vascular surgery division at Keck School of Medicine of USC, is scheduled to describe the Vascular Quality Initiative, an SVS database whose 12 registries have gathered demographic, clinical, procedural and

outcomes data from more than 500,000 vascular procedures performed in North America.

Dr. Weaver will discuss how tracking outcomes is crucial for both vascular surgeons and certified vascular surgery centers. "He's going to talk about the power of the database in influencing and improving outcomes in clinical practice," Dr. Hodgson said.

Finally, Larry Kraiss, MD, chair of the SVS Quality Council and professor and chief of the vascular surgery division at the University of Utah, will discuss his vision for this new SVS council and describe how the council is expanding the quality mission to include appropriate use criteria in addition to the long-standing clinical practice guidelines the SVS produces.

Be sure to attend this important session at VAM. **VC**



DR. HODGSON

2019 Vascular Annual Meeting Exhibitors

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Abbott	517	Elsevier, Inc.	405	Ronin Surgical Corp.	212
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BFW, Inc.	204	LifeNet Health	700	Terumo Aortic	717
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Datt Mediproducts Pvt. Ltd.	813	Penumbra, Inc.	300	Wexler Surgical, Inc.	601
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Learning the Latest on Venous Disease

New treatments and devices to treat venous disease will be front and center at VAM’s Postgraduate Course 3, “Venous Disease: Ensuring the Appropriate Venous Care in 2019.” The course is given in collaboration with the American Venous Forum and co-moderated by Drs. Patrick Muck and John Carson, who are members of both AVF and SVS, as are all presenters. “We will try to highlight the latest information for both superficial and

venous disease as well as, most importantly, appropriateness of care,” said Dr. Muck. “The venous field is just exploding with techniques and devices,” added Dr. Carson. “We think this session will be very, very informative.” The course will cover the first venous stent formally approved by FDA and the completed trial on ultrasound treatments for PE patients, OPTALYSE. Also highlighted will be new ablation strategies, using non-thermal, non-tumescent therapies for superficial ve-

nous disease, with four presentations. One focus will be identifying which patients *should* undergo procedures, as opposed to which patients *can*, said Dr. Muck. Drs. Elna Masuda and Marc Passman have been studying national data in venous therapies from various providers to create appropriateness of care criteria, he said. “Unfortunately, we’re finding people undergoing ablations or procedures who perhaps should not be.” Speakers will cover accrediting vein

centers and the role the SVS Patient Safety Organization Vascular Quality Initiative registries’ data performs in determining appropriate venous care. Presenters also will discuss therapies for DVT and PE in the wake of the landmark ATTRACT trial. “Each year we continue to strengthen the collaboration between AVF and SVS,” said Dr. Muck. AVF President Dr. Brajesh K. Lal is leading this collaboration with SVS President-Elect Dr. Kim Hodgson, Dr. Muck added. For more information on P3, view the VAM Online Planner at [vsweb.org/OnlinePlanner](https://www.vascularweb.org/OnlinePlanner). **vc**

Map Out VAM Experience With Online Planner

Get a jump start on planning your way through the Vascular Annual Meeting with the SVS Online Planner. It includes the entire VAM schedule plus those for the Society for Vascular Nursing’s Annual Conference and the Vascular Quality Initiative’s meeting, VQI@VAM. While the planner ([vsweb.org/OnlinePlanner](https://www.vascularweb.org/OnlinePlanner)) is always available for viewing and browsing, by creating an account it also can be used as a sched-

uler and calendar. Once signed in, simply mark a session you want to attend as a favorite. The planner adds it to your planner calendar and sets a reminder. Creating an account: Log in with your SVS credentials. That “single sign-on” log-in and password credential also is used for registration and all ticketed events (such as breakfast sessions, workshops, postgraduate courses and special events), automat-

ically transfer to the planner. When the mobile app is available and downloaded, all Online Planner details will transfer and be available on your phone or other mobile device. Non-SVS members or VQI attendees will need to create a guest account in order to take advantage of this functionality. The planner is a live site, and information is updated frequently. **vc**

Participate in Gala Silent Auction at Home

Bidders Need Not Be Present to Play

While it's true tickets to the SVS "Vascular Spectacular" gala to benefit the SVS Foundation are sold out (see the waiting list for single tickets at vsweb.org/gala19), everyone — whether present at the gala or not — can place bids on the offerings in the Silent Auction.

Here's how it works:

- When bidding begins in late May, register on vam19gala.givesmart.com.
- All offerings will be listed, with full descriptions and the majority with pictures.
- Place a bid. All bidders must be identified by name.
- If desired, participants can monitor the bidding, by setting up notifications when someone else has upped the ante.
- Continue to bid until the auction closes during the gala itself.



- Wait for your prizes to be mailed to you — and know you have contributed to continuing the important work of the SVS Foundation.

The gala live auction — preliminarily slated to include vacations, artwork and other attractions — takes place at the gala in its entirety.

"Dr. Starnes and I are very excited that the gala is sold out already!" said Dr. Cynthia Shortell, gala co-chair with Dr. Benjamin Starnes. "Under Dr. Makaroun's leadership, we have planned a truly "spectacular" evening where vascular specialists and guests can celebrate together and support the

Donations Coming In, Still Welcome

Donations to the auctions run the alphabetical gamut (Arcada Theatre and Anderson Japanese Gardens to the (Brookfield) Zoo, plus the geographical one (a one-week stay in Maine on one coast and a four-day expedition to Mount Rainier on the other).

Also available for bidding will be two engravings from Salvador Dali's watercolors created to illustrate Dante's "Divine Comedy." There will be week-long stays in several locations, including Florida, California, Colorado and even on a sailboat in the Caribbean; tickets to theatrical productions; a drawing from Tom Skilling, WGN television and radio meteorologist extraordinaire; an alligator bag; even an autographed Pittsburgh Steelers' football. This list just scratches the surface, as many more offerings await.

