



10 News From SVS

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VOL. 15 • NO. 11 • NOVEMBER 2019

Vascular Specialist

SVS | Society for Vascular Surgery | Official Publication

Vascular Surgeons: Plan and Prepare for Your Next Job

BY FRANK J. VEITH, MD

You are a well-trained vascular surgeon. You are competent and hard working. You provide good patient care for the appropriate indications. You are rising up the ladder of success in your institution or practice group. You are progressing academically. You believe your future is bright, and that you have firm job security in your present position.

Don't be so sure. Institutional and academic politics can intrude. Vascular surgery is a subordinate specialty in most places. Thus, the institutional or departmental decisions that threat-

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SPECIAL ISSUE Career Transitions For Vascular Surgeons

VAL08451/GETTY IMAGES

BY DAWN COLEMAN, MD, AND
MALACHI SHEAHAN III, MD
CHAIRS, SVS WELLNESS TASK FORCE

Vascular surgeons enjoy working with our hands. For most of us, the chance to creatively reconstruct vascular pathology was the motive for entering this field. Too often, though, our reimbursement is tied only to our ability to operate, and operate prolifically. Anyone with a business degree can tell you this is a precarious financial model. But it doesn't need

to be this way. A good vascular surgeon has important skills that extend far beyond technical ability. We are teachers, innovators, and leaders. We have talents that are valuable to industry, health care systems, medical schools, and the government. There are many pathways to put these skills to use, either while still in practice or after. We asked several national leaders to express their thoughts on the issue of career transitions for vascular surgeons. The responses have been compiled in this special issue of Vascular Specialist as a project of the SVS Wellness Task Force.



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Your Next Job

Prepare from page 1

en your job can have little to do with your performance, or they can be financially motivated from the crazy economics of medicine today.

Alternatively, job-threatening administrative decisions can be the result of the darker aspects of human nature within your own specialty group or the superior individuals they work for.

Some of the latter may be totally outside our specialty, like an administrator, a chairman of surgery, or a heart and vascular center director who has little appreciation for the skills and value of vascular surgeons. In addition, the jealousy and insecurity of your peers or superiors can motivate the destruction of your job security and even result in your termination.

Remember that nothing elicits the hostility of others like your successes – and this hostility may be carefully hidden until you are struck because of it.

Would such treatment be unfair? Of course it would. You believe that providing the best care for your patients is paramount and will protect your job security. Not so.

Those that control your destiny may have totally different motivation that may be financial or protective of another specialty that competes with

vascular surgery for patients.

What can vascular surgeons do about all this? First, be aware of some of the detrimental forces that exist today in American medicine.

Unfortunately RVUs, DRGs and



DR. VEITH

dollars are often more important than quality of care. Second, be aware that some qualities of human nature are malignant, and many of those who influence your professional destiny may be totally controlled by self-interest.

Third and most important, never stop preparing for your next job. This should always be in the mind of middle-range and more senior vascular surgeons.

When you decide to stop operating because of age or diminished physical skills, you will still have a

good brain and energy which will enable you to contribute to society or work in another capacity. Vascular surgery is physically demanding and in many ways a young man's or young woman's game.

So the message to all vascular surgeons is – never stop planning and preparing for your next job. You may need to take it sooner than you think.

If you slow down or quit early, you must prepare and have an alternative occupation to maintain your well-being and self-respect.

Your next job does not have to be financially rewarding, but it is not bad if it is. Maintaining more than a retirement income allows one to do all sorts of good things for yourself and others.

Vascular surgeons have many skills beyond the ability to operate or perform procedures.

If you start to prepare to use these skills early, you can have enormous

value to yourself and society after you quit being a vascular surgeon. Full retirement is not all it is cracked up to be once it happens.

Does preparing for one's next job also apply to younger vascular surgeons. You bet it does.

Your vascular surgery career can be negatively impacted by some of the unfair actions of our current health care system or others in your universe, as mentioned above. If it happens and you are ousted, do not seek revenge. It will only consume you and make lawyers rich.

Just be prepared to move on to another vascular surgery job. It likely will be better than the one you were forced to leave.

Similarly, if a vascular surgeon becomes unable to operate for any physical reason, his or her other skills can have extreme value in another related or unrelated field. Witness the physicians and surgeons who hold important positions in the U.S. congress.

So the message to all vascular surgeons is – no matter how much you love your profession – never stop planning and preparing for your next job. You may need to take it sooner than you think.

Dr. Veith is professor of surgery at New York University Medical Center and Case Western Reserve University, and the William J. von Liebig Chair in Vascular Surgery at the Cleveland Clinic Foundation.



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Vascular Specialist is the official newspaper of the Society for Vascular Surgery and provides the vascular specialist with timely and relevant news and commentary about clinical developments and about the impact of health care policy. Content for Vascular Specialist is provided by Frontline Medical Communications Inc. Content for the News From the Society is provided by the Society for Vascular Surgery.

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POSTMASTER Send changes of address (with old mailing label) to Vascular Specialist, Subscription Services, 10255 W. Higgins Road, Suite 280, Rosemont, IL 60018-9914.

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The Society for Vascular Surgery headquarters is located at 9400 W. Higgins Road, Suite 315, Rosemont, IL 60018. Vascular Specialist (ISSN 1558-0148) is published monthly for the Society for Vascular Surgery by Frontline Medical Communications Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609. Phone 973-206-3434, fax 973-206-9378

Subscription price is \$230.00 per year.

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The Future Ain't What It Used To Be: It's Better

BY R. CLEMENT DARLING III, MD

The great Yogi Berra once said, "The future ain't what it used to be" and as a senior vascular surgeon, one is always concerned about what is next. I would argue that, this time, Yogi might not be correct in the sense that we can make the future "better than it was." Although mild hyperbole, I would view that all of us as vascular surgeons have the similar course as any highly trained athlete. We spend much of our time perfecting our technique and then as our career comes to a close, it is difficult to see how much we have to offer outside the number of logged cases and our technical expertise.

I have had the privilege of working in an operating room environment over the past five decades as an operating room technician and a vascular laboratory technologist, as well as a vascular surgery trainee and attending. Unfortunately, I have observed first-hand how difficult it is for many to transition from a successful surgeon with a busy practice to a "nonproductive" physician whether real or perceived. Many senior surgeons simply cannot accept that their skills have eroded or they have "lost a step." However, they also do not recognize the tremendous intellectual and experiential assets they possess. I strongly believe that we are evolving, with the help of our younger mentees and trainees, into realizing that a career should not be solely based on our clinical output. Vascular surgeons are able to analyze and synthesize complex problems using their intellectual skills and life experiences into logical data-driven solutions. One of the greatest losses that I have observed over the years is not eroding technical skills but that many of the educational, intellectual, and problem-solving aspects of senior surgeons gets lost in this transition.