Have something to donate? Do so at vam19gala.givesmart.com. All contributions are welcome.

All gala proceeds will benefit the work and mission of the SVS Foundation.

Foundation at the same time."

"It's going to be a great evening," added Dr. Starnes. "We have a magic show planned with our own Dr. (Peter) Gloviczki, dinner and cocktails, the auctions — we expect some high-spirited bidding, by the way — and even dancing.

"Dr. Makaroun had a vision of bringing us all together for a great cause," he

said. "And our whole committee is very excited that it's happening."

Besides Drs. Shortell and Starnes, Gala Committee members include Drs. Enrico Ascher, William Jordan Jr., Melina Kibbe, Richard Lynn, Matthew Mell, Ben Pearce, Amy Reed, Russell Samson, William Shutze, Mal Sheahan, Maureen Sheehan and Anton Sidawy. **VC**

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Earn CME, MOC Credits at VAM

Physician registrants can get a big boost in collecting required Continuing Medical Education and Maintenance of Certification self-assessment credits at the Vascular Annual Meeting.

The Society for Vascular Surgery is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. SVS has designated the 2019 Vascular Annual Meeting for a maximum of 30 AMA PRA Category 1 Credits™. Physicians should claim only the credits commensurate with the extent of their participation in the activity. Full credit is not available for attendance at two sessions occurring simultaneously.

A number of sessions also permit earning of MOC credits. See the adjacent list for credit availability.

Participants may claim credits beginning at 12 p.m. Eastern time, Wednesday, June 12. Credits must be claimed by Dec. 31, 2019. **VC**

Sessions Offering CME, MOC Credits

The following sessions offer Continuing Medical Education credits:

- Postgraduate courses (CME+MOC)
- International Forum
- International Fast Talk
- VESS sessions 1 and 2
- Ask the Experts sessions 1-7
- Breakfast Sessions 4-9 (CME+MOC)
- Concurrent Sessions 2-7
- Von Liebig Forum (S1)

- E. Stanley Crawford Critical Issues Forum
- Scientific Sessions 2-10
- John Homans Lecture
- Roy Greenberg Distinguished Lecture
- "How I Do It" Video Session
- "Top 10" Papers
- Aortic Summit
- RPVI Review Course (CME+MOC)

Nurses and PAs Can Also Earn Credits

Physician Assistants: The Vascular Annual Meeting is designated for 30 AAPA Category 1 CME credits. Thursday includes 3.5 hours of programming specifically developed for PAs and the vascular team.

Nurses: Vascular nurses who attend the Society for Vascular Nursing Annual Conference can earn up to 13 contact hours. Those registered for both the conference and for VAM are eligible to attend educational sessions on Friday and Saturday for additional credit.

Learn Open Techniques From the 'Giants'

"If I have seen further, it is by standing on the shoulders of giants."

– Sir Isaac Newton

"Standing Upon the Shoulders of Giants" makes a comeback at the 2019 Vascular Annual Meeting, after a three-year absence.

As was the case then and in sessions years before that, the postgraduate course will focus on "Open Operative Techniques by the Masters." It is set for 1:30 to 4:30 p.m. Wednesday, June 12.

The endovascular revolution in surgical care has decreased the number of open surgical procedures in practice and for trainees, said Dr. Vikram Kashyap, chair of the SVS Postgraduate Education Committee, which oversees this and other VAM educational sessions.

"But we still do complex open surgical procedures, and many of the surgical giants we're fea-

turing in this session formulated or refined these procedures," he said.

Attendees tell organizers that they really want to hear about these open surgical procedures since they may use these techniques occasionally, he said, adding, "We're delighted to bring this back this year and anticipate it being very well-attended."

He, Chris Smolock, M.D., and Henrik Sillesen, M.D., from the European Society for Vascular Surgery, will co-moderate the session.

Up first is debate on the following topics: "Carotid Endarterectomy with Patch Closure is the Gold Standard," presented by Norman Hertzner, M.D., vs. "Eversion Endarterectomy is Safe, Simple and Durable," presented by Thomas Riles, M.D.

Two presentations then will cover "Intraoperative evaluation of neurologic function and carotid patency" (Wesley Moore, M.D.) and "Vertebral

Artery Revascularization" (Ramon Berguer, M.D.).

Dr. Richard Cambria will discuss "Exposure, Clamp Location and Renal Reconstruction in Complex Suprarenal/Thoraco-abdominal Aortic Pathologies," and Kenneth Cherry, M.D., will present "Mesenteric Bypass and Visceral Endarterectomy for Occlusive Disease."

In another debate, Dhiraj Shah, M.D., will present the view that "In-situ Bypass is preferable for Lower Extremity Revascularization," while Frank Veith, M.D., will take the position that "Reversed Saphenous Vein Conduit for Bypass with Angioscopy Gives the Best Results." Finally, Joseph Mills, M.D., will discuss "Spliced Vein Techniques, Alternative Conduits and Intraoperative Assessment."

Find the complete VAM schedule on the Online Planner, at vsweb.org/OnlinePlanner. **vc**

VQI@VAM to Discuss New Topics and the Role of VQI

In its fourth year, the Vascular Quality Initiative's annual meeting continues to emphasize not just new and emerging topics – including the opioid crisis – but also how VQI is helping its members address these issues.

VQI@VAM will be the afternoon of Tuesday, June 11, and all day Wednesday, June 12, at the Gaylord National Resort & Convention Center in National Harbor, Md. The meeting requires a separate registration fee of \$275.

VQI@VAM is designed to meet the needs of physicians, nurses, data managers, quality improvement professionals and administrators. Tuesday will feature a number of concurrent sessions on a variety of topics, and are intended particularly for data managers, though all attendees are welcome.

Wednesday's sessions will focus more on emerging issues and how data are being used to improve quality of care.