I have the luxury of working in an institution

where many in positions of power are physicians and they have clearly demonstrated that they can run hospitals, operating rooms, and billion-dollar organizations better than many hospital administrators who have no understanding of what we actually do. Vascular surgeons are not just proceduralists; they administrate, they adjudicate, and, more importantly, they make sure the right things are done.



DR. DARLING

As our senior surgeons transition out of clinical medicine, they should not be forgotten. Their skills can be used as first assistants in the operating room as open surgery becomes a lost art; they can be hospital administrators running large

corporations while maintaining an emphasis on patient care, not simply profit and loss. We need to be actively involved in legislation, advocacy, and in setting up accreditation of vascular centers around the country. Senior vascular surgeons can be instrumental in promoting vascular surgery as a specialty as we work with all of the external forces affecting all vascular surgeons' lives (hospitals, payers, legislators, and industry). We must do this, not only for ourselves, but for our patients.

In Albany, many of our retired surgeons and physicians who have transitioned from clinical practice are working with third-party payers; not to deny care, but to make sure the appropriate physicians are doing the appropriate care. They recognize the benefits of vascular surgeons as open surgeons and interventionalists and rely on us greatly for our expertise. Lastly, I believe we must create a new industry for many senior surgeons who have had storied vascular surgery careers to help mentor the young surgeons. As

endovascular surgery has advanced, many of the open techniques have been lost and the experience of many of our graduates and mentees does not allow them to have the confidence to be aggressive when endovascular therapy is either inappropriate or has not achieved the desired results.

Having a senior surgeon participate in the planning and execution of complex problems can provide intellectual backup and a sounding board for younger surgeons to become comfortable with performing complex open surgery. As we teach our fellows, the setup, albeit endovascular or open, is as important as the execution.

We need to train not only our senior surgeons but those in their early and mid-portions of their career in leadership skills. With the guidance of Ken Slaw, the SVS is doing this. The SVS is aggressively working on programs to help provide structure and courses to meet these needs. There are many programs, which can help us recognize these skills and allow us to feel confident in pursuing other jobs where these skills can be used

So, not only do I see the future as not "what it used to be" but I think it's going to be better. We need to keep our minds open, looking forward and using all the incredible skills that we have developed. Young and old working together, we will create a better world. We need to be involved; we need to set the standard. We need to use data-driven logical decisions that are patient driven. This is how we were trained, and this is who we are. Vascular surgeons are expert problem solvers, excellent leaders, and need to be in the forefront of decision making when it comes to the future in vascular healthcare in this country and every age can contribute.

Dr. Darling is Chief, Vascular Surgery, Albany Medical Center and Professor of Surgery at Albany Medical College, N.Y.

Take "The Road Less Traveled"

BY RUTH L. BUSH, MD, JD, MPH

It would have never occurred to me that I would be doing something else in life following college, medical school, and the subsequent lengthy surgical residency and vascular fellowship. To this day, I still take care of patients; review notes; check alerts, CTs, ultrasounds; triage consults; read vascular lab studies; and I still operate. Patient care activities now take up a lower percentage of my time than in prior years, but are still very important to me.

My nonsurgical positions have been challenging and rewarding but my decisions and success have been influenced and informed by the fact that I am a vascular surgeon. The fact that I am a surgeon makes me a better administrator. I believe that sur-

geons have leadership ability, some skills are innate and some skills develop over time with education and hard knocks. We are able to make



DR. BUSH

tough decisions – sometimes we have to do this with only partial information. We are able to internalize or try not to take outcomes personally, move quickly among activities, triage, and reflect

so that we can do it better the next time.

Opportunities came along several years into my career when I was doing a wide variety of operations from dialysis access to aneurysms and a

proud producer of RVUs. I was asked to lead a vascular fellowship, then to design and start a new one, and then progressively apply for more administrative-heavy educational positions within medical schools. The choice to go down "the road less traveled" was not one I took lightly. Leaving full-time patient care was an agonizingly difficult decision. My ultimate conclusion did not have to do with burnout, back pain, the all-encompassing electronic medical record, reimbursements, RVU benchmarks, etc. It had to do with impact and where I wanted to focus energy. Training the next generation of physicians, regardless of their medical specialty of choice, and being able to influence that training and professional identity formation from the beginning was where I found my calling. Being a medical educa-

tor is rewarding. Now as one of the founding faculty who are developing a new medical school, I am currently undertaking one of the hardest tasks I have ever faced. There are so many details to consider from getting a student admitted and enrolled, to designing a modern curriculum, to what standards are necessary to practice in today's increasingly diverse and complex world, to what the transcript will look like.

I always encourage mentees and those who ask to explore options. Gather information. Reflect. And have courage to go down the road less traveled.

Dr. Bush is the Associate Dean, Medical Education, University of Houston College of Medicine and Professor of Vascular Surgery, Houston.

Moving Beyond Surgery

BY DANIEL CLAIR, MD

As surgeons, we rely on both cognitive and physical skills to perform our regular tasks for providing care for our patients. We additionally rely on experience and in many instances incorporate this experience in making judgments regarding therapy and recommendations to our patients. This mandates that our cognitive function and decision-making skills are at their best in order to ensure we are providing the best care for our patients.

Unfortunately, as we age, our cognitive performance declines (JAMA Surg. doi: 10.1001/jamasurg.2017.2342) and our physical performance declines as well. While there is significant variability in the rate at which our performance declines, we cannot escape the inevitable decline in performance.

These issues affect our surgical performance as well (Med Care. 1999;37:93-103; Neurology. 2000;55:773-81; Ann Surg. 2005;242:344-8, discussion 348-52). The approach to this information can take on a form of denial with intent to practice until we can't make it to the operating room any more, or perhaps more appropriately as a motivation to develop a transition plan for when our surgical career ends. And there are many opportunities for surgeons to do this.

Surgeons are trained leaders, and the need for leaders in the health care system is significant. Leading the operating room team involves skills we can use in other areas of the hospital.

Additionally, the experience obtained by surgeons is incredibly valuable to medical students, residents and younger partners. There are many opportunities for surgeons to "branch out" from the operating room, and when we do this, we provide better representation for surgeons everywhere in the community.

Vascular surgeons are utilizers of some of the most expensive equipment in the hospital, and as such, we owe it to our partners, our hospitals, and our health care system to become involved in efforts to begin to try and reduce costs. Nearly every health system has in place a cost-containment strategy or initiative and most systems need physicians to get involved in this process. If you have been at a facility for longer than a year or two, you probably know who to speak with about getting involved in this process. And by working with others on this committee and following through on these commitments, other administrative doors in the facility will be opened.

Other issues need to be tackled in health care systems that can be valuable in driving care costs down as well. These include reducing length of stay, moving operating room procedures to outpatient facilities, and reducing variation among surgeons performing similar procedures to move to a "best practices" program that minimizes cost while providing continued or improved quality.

Most of these efforts will require working with other physicians, other surgical groups, or hospital administrators, but the better we are at doing this, and the more effort we put forth, the more value

any individual provides to the health care system we work for. In some instances, it is difficult to feel one has the ability to do these things across the institution; getting these efforts going in your own group provides immediate value and evidence of your ability to provide this type of service to the whole system. Hospital leaders are looking for physicians



DR. CLAIR

who can work with other physicians and administrators to make things like this happen.

Efforts to reduce costs for surgical care do not need to exclusively involve reducing costs of devices. Reducing length of stay, reducing readmission rates, and reducing opioid usage are all initiatives that can lower cost, increase quality metrics, and bring value to a health care system.

Attempts to achieve these goals will often involve coordination of care from differing areas including anesthesia, care planning, and pharmacy. The ability to provide a unified approach

Moving outside the environment we feel most comfortable in, caring for surgical patients, will place us in a different environment ... but in the end, these changes will be valuable.

to perioperative care is critical to improving outcomes for our patients, but it all has to start with a surgeon seeking to work with others to improve care for patients.

Beyond the facilities we work in, there are opportunities to work with medical device companies to assess and evaluate new products. Normally, individuals looking to do this kind of work have embraced innovative technology for some time.

It is difficult if your career has not involved at least some engagement with industry partners attempting to assess outcomes with devices, but even in situations where this has not necessarily been a primary focus of your practice to this point, you can provide value to a company.

All device companies want and need physician input regarding potential concerns or improvements in marketed devices, along with other uses for devices which can expand the market for technology. As physicians, and surgeons dealing with some of the most complex patients in the hospital, vascular surgeons can provide these insights.

Companies need physicians to evaluate trial outcomes, adverse events, and, after more extensive relationship building, to help design trials and make decisions regarding investment in technolo-

gies, registries and individual physician investigations.

Surgeons are also needed as experts outside the health care system. In the United States, a significant number of physicians will be involved in some way in malpractice litigation. Having had an expert surgeon provide his services for defense in a case I was involved in, this need hit home for me.

While I had routinely neglected to even investigate complex legal cases, I realized how powerful having an experienced senior surgeon come and testify in court on my behalf was in defending a case I was involved with. Our specialty needs physicians with expertise in this area and an interest in helping others. While providing this service sounds like it should be easy, it can be incredibly stressful, and involves a good deal of effort on the part of the expert.

In order to be successful in this arena, one needs time, expertise, and likely some coaching to ensure he/she understands the legal process and how best to be of value. There are many avenues to gain experience in this regard, and if the legal counsel at your facility is available, a visit to meet with them to discuss this interest is probably a good place to start.

These experts know attorneys in your area who deal with this and could get you some early experience in this area. But be wary of taking cases in your own area, as conflict with local groups or physicians may pose a political problem for you, your hospital, or your group.

There are other needs for vascular surgeon input in facilities and there are numerous areas where we have had little to no input within our facilities. Examples of areas beyond these include wound care centers, surgical education, EMR enhancement for surgeons, ethics committees, fund-raising, free-care initiatives, and physician mentoring.

All a transition really takes is interest and effort. There are likely multiple areas other surgeons could provide as areas of interest which have served them well as a method of practice transition. It is important to recognize that most of these will involve a need to reduce either clinical practice or other activities as you move to try and achieve success in your new area of interest. It is also helpful if vascular surgeons as mentors provide younger surgeons with opportunities to work in these areas to see where they can be successful and where they have an interest.

There is also no doubt this transition will be somewhat stressful. Moving outside the environment we feel most comfortable in, caring for surgical patients, will place us in a different environment, often working with individuals we won't relate to in the same way, but in the end, these changes will be valuable for us, our patients, our health care systems, and ourselves. As Brian Tracy puts it, "Move out of your comfort zone. You can only grow if you are willing to feel awkward and uncomfortable when you try something new."

Dr. Clair is Chair, Department of Surgery, Palmetto Health/ University of South Carolina Physicians Group, Columbia.



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Transitions for Older Vascular Surgeons

BY INA Y. SOH, MD, AND
SAMUEL R. MONEY, MD

When I was asked to write about end-of-career transitions for vascular surgeons, I thought nothing would be better than to write with a young vascular surgeon just embarking on her career in our specialty. Therefore, I have invited our senior fellow to help with this commentary.

For most of us, our career as vascular surgeons is what defines us. Our surgical work is our life. We generate a tremendous amount of personal fulfillment and identity from being a vascular surgeon. In view of this, and the fact that one-third of surgeons are over 55 years of age, the impact of late-career transitions becomes apropos. Can we find meaning in our lives after the practice of vascular surgery has left us? Can we find personal satisfaction in golfing, gardening, wood work, or world travel when we retire? Will these interests outside of surgery be satisfying alternatives to operating?

The decision to transition out of clinical practice is deeply personal.

I believe very few people do it well. In a recent study of Canadian surgeons, the median age of surgeons planning to retire from all clinical work was actually 70 years. A significant percentage of them preferred to stop doing big cases at 65 years, instead doing smaller cases during the last years of their career. The

If you go out too early, you are wasting years of experience and care.

most common reasons for continued clinical activity were enjoyment of the work, sense of purpose or identity, and camaraderie with surgical colleagues. Many surgeons feel reluctant to give up the respect and dignity commensurate with that of lifelong commitment to a demanding and challenging profession. It is worth noting that the majority of older surgeons continue practice for reasons other than financial security.

Of course, individual financial stability is also of tremendous importance, but is probably a topic best discussed through another venue. Again, it the desire to be happy and fulfilled, not the desire to be wealthy, that keeps most of us working.

The time to leave clinical vascular surgery is variable. When is the right time to leave? Is it when you notice difficulty doing a carotid endarterectomy, difficulty doing an arteriovenous graft, or difficulty talking to the patient with varicose veins? It is an individualized decision that each surgeon must make, and few time it perfectly. If you go out too early, you are wasting years of experience and care of numerous patients. If you leave too late, you probably hurt numerous patients. In fact, the mortality of carotid endarterectomy increases significantly when performed by older surgeons.

Transition to a secondary career and lifestyle planning is therefore of paramount importance. Planning should not start at 63 years old, or at 60. End-of-career planning should start as early as financial planning. Just as a 401K builds upon the first few years of investment, so should our interests outside of surgery in preparation for leaving clinical practice. We have invested an immense amount of time, energy and personal sacrifice into being vascular surgeons, so the transition out of this role is momentous. There are many opportunities for the retired vascular surgeon outside of the operating

room. Mentoring of new faculty and residents is indispensable. The value of surgical experience in dealing with anatomic variations, altered tissue conditions, unusual disease behavior and rare findings is essential to patient outcomes. The aging surgeon carries status in the hospital and can introduce newly recruited surgeons to the finer points of practice. Leadership roles within our specialty's local, regional, and national societies can be intensely rewarding. These nonclinical roles among late career, seasoned surgeons, must be encouraged.