Medical Director Dr. Jens Eldrup-Jorgensen offered some VQI@VAM program highlights:

- **Enhanced Recovery Programs (ERP)** in vascular care cases and how they are evolving. In addition, this session will look at how the VQI and these programs can help manage the opioid crisis.

- How a **pilot project linking cost data and clinical information** may provide more understanding into the total costs of vascular procedures and their related quality outcomes.

"In PVI and EVAR areas, we are becoming aware of the actual cost of these procedures are delving into actual case outcomes, and how these facts are related," said Dr. Eldrup-Jorgensen.

- **Updates on TCAR (TransCarotid Artery Revascularization) and research.** VQI is in the process of analyzing the benefits of TCAR versus carotid endarterectomy. During this analysis period, surgeons who submit their cases to the SVS VQI's CAS registry can contribute to this analysis and receive reimbursement for them.

- Approximately 30 posters and case studies featured during the **networking reception** from 5:00 to 6:30 p.m. Tuesday. Most focus on quality improvement projects, with the remainder more clinically based. Attendees can meet the projects' authors to understand how VQI data are being used for the purposes of improving the quality of care.

- A late-breaking abstract session on physicians voluntarily choosing to add the use of SVS VQI metrics to their employment agreements as a means to engagement and drive quality improvement. "The main impetus to be part of VQI is to use your surgical data to analyze your care practice and implement quality improvement practices," said Dr. Eldrup-Jorgensen. "At its heart, it's about improving care for patients. Members can use VQI data to analyze areas for improvements and benchmark yourself against your

peers and other institutions."

- How to use the VQI Quality Guide and other resources. This session will demonstrate how VQI data can be used with common

quality improvement tools to help solve a particular issue.

For more information on the meeting or on VQI, visit vsweb.org/VQI. **vc**

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ANNUAL MEETING
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Foundation

VAM Audience Will Help Choose Grant Recipient

Research as an audience activity? And fun to boot? No, it's not crazy. The Clinical Research Seed Grant Challenge Wednesday, June 12, at the opening day of the Vascular Annual Meeting will feature research grant applicants explaining their proposals, getting feedback from a panel of experts and audience members helping decide who takes home the prize.

Between the audience's participatory role and the \$10,000 SVS Foundation research grant at stake, "we hope it will be energetic," said Matthew Corriere, M.D., of the SVS Clinical Research Committee. He and Raul Guzman, M.D., committee chair, will co-moderate the session.

The entire process of awarding research grants can seem mysterious, and it may not be clear how and why certain grant projects are selected over other proposals, Dr. Corriere said. This competition was created as a way to let audience members not only hear some very interesting research pitches, but also learn about the SVS Foundation Clinical Research Seed Grant itself.

The two winners who already have been selected will give a short presentation on their proposals at the session. Then, runners-up will appear before the audience and the panel and present their ideas, answer questions, and receive feedback and clarification in competition for the third SVS Foundation grant, which

will be awarded that day.

"It's a blend of learning about the process, including what constitutes a good proposal and how to make a proposal better," said Dr. Corriere. "And then we'll hand out the money." He and the other committee members want to increase awareness of the seed grants, including the kinds of research projects that have been funded and how to prepare a competitive proposal. Leaders also want to encourage interest and development of clinical investigators among the SVS membership, especially younger members or those with limited experience as a principal investigator.

"We envision this as a constructive and, hopefully, positive experience even for those who don't receive the grant money," said Dr. Corriere. "It's a real opportunity to hear experts in the field as to how to translate a good idea into a competitive proposal. We hope all the participants can benefit from that feedback, even if it's not their specific project."

The Experts Panel members will be selected based on grant topics, to match the topics with areas of expertise.

Dr. Corriere said even surgeons who aren't involved in grant-writing will enjoy the session. "It will be fun – and informative and interesting – to hear about innovative ideas to understand and address clinically relevant problems in vascular surgery," he said. **vc**

Collaborating to Treat Diabetic Patients

P5: 1:30 to 4:30 p.m. Wednesday; Recommended by the SVS Community Practice Committee

The postgraduate course "Multidisciplinary Teams and Techniques for Limb Preservation" will offer updates and new technology and research in limb preservation – for both vascular surgeons and podiatrists.

"It's geared towards both sides of the aisle," said Dyane Tower, DPM, and a member of the American Podiatric Medical Association, which is collaborating with SVS on the course. Her two co-moderators are Drs. Christopher Abularrage and Niten Singh.

The two societies have long collaborated on this specific session, typically a well-attended, well-received one. "So many of us work in collaboration with podiatrists in terms of wound healing and limb salvage, said Dr. Abularrage. "It's well known that multidisciplinary teams have much better outcomes in terms of limb salvage" than clinicians working alone.

Organizers generally divide the session into two parts. The first includes presentations on topics of mutual interest. Debates – this year on bypass strategies, vascular interventions and amputations – comprise the second portion.

Presenters aren't providing answers in the debates, emphasized Dr. Abularrage. "We hope to stimulate strong discussion in the room to find out what other people think – not just the debaters. We want to get to the state of things in 2019."

Some topics this year grew out of impromptu discussions in the past few years of joint sessions, said Dr. Tower. These include:

Timing for vascular surgery. "If a patient has both a foot wound and poor lower extremity blood flow and

the podiatrist is considering surgery, we want to know, what's the best timing of surgery? If there's a vascular intervention, do we need to let a certain amount of time pass before any further treatment," said Dr. Tower of the issue. "What's the window for wound debridement? These are topics of great interest and importance."

Toe amputations and frailty. When should amputations of individual toes end in favor of a more aggressive treatment such as transmetatarsal amputation? "Sometimes there are few good options," she said. "Blood flow issues can mean distal interventions aren't possible and the patient needs above- or below-the-knee amputation. Once we decide on level of amputation, what's the likelihood the patient will be able to ambulate with a prosthetic device?"

Other subjects include an update on local wound care for venous stasis disease, vascular intervention (both deep and superficial) for venous disease, lymphedema, key components of a multidisciplinary limb preservation team, stem cell therapy as emerging wound care technology and hyperbaric oxygen therapy.

These collaborative sessions ultimately help patients, said Dr. Tower. "It's a good partnership that helps us learn what treatment options might be available from our vascular colleagues, so we can then educate our patients," she said. At its simplest level, "podiatrists can then discuss with their patients what they can expect when they see a vascular specialist and how it will help them heal their ulcer."

Patient outcomes are key, agreed Dr. Abularrage. "The care isn't strictly about the wound. It's about whether we're providing a good functional outcome, with the patients walking and independent." **vc**

PAC Reception Set for Wednesday at VAM

Reception Restricted to PAC Donors

Awards and special guests will highlight the SVS Political Action Committee Reception at the Vascular Annual Meeting in June. And given that Washington, D.C., isn't far at all from VAM's location, it's a good bet that "special guests" might include a member of Congress or two. Or three.

The reception will be from 5 to 6:30 p.m.

Wednesday, June 12, in Chesapeake 1, at the Gaylord National Resort & Convention Center. This is an "invitation-only" event, restricted to those who contribute to the PAC before the reception, including on June 12 itself.

PAC representatives will be at the PAC Booth throughout VAM. It will be outside Potomac A/B, where the abstract-based scientific sessions are held. All attendees, particularly SVS members, are

urged to stop by the booth on their way to and from sessions to learn about the PAC as well as important issues SVS is engaged in on its members' behalf.

The SVS PAC works for vascular surgeons only, to ensure SVS members have access to lawmakers to discuss issues that have a major impact on members and their practices. Learn more and contribute at vsweb.org/PAC. **vc**

Adverse Effects

Complications from page 1

All of the studies indicated that surgeons were affected emotionally after patient complications, which led to adverse consequences in their professional and personal lives. The study authors identified four themes from the literature.

- **The adverse emotional influence of complications** (including anxiety, guilt, sadness, shame, and interference with professional and leisure activities) after intraoperative adverse events; one study diagnosed acute traumatic stress (using valid diagnostic criteria) in one-third of their participants 1 month after a major surgical complication.
- **Coping mechanisms used by surgeons and trainees** (including limited discussion with colleagues, exercise, artistic or creative outlets, alcohol and substance abuse); emotion-focused coping strategies reported included rationalization, seeking reassurance, blaming oneself or others, and dissociation with self-distraction. Other adaptive strategies used included engaging in artistic endeavors and exercise, although maladaptive strategies were also adopted by some, including alcohol and substance use disorder.
- **Institutional support mechanisms and barriers**

(including clinical conferences, discussion with mentors, and a perception that emotional distress would be perceived as a constitutional weakness). For example, surgical trainees in one study did not believe that morbidity and mortality meetings addressed the emotional needs of trainees, and respondents in another study pointed to poor institutional support with a competitive, unsympathetic surgical culture, with the morbidity and mortality meeting being regarded as accusatory and hostile without providing support.

- **The consequences of complications in future clinical practice** (including changes in practice, introduction of protocols, education of staff members, and participating in root-cause analysis). Participants in several studies believed that dealing with errors and complications improved their subsequent performance. For example, 92 of 123 respondents (74.8%) in one study believed that their professional ability was not impaired after a complication, and in another study half of the surgeons did not believe they should stop operating for a brief period after an intraoperative death.

“However, respondents in other studies described a combination of anxiety and shock affecting their ability to rectify the operative problem in a practical sense immediately after an intraoperative complication. Some respondents reported impairment for weeks after the incident, describing ongoing rumination, difficulties in concentration, adversely affected clinical judgment, and loss of confidence,” according to the researchers. Surgeons in another study described an initial denial and minimization of the severity of the consequence potentially delaying the necessary treatment, while some surgeons reported avoiding or stopping certain operations as well as contemplating early retirement. “Surgeons across the studies indicated that they deal with these problems in isolation with significant personal and clinical consequences. With *primum non nocere* remaining a cornerstone of medical practice as applied to patients, a similar philosophy needs to be embraced by the surgical community for the betterment of health of the profession,” the researchers concluded.

The authors reported that they had no conflicts of interest.

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SOURCE: Srinivasa S et al. JAMA Surg. 2019 Mar 27. doi: 10.1001/jamasurg.2018.5640.

Survey of Surgeons

Bias from page 1

who conducted the survey as part of a mentoring program for young women at AdventHealth, Ms. Jadick reported on results of an online survey completed by 190 male surgeons. She noted that, while women represent more than 50% of medical school students, they constitute only 19% of general surgeons in the United States. “Especially in the face of a projected shortage of practicing surgeons, it is more important now than ever to investigate, understand, and work to eliminate the barriers encountered by this large and unique talent pool,” she said.

The anonymous survey was extensive, including 70 five-point Likert-scale questions and 63 multiple choice and binary answers. Regarding the male surgeons who completed the survey, 84% were attendings with more than 5 years of experience, and 8% had less than 5 years in surgery. The remainder were residents, fellows, and interns.

When asked if women are as capable as their male counterparts, 80% agreed, with the remainder split between “disagree” or “no opinion.”

“Although this is very small in comparison, that’s actually pretty significant,” Ms. Jadick said of the 10% who disagreed.

When asked if women make good surgeons, 67% agreed, 10% disagreed, and 23% selected neither. “We found that older male surgeons

were more likely to believe women make successful surgeons, as opposed to younger male doctors,” Ms. Jadick said. She called this finding “surprising” because younger doctors are expected to have more progressive ideas. “However, this response seems

“We found that older male surgeons were more likely to believe women make successful surgeons, as opposed to younger male doctors.”

to indicate otherwise, and that’s an important part of the conversation.”