Of course, recognizing the need for meaning outside of the practice of vascular surgery, is far easier than executing a plan to achieve it. After finishing a fellowship, we put our heads down and get to work, only to look up and see that half of our careers have passed. Some professional goals never materialize. More than two-thirds of surgeons between the ages 50 and 60 report no career retirement plan. A third of surgeons between ages 60 and 70 report no career retirement plan. Without proper planning, time sneaks up on all of us. Today's vascular surgeon must prioritize diversifying themselves early on, fostering interests outside of clinical practice. These interests may become areas of focus or pleasure during retirement, and allow for continued contribution to this profession well after "hanging up the scalpel."

Dr. Soh and Dr. Money are vascular surgeons at the Mayo Clinic-Phoenix.

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Transitioning to Administration

BY JULIE A. FREISCHLAG, MD

I feel that vascular surgeons are uniquely qualified to assume leadership roles in health care administration because of their presence in both the outpatient and inpatient arena. We offer treatment plans that include operations but also lifestyle changes such as exercise, diet, smoking cessation, and medications. We make tough decisions on which operation to offer according



DR. FREISCHLAG

to our patient's health, prognosis, and long-term outcome. We are also involved in elective and emergency situations. We have advanced technology in our field and have reviewed our results and altered the indication and method. Being an administrative leader as a concerned and experience clinician allows better decisions to be made because of our unique interface with the patient and their family and friends. It is the special sauce that allows better decisions to be made and if necessary changed. Because that is what we do every day with our patients.

Dr. Freischlag is the chief executive officer of Wake Forest Baptist Health and dean of Wake Forest School of Medicine, Winston-Salem, N.C.

Gaining a Part-Time Colleague

BY RASESH M. SHAH, MD

It was a Sunday morning, on a weekend “off,” that I sat down to try and get “caught up on some work.” I had to complete a call schedule, so I opened up a couple of programs to get started. Our on-line scheduler for call and time off as well as our outlook calendars for office and hospital assignments as well as scheduled cases. As I started, the gravity of it hit me – 8 hospitals/6 offices/3 Vein Centers/multiple OR and angio venues/3 regional call schedules to cover. Short 2 faculty members and at least 1 APP, performance metrics that seemed unattainable, 6 fellows and multiple residents to supervise/train, expected meeting attendance for our Medical Group and all the hospitals we support, and the overarching RVU target to meet – how will we get all this done?

Somehow I managed to get the call schedule made and all the venues covered. But as I finished up I realized I was overlooking one very important piece of the puzzle. I forgot about my division members and the support and nurturing they need and deserve. I forgot about the junior partner who had scheduled a complex open aortic reconstruction and the only help would be a fellow and a surgical assistant. All our partners were slated to fill in the other “boxes.” How could I support this partner and this patient in better way? My mind now wandered to other ‘worries’. One of my senior partners is going to retire soon, and I don’t know how we are going

to maintain his >30-year-old TOS clinic. We have known about his retirement for some time, but have had not had the redundancy to fully train a junior partner to take over this practice. Similarly another senior partner is thinking of retiring in the next year or so, and I need to adequately train

His measures of success would be seen in support/mentorship of junior faculty and fellows, as well as the enhanced academic stature of our program.

someone to run the Vein Center of Virginia which has been in business for >30 years as well. I don’t need someone who knows how to do vein ablations, but someone who understands how to RUN a full-service vein center.

I mused over a thought I’ve often dreamed of – “wouldn’t it be great if I had a senior partner who had no responsibilities other than checking some of the boxes that I see as fundamentally important to a thriving practice” – being available to discuss complex cases and then actually be able to scrub and assist on these open procedures – run a TOS clinic

WITH a junior partner and scrub on those cases until the junior partner felt completely ready to manage this complex group of patients – attend all our educational conferences and help train fellows/residents in the art and science of vascular surgery – mentor young faculty academically. I then awoke from that “dream” and tried to enjoy the remainder of my (nearly gone) weekend.

Monday morning my partner Jean Panneton, MD, told me an old friend and colleague was looking for a part-time position and did I think we could accommodate him? When he told me it was Ken Cherry, MD, I truly thought I had been handed a winning lottery ticket, and that it was now my job to figure out how to “cash it in.” How could I convince my bosses in the organization to see the value in someone that is not just a “revenue generator?” (See related article below).

How could I value Ken’s time and come up with the ROI number I knew they were looking for? I met with Ken a number of times and we came up with a plan for how we could use his extraordinary experience and talents to enhance our program at EVMS and Sentara. I first had to convince my partners that he was not coming to establish his own practice and “take RVU’s from our pool.” He would come on salary with NO RVU target, and that his measures of success would be seen in support / mentorship of junior faculty and fellows, as well as the enhanced

academic stature of our program. I had full support from L.D. Britt, our Chair of Surgery. Now I had to convince Sentara to support this mode.

I had a proposal ready when I met with my boss. To his credit he understood what I hoped to achieve. He was able to see that the salary we would pay Ken, without necessarily seeing any increased revenue, is a paltry sum for what we would get. I thank him for his vision and for supporting our proposal through the finance hurdles which ultimately were overcome to get it approved.

In the past 6 months since Ken joined us, WE have achieved all of OUR goals. The faculty (quite frankly junior AND senior) are thrilled to be able to bounce cases off him and then actually have him available to scrub. Our educational conferences are enhanced with his presence, and I believe we will see an increase in academic productivity as he is fully integrated. But for a partnership to actually succeed, it is not enough for US to have achieved OUR goals, but also for KEN to have realized HIS. I believe we have afforded him the opportunity to remain productive and continue to contribute. As our manpower needs in vascular surgery continue to grow, perhaps this role Ken has filled will be seen as a model for others. I believe that I indeed was able to “cash in my winning ticket.”

Dr. Shah is the Medical Director, Sentara Healthcare Vascular Service Line, Norfolk, Va.

Becoming a Part-Time Colleague

BY KENNETH CHERRY, MD

I retired from the University of Virginia in April 2018, after a 37 year career there and at the Mayo Clinic in Rochester. In some respects, my retirement was timely, but in others, not. In the initial months following retirement, I enjoyed my family, my friends, my hobbies, and my whims.

After some months, however, I found I missed operating, teaching fellows and residents, and my interactions with patients and their families, my colleagues, and with nurses and other paramedical personnel. I still felt youthful, the calendar notwithstanding. I did not miss the overweening bureaucracy of modern medicine, nor the distinctly and inherently discourteous and coarse electronic mode of communication. Simply, I missed being a physician and surgeon, but not a “health care provider.”

Dr. Rasesh (Raj) Shah and his colleagues in Vascular and Endovascular Surgery, notably an

esteemed colleague of long standing, Dr. Jean Panneton, at Eastern Virginia Medical School-Sentara Norfolk General Hospital, offered me the opportunity to work part time with their attending

After some months, I found I missed operating, teaching fellows and residents, and my interactions with patients and their families.

and resident staff. My primary role would be to mentor their young staff in complex aortic and aortic branch surgery, as well as other complex open cases. The staff there were capable of that to be sure, but their very busy clinical, educational,

administrative, and consulting schedules rendered such mentoring rushed, random, and subject to last minute change. In addition, I had been most fortunate to have been trained at the University of California-San Francisco by exquisite and pioneering vascular surgeons and to have had a career at busy, high-volume institutions spanning the heyday of open complex vascular surgery.