When asked if women have the same advancement opportunities as men, 75% agreed and 9% disagreed. When the question was flipped – that is, if men have more opportunities than women – 32% agreed and 43% disagreed. Half of responders concurred that women are discouraged from entering surgery because program directors question their ability to complete surgical training, yet

95% agreed that men and women residents receive equal training. “This is especially a problem,” Ms. Jadick said of the latter finding.

The survey also found wide disparities in how male surgeons feel about family roles. A high percentage – 80% – agreed that a woman can be both a good surgeon and a good parent. But an even higher percentage – 96% – said a man could be good in both roles. “When looking at the disagreement to these statements, 13% said it is not possible for a woman to be both a good surgeon and a good parent, while not one single male respondent said the same for men,” Ms. Jadick said. Of the men surveyed, 84% agreed that female surgeons are under greater pressure than men to balance work and family life.

Exploring the family issue even deeper, 46% of the respondents said that having children adversely affects a female surgeon professionally, whereas only 9% said the same of men. Conversely, 31% said children do not affect a female surgeon’s career, but 81% said children do not affect a male surgeon’s career.

“Clearly the topic of family obligations is a huge issue in the context of gender discrimination against women in surgery, and this is the case even though many have indicated that women and men have similar commitment to families outside of work,” Ms. Jadick said. “This has proven to be a big part of the issue in the past and likely moving forward as well. That’s why it’s of paramount

importance for us to take this into consideration and understand that it’s happening.”

When asked about working with women in the operating room, 20% of male respondents agreed that women surgeons are aggressive co-workers, and 19% said that it’s easier to work with male colleagues. This attitude may be a function of the stereotype of women being deferential to leadership rather than assuming it, she said.

When asked frankly if discrimination exists in surgery today, 43% answered “yes” – but 57% said “no” or “unsure.”

“This finding clearly portrays the problem does persist in surgery, and therefore, it’s very important for [male] surgeons in particular to remain aware of that problem and actively work to eliminate that disparity within that work environment,” Ms. Jadick said.

However, the 57% who said discrimination is not a problem is more unsettling, she said. “That’s incredibly significant because the first step to solving any problem is recognizing that there is one,” Ms. Jadick said. “However, then we must commit to solving it. Only by promoting an equitable and inclusive work environment that promotes the engagement of women can we improve the future of surgery for the betterment of all of its stakeholders, especially patients.”

Ms. Jadick had no financial relationships to disclose.

Quality: New Global Guideline on CLTI Finalized, Will Be Published Soon in JVS

After four years of work and research, vascular experts from around the world have released a new, far-reaching global guideline on managing chronic limb-threatening ischemia (CLTI), a problem of increasing prevalence and higher health care costs world-wide.

The *Journal of Vascular Surgery* is publishing the guideline, with 113 specific recommendations, as a supplement to the June edition. It is to be available online before late May.

The guideline creates a new conceptual framework for treating CLTI, the end-stage of peripheral arterial disease. The document encompasses nomenclature, disease staging and a platform for evidence-based revascularization that will allow for future evolution and quality improvement in the field.

Three co-editors, one each from the Society for Vascular Surgery (Michael Conte, M.D.), the European Society for Vascular Surgery (Philippe Kolh, M.D.) and the World Federation of Vascular Societies (Andrew Bradbury, M.D.), and nearly 60 additional authors worked on the guideline. Participants spanned six continents and represented all specialties treating CLTI.

In addition, an extensive evidence review was

undertaken, directed by a methodologist, to support the writing group's work. The final result is a unique practice guideline, reflecting the spectrum of the disease and approaches seen worldwide, said Dr. Conte.

Major recommendations cover the need for comprehensive assessments in patients with suspected CLTI; optimal medical therapy, including a variety of treatments for CLTI patients; and prompt and effective revascularization for patients with advanced ischemia and limb threat. The document also outlines the importance of an individualized approach to improve patient care and reduce limb loss.

A major change is the name itself. The term "critical limb ischemia (CLI)" is "outdated and fails to encompass the full spectrum" of patients evaluated and treated for limb-threatening ischemia, the authors said.

Other significant changes include:

- **Staging Limb Threat and Anatomic Complexity: WIfI and GLASS**

The guideline endorses the SVS Threatened Limb Classification System based on grading wound, ischemia and foot infection (WIfI) in the affected limb. And it introduces the Global Limb

Anatomic Staging System (GLASS) to stratify the patterns of arterial occlusive disease in the affected limb. GLASS integrates the complexity of disease along a selected target artery path (TAP) from groin to foot. GLASS stages (1-3) are designed to correlate with immediate technical success and 12-month limb-based patency (LBP) following peripheral vascular intervention.

- **Decision-Making: Have a PLAN**

"Perhaps most notably, the guideline supports a structured approach to decision-making regarding revascularization based on Patient risk, Limb severity and ANatomic complexity (PLAN), in that order of priority," said Dr. Conte. "The guideline seeks to provide a new foundation for practice but also for data collection to support evidenced-based revascularization in CLTI."

Beyond improving patient care, identifying key research priorities is an important secondary goal for the guideline. Thus, each section includes such priorities and where efforts and resources should be focused to improve patient care and advance the science.

Read the new guideline at vsweb.org/CLTIGuideline.

Your SVS: Membership Application Deadline Is June 1

The second membership application deadline for 2019 is just a few short weeks away, on June 1.

Membership in SVS confers a substantial number of benefits, including professional standing; publications; education and networking with leaders, at exclusive member pricing; management resources, including evidence-based clinical practice guidelines; mentorship; leadership opportunities; scholarships; research grants for every stage of a vascular

surgeon's career; advocacy in Washington for decisions that affect members' lives and livelihoods; a job board and more.

Active members in good standing also may take advantage of SVS' new professional, trademarked Fellow designation. They may add the initials FSVS™ after their names in any usage, such as signature lines, letterhead and door signage.

View membership benefits in detail at vsweb.org/MemberBenefits.

SVS Spotlight

Spotlight highlights significant honors and achievements our members receive, medical and otherwise. Send information (with "Spotlight" in the subject line) to communications@vascularsociety.org.

SVS member Elliot L. Chaikof, MD, PhD, Chair of the Department of Surgery and Chief of Surgery at Beth Israel Deaconess Medical Center (BIDMC), has received the American Surgical Association's 2019 Flance-

Karl Award. This award recognizes one surgeon in the United States for seminal contributions in translational research that have applications to clinical surgery of any specialty. Dr. Chaikof, a past recipient of the SVS Foundation E.J. Wylie Traveling Fellowship, has led multiple research efforts; most recently, his work has focused on drug discovery to develop more effective treatments for, among other conditions, atherosclerosis and venous thrombosis.

SVS Creates New Section for Outpatient Care

With an increasing number of procedures transitioning to office and outpatient settings, the Society for Vascular Surgery has created the new member Section on Outpatient and Office Vascular Care (SOOVC), specifically geared to clinicians who work in these environments.

The SOOVC is designed to increase awareness, education and representation of the movement to outpatient and office-based settings.

Past President R. Clement Darling spearheaded the initiative and the response (approximately 130 members joining with the first few months) has been "tremendous," said section Chair Deepak Nair, M.D. "Clearly we are meeting a need."

Section members want to raise awareness, particularly "within our house of vascular surgery" on the ongoing shift to more minimally invasive surgical procedures, many of them done outside of hospitals, said Dr. Nair. Members in academic research environments or employed by large hospital systems, in particular, may not be cognizant of

this paradigm change, he said.

Representation and education are important goals as well. "We have a large number of members in community-practice settings and other hospital-based specialists who increasingly perform more outpatient procedures and office-based care," he said. "This big group is continuing to grow and now has representation."

And education "from the ground floor up" is required. Though the clinical indications and treatment options for care are the same, components as basic as billing and coding are very different, as are practice patterns and equipment choices, said Dr. Nair. Representation and education can play important roles in supporting a move into the outpatient realm, he said. "There's always a way to go into inpatient care, but it's not as intuitive to go the other way. The new section absolutely can help."

Leaders also stress diversity and inclusivity. They welcome all who work in outpatient and office settings as section members. Dr. Nair

Care continued on following page

Leadership: Spotlight on Linda Harris, MD

BY PETER ROSSI, MD
On behalf of the Leadership Development and Diversity Committee

This interview continues our series of conversations with national vascular surgery leaders based on topics from the Kouzes and Posner book “The Truth About Leadership.” This column highlights the evidence-based behaviors regarding “Leadership is an Affair Of The Heart.”

Dr. Linda Harris is a Professor of Surgery at the University of Buffalo, State University of New York, where she is Fellowship Program Director and has served as the Division Chief. She has been a reviewer for numerous peer-reviewed journals and has served on the editorial board of the *Journal of Vascular Surgery*, *JVS: Venous and Lymphatic Disorders* and *CIT* as well as *VASCULAR SPECIALIST*. Leadership positions include president of the APDVS and of the Eastern Vascular Society and Distinguished Fellow of the SVS; she has mentored numerous trainees in surgery through their clinical and research interests.

portant to your career/practice and you can't resolve it after a reasonable effort, that's when it makes sense to leave. Otherwise it makes more sense to fix what you have, because it may be better than what you would be



DR. HARRIS

going to. While it is true you have more “power” when you first come, that power is rapidly lost. All of our institutions can provide a great deal. Unfortunately, many of them do not realize our importance in vascular surgery. Across the country, we are trying to get people to realize what we do and who we are, and to show how valuable vascular surgery is to the universities and to the hospitals for patient care. We can't do this from the bottom. When trying to make changes, it is much easier to do this from the top. When you are near the top, then people listen to what you say.

Q: It's an interesting problem, this inability to make hospitals understand the value we provide to other services. We rescue everyone else and no one rescues us. Why is this so hard for other people to understand? How do we get people in early stages of training to understand what we do?

A: Until hospital leadership actually understands what we do, they just can't appreciate us as a specialty. Ask a first- or second-year medical student — they often don't know who we are as vascular surgeons. We are one of the youngest specialties, and we get confused with other specialties all the time. What I tell students is what I tell my own children. Find a career you are passionate about because otherwise you're not going to be good at it in the long run. Can you imagine doing something 20 years from now that you don't love and having to keep up to date with it? You see this more clearly in some of the “lifestyle” fields. For example, if you have a radiologist who loves what he or she does, that person is one of your best partners in caring for patients, whereas the ones who don't enjoy it you have to call and point out what they have missed. We want to recruit students and residents who are the right fit, with the

right mentality, technical ability and personality to help grow our field. We need to show them the passion for what we do. I love what I do. Not that I don't get frustrated at times, but I love what I do. There is nothing more fulfilling than saving people's limbs and saving people's lives. We make an impact on people and have a long-term relationship with them as they go through the next stages of their health. Patients truly get to know us and we get to know them. This is very unique in a surgical field.

Q: You have been in a large number of leadership roles both locally and nationally. That's not for everyone; some people are content doing the operations and letting other people deal with the “headaches.” What in your career made you realize that moving into more challenging leadership roles was for you? Was it even conscious?

A: When I was a young kid, I was actually extraordinarily shy and introverted. I forced myself into some things that got me out of my shell. In

doing so, I got elected to leadership roles in high school and college; in college I was in student government, in medical school I got involved in AMSA on a national level. I was only a few years out of residency and fellowship when the local ACS chapter asked me to represent them in the Young Surgeons group. They kept asking me to come back and eventually I worked my way up to being president and governor. In vascular surgery, my break really came with Tony Sidawy. He is clearly one of the forward-thinking people in our field; he realized early on that we needed to get young surgeons involved in leadership or our field was going to die. He asked me to chair the first young surgeon ad hoc committee which he was creating at the Eastern Vascular Society. I chaired for several years and that helped to launch my involvement in leadership in a number of other societies.