Additionally, I was asked to resume some of my “niche” practices with external iliac arteriopathy (external internal iliac endofibrosis), popliteal entrapment, and thoracic outlet syndrome, and to mentor my eventual successors in treating these patients. Importantly for me, my roles and my income would not be based on RVUs, and I would not be asked to take emergency call.

In May 2019, I went back to work after a retirement of 13 months. Working in Norfolk with Dr. Shah’s group has proved a blessing for me and

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Getting Ready for What's Next

BY JOHN F EIDT, MD

I can't wait to retire! I dream of the day when I can say goodbye to the EMR, insurance companies, utilization reviews, quality oversight, plaintiffs lawyers, human resources, disgruntled employees, and dissatisfied patients. Say hello to sleeping late, relaxing on the back porch, smelling the roses, and being free to pursue my lifelong passions. But then I wake up and realize that my definition of self is inextricably intertwined with my ability to fix a ruptured aneurysm and that my life-long passions are mostly connected to being a vascular surgeon.

The retirement experts all advise us to "Retire TO something, not FROM something." But retire to what? Riding my bike, playing golf, fishing, painting, writing poetry, volunteering, gardening, farming, raising cattle, or playing with grand kids (I don't even have kids!)? As a practicing surgeon, I have a reason to get up every day, go to the hospital, unravel clinical mysteries, develop novel treatment strategies, teach the next generation of surgeons, perform complex operations, and hopefully change my patients lives for the better. In retirement, I'm just an old guy with a bad back, thinning hair and faulty memory hoping my savings will be enough to last to the end. It is not surprising that many surgeons approach the end of their surgical careers with trepidation.

For most of us, life is divided into three distinct phases: the "getting ready" part, the "doing" part, and the "reminiscing" phase. In comparison to other professionals, it is painfully obvious that we invest more time and effort preparing for our eventual careers. Even for those of us who have taken a fairly linear pathway through high school, college, medical school, residency and fellowship with few

excursions off the education expressway, the preparation phase consumes 30-35 years. We are poster children for "delayed gratification." Given the head start that other professionals enjoy, it is not surprising that by the time we leave the starting gate there is a sense of urgency to play catch up and focus on paying off debt and accumulating a nest egg for retirement. We sit at the



DR. EIDT

top of the "blue collar" ladder, meaning that we get paid to work. No cases, no RVUs, no income. Many surgeons, particularly those working in an "employed" model, do not enjoy significant so-called passive income from ownership of such entities as surgical centers, office-based labs, or specialty hospitals. Developing a retirement strategy that allows you to progressively taper your clinical workload while simultaneously trimming your overhead is crucial.

The physician work force, like the rest of the population, is getting older. According to the American Medical Association, in 2017, more than 120,000 physicians over 65 were engaged in patient care. It is expected that the number of surgeons practicing beyond the usual retirement age of 65 will increase significantly in the coming decades. Most experts believe that it will be essential for some older surgeons to continue in active practice to mitigate the expected shortage of surgeons needed to accommodate the aging baby-boomers. Currently, there is no mandatory retirement age for surgeons in the US though mandatory retirement is enforced in some countries.

But how long can I keep doing surgery? How will I know when I should give up operating? Will my colleagues

tell me when I'm over the hill and dangerous? Hospitals are keen to manage their exposure to risk by identifying suspect clinicians. One strategy is to require some type of neurocognitive testing of all aging clinicians. One of the most widely used screening tests is called MicroCog. Developed in 1993 by the Risk Management Foundation of Harvard Medical Institutions, the MicroCog is now marketed by Pearson as an appropriate way to detect mild to moderate cognitive impairment for anyone from age 18 to 89. MicroCog is an hour-long computerized test with five question domains: attention and mental control, memory, reasoning and calculation, spatial processing, and reaction time. Many physicians have questioned the accuracy of MicroCog and noted that there is lack of evidence that performance on the test components is related to clinical outcomes. Some prominent institutions have abandoned mandatory cognitive testing in favor of peer review for older clinicians. Stanford University was using the MicroCog to screen its clinical faculty after they reached age 74.5. But after many senior physicians protested, the policy was abandoned.

While a small number of U.S. hospitals have developed policies mandating physical and neurocognitive assessment of aging surgeons, most hospitals have not adopted these strategies. The American College of Surgeons does not support mandatory testing of surgeons at any age but does recommend that, starting at age 65 to 70, surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician for overall health assessment. This recommendation stands in contrast to the perception that surgeons are notoriously myopic when asked to judge their own personal performance.

The relationship between surgeon age and real-world surgical

performance is unclear. While it is undoubtedly true that a variety of tests of neurocognitive performance decline with age, there is scant evidence correlating test scores with real-world ability to take care of patients. The importance of experience, accumulated wisdom, and pattern recognition are poorly assessed by current forms of neuropsychiatric testing. While some earlier studies suggested that operative mortality following carotid endarterectomy was higher in older, low-volume surgeons, a more recent study failed to establish a relationship between surgeon age or sex and mortality (BMJ. 2018;361:k1343).

The core problem is that there are no ideal methods to assess surgical performance. Certification by the Vascular Surgery Board of the American Board of Surgery requires successful completion of the written exam, designed to test knowledge, and the oral exam, designed to test surgical judgment. Currently, there is no practical examination of either open or endovascular skill.

Retirement is not for the weak. Preparation for retirement is just as critical as preparation for your career. Most surgeons take for granted the need to obtain expert advice to achieve finical independence. But it is probably equally valuable to seek advice from others who have successfully negotiated the transition from active practice to retirement. Ideally, we can develop a plan that allows a gradually descent from 40,000 feet to a smooth landing, rather than nose-diving into the abyss of life after surgery. Have a great retirement plan? Share it with us.

Dr. Eidt is Professor of Surgery, Texas A&M Health Sciences University, Vice Chair of Surgery, Baylor Scott and White Heart and Vascular Hospital, Dallas.

Colleague

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has been a source of rejuvenation. It is fun. The vascular surgeons, and indeed, the Department of Surgery led by Dr. L. D. Britt, have been gracious beyond expectation.

I consult with the staff about those cases they bring to me. I also discuss patients referred to me with them. These are bright, innovative, and gifted surgeons. Often, their endovascular and hybrid approaches have more to recommend them than strictly open strategies. At their invitation, I scrub

with them on their complex, reoperative, difficult, or unusual open cases. In the OR, I work with both the staff and the fellows. The defined "niche" practices have been getting busier, and the young staff members participate from workup through operation and followup in a meaningful way, preparing themselves to inherit those practices when I finally master the concept of retirement.