How did I become a leader? When people ask me my opinion, I'm not afraid to speak my mind. I want to
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Q: It is said often that “institutions won't love you back.” To be anywhere and excel for a long period of time, as you have, can be challenging, especially trying to avoid getting lost in the shuffle. How have you managed this over the course of your career?

A: Certainly no institution or organization is going to be perfect. Many times when people bounce from one institution to another, it is because they think the grass is going to be greener. Every institution, I don't care how large or how small, has issues. If you have an issue that is truly im-

Care continued from previous page

touts the tremendous diversity in geography and practice setting within the SOOVC. “Some have angio-suites, some do not, some are academic, and some are in private practice and some don't do any inpatient care. This variety is very important as it demonstrates the breadth of practice types within our Society,” he said.

Other members of the SOOVC Executive Committee are Drs. Clifford Sales (vice chair), Ellen Derrick, Robert Molnar, Brad Thomas, Boulos Toursarkissian and Maureen Sheehan.

SVS Foundation Participating in AAA, PAD Screening

SVS Foundation, SVN and SVU team up with AAAneurysm Outreach

The SVS Foundation, the Society for Vascular Nursing and the Society for Vascular Ultrasound, have joined forces with AAAneurysm Outreach to sponsor a free screening for abdominal aortic aneurysms and peripheral arterial disease in June. W.L. Gore & Associates is also a sponsor and has provided funding for the event.

GW Medical Faculty Associates in Washington, D.C., will provide the screenings, set for 8 a.m. to noon at 2150 Pennsylvania Ave. NW.



This is the first time the SVS Foundation, SVU and SVN have jointly sponsored such a screening with AAAneurysm Outreach. In both 2017 and '18, the SVS Foundation

worked with AAAneurysm Outreach on screenings at the national conventions of Veterans of Foreign Wars and VFW Auxiliary. In 2018, screeners discovered 11 aneurysms that required medical attention.

SVS Foundation participation in such screenings is part of its expanded mission that includes an emphasis on members in community practice, prevention, patient education and, ultimately, the public's vascular health.

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make a difference. You have to be willing to put yourself out there, even if your view is not always right. If you aren't willing to challenge the status quo, life will not change on its own. When you do voice your opinions, you are often given the opportunity to get involved in changing things for the better.

Q: Our major societies are very academically oriented. Large societies have committees relating to private and non-academic practice, but those surgeons are not often seen in national leadership roles. What can we do to get our colleagues involved on a national level?

A: This depends on what we mean by "getting them involved." There is a big difference in what we need from the organizations in terms of academic and non-academic practice. Take the Vascular Annual Meeting. Education has so many venues – online, journals, hundreds of meetings, etc. Academ-

ics have to punch certain tickets for promotion so you have to be involved, presenting, doing research. Non-academic surgeons may participate for education, or they may go for industry interactions that might not otherwise be available, they may come because of collegial relationships, and they may be interested in leadership. We need to reach out directly and find out what they need and to allow them to participate in ways that will benefit their careers and lives, not fit them in to our molds. While lines are blurring, and academic and non-academic practices are not so different anymore, we still need direct outreach to see how we can best help them as a Society. Moving forward, our web-based platforms for interaction may attract more community practice surgeons' involvement and participation. For example, SVSConnect (online community) does not require time away from work. We can't measure involvement solely on attendance at VAM. Once those in non-academic practices show an interest, we need to give them the

opportunity and the support for their involvement and advancement, and leadership opportunities.

Q: There were some recent talks in an ACS leadership meeting about leading from the front versus leading from behind. Which technique is better, or is it a combination?

A: There are a lot of different ways to lead effectively. The concept of the "dictatorial leadership" is rarely effective today. We are working in a different environment with multiple generations. We do need to lead by example, because, you cannot expect from others what you are unwilling to do yourself. By the same token, you don't have to be the lead on everything. A good leader will give people opportunities to excel. That is how you grow massively as an organization, because lots of people are working at the top of their game for a united goal. As an individual, I can only accomplish so much, but if I motivate, or allow motivated individuals to all work towards a goal,

we will accomplish much more than I could have ever done by myself. In groups that work the most effectively, all members feel invested. That means you give recognition to those who perform, and you provide the tools to allow people to succeed.

Q: To wrap up, any thoughts on when you learned to say "no?" Certainly, I struggle with this.

A: I still have a hard time with this, but I do occasionally say no. You have to know what you can realistically accomplish. It is worse to over-commit than to say no. You do not want to say yes, and then perform poorly because you don't have time. If you have the time and it is part of your personal plan, it makes sense to take on opportunities when they are offered. If the opportunity isn't part of your original plan, make sure of your own interest and willingness to devote time to it before saying yes. Our plans change over time, so it is important to reassess when opportunities are presented.

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Hospitalized PE Nearly Doubled in 2004-2015

BY MITCHEL L. ZOLER
MDEDGE NEWS
REPORTING FROM ACC 2019

NEW ORLEANS – During 2004-2015 the incidence of all diagnosed pulmonary embolism (PE), based on discharge diagnoses from the National Inpatient Sample, rose from 5.4 cases/1,000 hospitalized patients in 2004 to 9.7 cases/1,000 hospitalized patients in 2015, an 80% increase, Joshua B. Goldberg, MD said at the annual meeting of the American College of Cardiology. The incidence of major PE – defined as a patient who needed vasopressor treatment, mechanical ventilation, or had nonseptic shock – rose from 7.9% of all hospitalized PE diagnoses in 2004 to 9.7% in 2015, a 23% relative increase.