There is time and opportunity to work with individual fellows who may be struggling with some aspect of their training.

The role seems to be developing in deeper and complex ways. One goal is to help increase clinical research publications. A personal goal for me as

an older surgeon is to help the young staff meet requirements for membership in our societies, and to encourage their speaking at regional and national meetings. Just as an old upland bird hunter would much rather watch his dog work well, and his children hunt and shoot well, than shoot another bird himself, I feel more joy and a greater sense of accomplishment seeing my young colleagues thrive clinically, academically, and professionally. It has been an excellent reason to come out of retirement.

Dr. Cherry is a vascular surgeon with Sentara Vascular Specialists, Norfolk, Va.

Reinventing Yourself

BY M. ASHRAF MANSOUR, MD

People reinvent themselves all the time, sometimes it is out of necessity and sometimes it is because of a health condition or family issues. Indeed, in many instances, it is a different phase of life or a different job opportunity, a sort of natural progression in the nonclinical world.

Vascular surgeons are no exception. Nobody gets bored being a vascular surgeon for sure, but some of us seek different positions that seem to be more exciting or challenging and a few are called upon to assume certain leadership positions on a temporary basis. For years during the 1970s and 1980s, we had essentially two models: academic and private practice. The academic practice meant an affiliation with a medical school, with teaching and research being part of the job description. In private practice, it was taking care of patients and usually running between several hospitals and clinics.

Of course, there is always a subgroup of surgeons who can manage a “hybrid” model, a combination of private practice and academic practice. This typically meant operating with residents and fellows at the VA, City or University hospital, however, trainees were not invited to participate in the private practice clinic.

As our health care systems evolved, the burden of administration, such as running a department, a medical school or even a hospital system became such that additional time needed to be carved out or a creative reallocation of the FTE (full time equivalent) was required.



DR. MANSOUR

I know of at least three vascular surgeons in the last decade who have gone from department chair to dean, and two of them continued to rise to Chancellor positions. There are currently 9 chairs of surgery departments who are vascular surgeons and three of them are women. There are no prerequisites for the Department chair job, but running a division or program is probably helpful. Although most surgery departments have managers to keep an eye on the finances, it is a good idea for the chair to understand where the money is coming from and more importantly, where it is going. Some have pursued a business or management degree. It seems that physicians who seek hospital or medical school administrative positions tend to plan ahead and acquire an advanced degree of some sort, such

as MBA, MHA or MMM.

There have been several vascular surgeons with inventive minds who designed instruments, grafts or endografts. Dr. Thomas Fogarty and Dr. Juan Parodi have certainly been successful in translating their concepts into devices that have been used in thousands of patients. Even if a surgeon does not invent or design a device, there are opportunities to work for large companies overseeing their research or the FDA to help with the regulatory side; there have been surgeons in both those lines of work. With the vast knowledge that vascular surgeons possess in clinical trials, there have been many individuals who either work as part time consultants for large companies or themselves started a consulting company aiming at running clinical trials for potential devices that will come to market.

Career transitions happen all the time. In our hospital, years ago there was a medical staff rule (unwritten) that when a surgeon got to the age of 55, they were not required to take call anymore. Of course, that rule somehow did not apply to the vascular and cardiac surgeons who kept on working till they retired! Many surgeons though choose to modify their work schedule or transition to a more predictable lifestyle. Certainly, there have been many surgeons

going into the elective vein practice or wound clinic to achieve this. It is always concerning that we have not completely figured out how to prevent overwork and burnout in the vascular surgeon. Vascular educators need to constantly stress to trainees that they need to seek a balanced life, and the importance of family time and hobbies/activities outside the hospital. We all work long hours and need to find ways to de-stress.

Vascular surgery is an exciting career with many rewards obtained from being a busy and compassionate clinician. The burden of work and the call schedule will catch up with us as we age. But there are many other reasons to explore employment opportunities outside of clinical vascular surgery. One of my friends (a department chair) counseled me a long time ago that if I pursued an administrative position I should continue to practice. I think that is sound advice but it is also difficult to do sometimes. One should be careful of the one-way street, once you get going it is hard to turn back, and return to clinical practice without some re-training or re-introduction to practice.

Dr. Mansour is academic chair, Spectrum Health Medical Group Department of Surgical Specialties, Grand Rapids, Mich.

Postsurgical roles – Is There Life after Vascular Surgery?

BY KEITH CALLIGARO, MD

I didn't start thinking about what I would do when I stopped operating until recently. But why should these thoughts cross my mind? Being 63 years old is not what it used to be when retirement was expected a couple of years later. I think I still think as clearly as I think 30 years ago, but now my thinking is tempered with maturity and reason. I still feel immense satisfaction when a patient does well after performing a challenging operation. I recently discussed the idea of retirement with an older anesthesia colleague who I greatly respect. He enthusiastically told me that I should not even consider not operating for many years because my experience and knowledge is invaluable to my patients, our vascular fellows, and younger vascular surgeons.

But having had two cervical spine operations, which were almost certainly related to performing prolonged vascular operations with my chin on my chest trying to get the best view of the operative field, I find I don't recover from an 8-hour operation

as quickly as I did even 5 years ago. The threat of a malpractice suit is pervasive in Philadelphia, and when the inevitable complications occur, I don't sleep well.

So what to do, especially knowing the average 63-year-old American male who exercises five times a week, has soup or salad every day for lunch, and is an incredible human specimen like myself might live another 20-30 years? I attended a session at VAM this past June where senior vascular surgeons older than me offered opinions regarding post-surgical roles. Their choices included 1) slowing down but continuing to operate (not a bad idea), 2) performing more administrative or teaching tasks (possible), 3) working in a health care-related industry (not for me), or 4) becoming



DR. CALLIGARO

a hospital administrator (shoot me). One of my partners wants to operate until he's 70 years old, as many of my mentors have done and continue to do. However, not one speaker at the VAM session suggested retirement as an option – hanging out with grandchildren, devoting time to charity, reading books, and traveling. Not one – even after I rose and

mentioned this possibility at the end of the panel discussion. I'm sure these activities sound good to some vascular surgeons.

Occasionally I fantasize about this last choice as to where I would spend most of my time in my favorite place – on my back yard patio. Every late Sunday afternoon I try to sit there for an hour or two with my wife of 35 years and our dog and smoke an occasional cigar (yes, I have vices) and have a glass of bourbon (definitely not a vice). I gaze at our house (almost paid for), our beautiful garden (we have a very expensive gardener), and our backyard, where I fondly recall the many barbecues for friends and where I taught my son to play baseball and football and where he routinely embarrassed me playing soccer when he turned 7 years old. It's the place where I most often realize how lucky I am personally and professionally. And it's where I most often ponder the future.