During the study period, treatment with systemic thrombolysis for all PE rose nearly threefold, and catheter-directed therapy began to show a steady rise in use from 0.2% of all patients in 2011 (and before) to 1% of all patients by 2015. Surgical intervention remained lightly used throughout, with about 0.2% of all PE patients undergoing surgery annually.

Most of these intervention options focused on patients with major PE. Among patients in this subgroup with more severe disease, use of one of

these three types of interventions rose from 6% in 2004 to 12% in 2015, mostly driven by a rise in systemic thrombolysis, which jumped from 3% of major PE in 2004 to 9% in 2015. However, the efficacy of systemic thrombolysis in patients with major PE remains suspect. In 2004, 39% of patients with major PE treated with systemic thrombolysis died in hospital; in 2015 the number was 47%. “The data don’t support using systemic thrombolysis to treat major PE; the mortality is high,” noted Dr. Goldberg, Westchester Medical Center in Valhalla, N.Y.

Although catheter-directed therapy began to be much more widely used in U.S. practice starting in about 2015, during the period studied its use for major PE held fairly steady at roughly 2%-3%, but this approach also showed substantial shortcomings for the major PE population. These sicker patients treated with catheter-directed therapy had 37% mortality in 2004 and a 31% mortality in 2015, a difference that was not statistically significant. In general, PE patients enrolled in the catheter-directed therapy trials were not as sick as the major PE patients who get treated with surgery in routine prac-



DR. GOLDBERG

tice, Dr. Goldberg said in an interview.

The data showed much better performance using surgery, although only 1,237 patients of the entire group of 713,083 PE patients studied in the database underwent surgical embolectomy. Overall, in-hospital mortality in

these patients was 22%, but in a time trend analysis, mortality among all PE patients treated with surgery fell from 32% in 2004 to 14% in 2015; among patients with major PE treated with surgery, mortality fell from 52% in 2004 to 21% in 2015.

Dr. Goldberg attributed the success of surgery in severe PE patients to the definitive nature of embolectomy and the concurrent use of extracorporeal membrane oxygenation that helps stabilize acutely ill PE patients. He also cited refinements that surgery underwent during the 2004-2015 period based on the experience managing chronic thromboembolic pulmonary hypertension, including routine use of cardiopulmonary bypass during surgery. “Very high risk [PE] patients should go straight to surgery, unless the patient is at high risk for surgery because of conditions like prior sternotomy or very advanced age, in

which case catheter-directed therapy may be a safer option, he said. He cited a recent 5% death rate after surgery at his center among patients with major PE who did not require cardiopulmonary resuscitation.

The database Dr. Goldberg and his collaborator reviewed included 12,735 patients treated by systemic thrombolysis, and 2,595 treated by catheter-directed therapy. Patients averaged 63 years old. The most common indicator of major PE was mechanical ventilation, used on 8% of all PE patients in the study. Non-septic shock occurred in 2%, and just under 1% needed vasopressor treatment.

Published guidelines on PE management from several medical groups are “vague and have numerous caveats,” Dr. Goldberg said. He is participating in an update to the 2011 PE management statement from the American College of Cardiology and American Heart Association (Circulation. 2011 April 26;123[16]:1788-1830).

The study received no commercial funding. Dr. Goldberg had no disclosures.

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PERSPECTIVE by Dr. Linda Harris

Best Option Not Clear

Dr. Goldberg reviewed the NIS data assessing PE therapy. He found an increase in PE, which he suggests demonstrates the need for improved prophylaxis. While it is clearly possible that there is a true increase, it is equally likely that diagnosis has improved and the actual events remain stable. Further, the acuity of hospitalized patients has increased as more patients are treated in outpatient centers or with outpatient procedures, leaving only the most ill in hospitals.

He found that mortality decreased to the greatest extent with open surgical management, concluding that surgery should be the primary option for intervention.

Unfortunately, few patients with severe PE are treated with any intervention. The majority of the increase is related to systemic thrombolysis, which had a high mortality, 47%. Based on this, he suggests use of systemic thrombolysis is not indicated. What is not available from this data is whether these patients were in locations where there was access to either open surgery or catheter directed thrombolysis, and what would have

been the expected mortality if no therapy had been offered.

He goes on to say that catheter-directed thrombolysis, which had a mortality of 31-37%, is being used for patients who are “not as sick” as those who undergo open surgery. This, however, is conjecture. He is basing real world therapy off of clinical trials, which always have a more defined population. He does not provide any data to suggest that this is the case in the NIS. He goes on to state that surgery, which occurred on 0.001% of the patients, is the best method of intervention for the sickest patients. What again is unclear is how the decision is made for each patient as to what therapy to offer. In some institutions, CT surgeons may choose NOT to operate on the sickest patients, sending those patients to the vascular surgeon, interventional radiologist or cardiologist, who performs catheter-directed thrombectomy and thrombolysis. In other centers, only one therapy may be available.

I think most physicians would agree that catheter-directed therapy is superior to systemic, when it is available. Surgery should clearly be

considered for patients who are too unstable to undergo endovascular interventions, and who will not otherwise survive. However, from this data, it is not at all clear which modality is superior when all circumstances are equal. Again, both interventions are not necessarily available in every hospital, so the question becomes is it better to have systemic thrombolysis or anticoagulation alone, if catheter-directed interventions or open surgery are unavailable. Most of these patients are not stable enough for transfer to tertiary centers where these advanced therapies are available. Ideally, this could be assessed with a randomized, controlled study looking at endovascular mechanical thrombectomy and thrombolysis versus open surgical repair. Clearly, it is also easier to develop a program for endovascular intervention than for open surgical thrombectomy, as the latter requires a full cardiac team, where the former requires trained interventionalists.

Linda Harris, MD, is a professor of surgery at the University of Buffalo, State University of New York, where she is Fellowship Program Director. She is an associate medical editor for VASCULAR SPECIALIST.

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