Vascular surgeons are a lot like professional athletes. Both expended incredible amount of time, energy, devotion, talent, and physical and mental effort from high school through the end of a career to be successful. It's hard to hang up the cleats or walk out

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Give to SVS Foundation on 'Giving Tuesday'

Shopping on Amazon? Don't Forget to 'Smile'

This year's late Thanksgiving on Nov. 28 means the "official" holiday shopping season starts a little later than usual. "Giving Tuesday," the annual day of global giving that follows Thanksgiving and its companion shopping days, Black Friday and Cyber Monday, is later as well.

Giving Tuesday is Dec. 3 this year. This annual event celebrates the charitable season, when many people focus on their holiday and year-end giving. Nonprofits, small businesses schools, and religious organizations all over the world celebrate Giving Tuesday, with many organizations receiving the bulk of their yearly donations in just one day.

For the second straight year, the SVS Foundation is involved in Giving Tuesday. Funds will go to the many Foundation projects, including basic and clinical research grants as well as community outreach initiatives. These were added two years ago, when the Foundation's core mission was expanded to include public education and awareness.

"The prevention and education initiatives are a quite natural addition to our activities," said Foundation Chair Michel S. Makaroun, MD, "because behind every research award, every scholarship and every grant there is one singular aim: impacting and improving patient care."

"I encourage you to be very generous in supporting your Foundation as we aim to make it a more influential force in treating vascular disease and improving vascular health," he said.

Please donate at [vsweb.org/GIVE](https://www.vsweb.org/GIVE).



SMARTBOY10/DIGITALVISION VECTORS

Start Shopping at Amazon Smile Site

With the holidays close upon us, many SVS members will be shopping this month and next, both online and in person.

If purchasing online on Amazon, please remember to start your shopping at smile.amazon.com, with the SVS Foundation your designated charity. The Foundation will then receive 0.5 percent of the cost of eligible purchases.

If it's your first visit, you will need to select the SVS Foundation as your charitable organization. The website will remember your selection and, if you start your shopping on the "smile" site, will result in the Foundation receiving donations from your holiday purchases.

SVS Foundation Annual Report Published

Physician stories on SVS Foundation grants and their impact on patient health and care are at the heart of the just-published SVS Foundation 2019 Annual Report.

In "Impact," six SVS members and Foundation grant recipients discuss their research and the very

real patients behind these efforts, such as a diabetic grandmother and the man who wishes he could walk and wear out his shoes the way he used to. Readers will learn the importance of a simple buckeye, how a Foundation grant helped ascertain the quality of care provided in rural areas, the struggles faced by amputees, and the opportunities afforded by telemedicine. Members will see and understand that SVS Foundation funding "touches patients every day."



The report details financial information, deadlines for 2019-20, various Foundation funds and ways to give. Also included in its pages are 2019 award recipients, community outreach projects funded by this year's Community Awareness and Prevention

Project grants, a wrap-up of the hugely successful "Vascular Spectacular" gala held during the 2019 Vascular Annual Meeting which benefited the SVS Foundation, and 2018-19 donors.

Read the report to learn how donor dollars impact patient health and vascular care, at [vsweb.org/FoundationReport19](https://www.vsweb.org/FoundationReport19).

SVS Foundation Award Applications Due in January

Applications for two SVS Foundation surgeon-scientist awards are due in January 2020.

Applications for the prestigious Resident Research Award are due Jan. 15, 2020. This award — one of the most important opportunities for surgical trainees in vascular laboratories — is for early-career surgeons interested in research on the biology of vascular diseases and potential translational therapies.

The **Resident Research Award** is designed to provide special recognition of original scientific work that has yet to be published in manuscript form. This is an excellent opportunity for surgical trainees to be recognized and rewarded for their research efforts.

The winner will present his or her research at the 2020 Vascular Annual Meeting in Toronto, Canada, plus

receive \$5,000 and a one-year subscription to the Journal of Vascular Surgery.

Trainees may apply for the **Vascular Research Initiatives Conference Trainee Award** through Jan. 7, 2020. Authors of top-scoring abstracts will be selected and will receive complimentary registration to VRIC and to the American Heart Association Vascular Discovery Scientific Sessions, plus \$1,000 for travel costs.

The award is open to current pre-med or medical students, general surgery residents and vascular residents or vascular fellows. Local winners will not receive travel funds.

VRIC will be Monday, May 4, 2020, in Chicago. Learn more at [vsweb.org/VRIC20](https://www.vsweb.org/VRIC20).

More awards information is at [vsweb.org/awards](https://www.vsweb.org/awards).

Spotlight

Texas Gov. Greg Abbott appointed Devinder S. Bhatia, MD, of Houston, to the Texas Medical Board; the term expires in 2025.

Graeme E.B. McFarland, MD, has been named the American College of Surgeons' first Gerald B. Healy, MD, Traveling Mentorship Fellow. Dr. McFarland, of Birmingham, Ala., will use his \$5,000 award for mentoring visits to fellow SVS member, Joseph L. Mills Sr., MD, in Houston. Dr. McFarland is building a program for treating patients with chronic limb-threatening ischemia.

In Memoriam

- **Mai T. Pham, MD**, of Seattle, Wash., Aug. 23.
- **John Mannick, MD**, Boston, Oct. 13. He served as president of the American Association for Vascular Surgery in 1992 and received one of the SVS' highest honors, the Lifetime Achievement Award, in 2014. He was Mosely Professor of Surgery at Harvard Medical School for nearly 20 years and was a national and international leader in vascular surgery and surgical research.

From Our Journal

Endovascular aneurysm repair outside of the anatomic guidelines may result in reduced long-term survival compared with open repair. This is according to the results of a multicenter retrospective cohort study published in December's Jour-

nal of Vascular Surgery. "Caution should be applied in considering standard EVAR for patients with anatomy outside of IFU," the study concluded. The article is open-source through Jan. 31, 2020, at [vsweb.org/JVS-EVAR](https://www.vsweb.org/JVS-EVAR).

Your SVS: Wellness Program Launches

The Society for Vascular Surgery has officially launched a member support component of its wellness program, designed to help vascular surgeons enhance their personal resilience and continue development of a compassionate and accountable peer community.

Members are encouraged to access the first monthly topic, "Creating Wellness Through a Peer Support Community," and accompanying self-study exercises. SVS Wellness Task Force members and professional coaches, will be actively engaging member feedback and comments through the online SVSConnect community. (Visit vsweb.org/SVSConnect.)

The member support portion of SVS' wellness initiative is offered in partnership with *SurgeonMasters SM*, medical professionals dedicated to improving physicians' well-being, practice performance, and patient outcomes. The *SurgeonMasters* community "empowers surgeons to cultivate a thriving, lifestyle-friendly practice contributing to personal and professional excellence."

"This is a community-led support system, run by us for us, working with

SurgeonMasters," said Dawn Coleman, MD, chair of the SVS Wellness Task Force. "We will have a new topic every month, chosen specifically because it is relevant to our members and the concerns they've brought forward." The December topic will help members recognize the signs of burnout.

Members will also share their own stories of burnout and coping mechanisms. "Who knows the challenges of our lives better than other vascular surgeons?" she asked. "This program is unprecedented at this level. There are evolving data indicating this kind of system-level support with individual targeted interventions can optimize wellness for physicians."

The wellness initiative began more than two years ago, with a series of articles on burnout by Dr. Coleman and Mal Sheahan, MD, task force vice chair. "We are pleased to see the work done by so many people come to fruition like this," said Dr. Coleman. This is an exciting moment and an important initiative. We hope everyone takes advantage of this program."

Visit vsweb.org/WellnessSupport for information on accessing the first article.

Your SVS: Renew SVS Membership by End of Year

Graduated Candidates in Year 4: Transition to Active Membership

With approximately six weeks left in 2019, it's time for SVS members to pay their 2020 dues.

Dues invoices have been distributed to all members via email and/or mail. Dues must be paid by Dec. 31 to maintain SVS membership and access to the Journal of Vascular Surgery, SVSConnect and other benefits.

Graduated Candidates in year four of their "graduated candidate" membership must transition to Active membership. Only those who apply for such membership by Dec. 1 will continue to enjoy benefits without a lapse.

SVS has many new initiatives in the planning and early-implementation stages now, including the rapidly developing community on SVSConnect, wellness and branding initiatives, a Mentor Match program and more. All are open only to SVS members.

Other additional benefits include

a growing stable of peer-reviewed publications and clinical practice guidelines and reporting standards to facilitate exemplary patient care.

Those who need hard-copy invoices may email membership@vascularsociety.org.

Apply for Membership by Dec. 1: The final date this year to apply for membership is Dec. 1. Visit vsweb.org/Join.

SVS Collaborating With STS on Aortic Session: The Society for Vascular Surgery is collaborating with the Society of Thoracic Surgeons to co-sponsor a session during the STS 56th Annual Meeting.

"SVS/SVS: The Aorta Service Line From Root to Foot" — targeted to cardiothoracic surgeons and their teams, including vascular surgeons — will be from 11 a.m. to 12 p.m. Tuesday, Jan. 28, at the Ernest N. Morial Convention Center in New Orleans.

SAVE THE DATE | MAY 4TH 2020

The 2020 Vascular Research Initiatives Conference

CHICAGO



The SVS 'Annual Meeting' for Basic & Translational Research

SUBMIT ABSTRACTS:

Oct. 29, 2019 through Jan. 7, 2020

SVS | VRIC
vsweb.org/VRIC20

New Program Will Teach Surgeons To Lead

Vascular surgery leaders are selecting the first 20 participants for the new Leadership Development Program, aimed at accelerating the leadership development of the next generation of vascular surgeons.

SVS is collaborating on the ground-breaking initiative for early-career surgeons (5 to 10 years in practice) with the Vascular and Endovascular Surgery Society and the Society for Clinical Vascular Surgery.

More than 300 people serve on SVS councils, committees, and task forces. This provides SVS a “profound self-interest” in leadership development, said Melissa Kirkwood, MD, chair of the SVS Leadership and Diversity Committee, co-developing the program with the SVS Education Council. “It gives us a chance to grow and optimize our leadership pipeline for the future.”

Institutions and practices are sponsoring the applicants. Course activities will include self-study and monthly online education and a two-day live

leadership skills course in April 2020, plus recognition at the 2020 Vascular Annual Meeting in June. Each participant also will identify and complete a project to address a leadership challenge in his or her institution or practice.

“The practice of vascular surgery is complex, particularly in this changing health care environment,” Dr. Kirkwood said. “We hope to keep the SVS on the cutting edge by equipping members with the latest knowledge in leadership training.”

The program answers a request SVS members expressed in a 2017 needs assessment survey for a more comprehensive, vascular surgery—specific leadership development program.

“Surgeons face different challenges and different responsibilities at different stages of their careers, both in their health systems and their communities,” said Rabih Chaer, MD, chair of the SVS Education Council. This new program will empower vascular surgeons to be leaders in all of these settings, he said.

“The need spans multiple institutions and providers,” he added. “Participants will be taught how to lead.”

The content has been drawn from the highest quality research on leadership and will focus on applying this knowledge to the real-life leadership and management challenges vascular surgeons face each day.

“The aim is to fast-track leadership development of our community of vascular surgeons to reach their full potential as leaders and make the most positive impact possible in our specialty, their workplaces, their communities, and other areas of importance in their lives,” said SVS President Kim Hodgson, MD.

The program will strengthen the Society, Dr. Kirkwood said. “It will serve as forum where future leaders can meet, and it will provide formal training in transferable skills that can be applied to future SVS initiatives and program development efforts at individual institutions.”

Leadership: Dealing With Change

BY PETER ROSSI, MD, FACS, FSVS
ON BEHALF OF THE SVS LEADERSHIP
AND DIVERSITY COMMITTEE

I had the pleasure of walking to the office next door to mine to interview my good friend and practice partner, Kellie

Brown, MD, FACS, DFSVSTTM, as part of our ongoing series of interviews with national leaders in vascular surgery. Dr. Brown is a Professor of Surgery and Radiology at

the Medical College of Wisconsin in Milwaukee, where she is fellowship program director. Her national leadership roles include serving as vice chair-elect of the American Board of Surgery’s Vascular Surgery Board, as well as president of the Midwest Vascular Surgical Society and chair of the SVS Education Committee.

This interview continues our series of conversations with national vascular surgery leaders, with topics from the book “The Heart of Change” by John Kotter and Dan Cohen; the topic of this interview is dealing with the anxiety of change.

Q: Today we are talking about dealing with the anxiety of change. We have been through a lot of changes in our own shop over the last few

years. What did you do to help get yourself through?

A: That’s a tough question. I sometimes don’t sleep well! When we were going through our leadership transformation, what I really tried to focus on was what my priorities were and really what was in the best global interest of the group, and focus on the things that I could control while trying to not worry too much about the things that I had no control of. I

feel it’s important to maximize your influence over the things that you can control. I tend to second-guess, but if I can make myself put what is important first – my patients, my partners, my practice and not personal gain or ego – that’s the most important.

For me, preserving our group dynamic and continuing to work with a group of people that I really enjoy was absolutely paramount. Making sure we could preserve that was the goal, so making efforts toward that goal was what I needed to do to be happy. Like anything else, sometimes I am more successful than others. One of the most anxiety-provoking things in our world, in my opinion, is change. Change is inevitable, so when I am facing change, I try to

think about what I can control, and let go of those things I cannot control. I try to plan ahead, and manage the things that I am able to manage.

Q: What career changes along the way have been anxiety-provoking for you?

A: The early part of a career in academic medicine was pretty easily defined. Medical school, Step 1, 2 and 3, on to residency, then assistant professor, then associate professor, then professor. You have the requirements, you do them, then you get there.

Later though, figuring out the next step was hard. Figuring out my next goal has been anxiety-provoking for me. I needed to figure out how to stay motivated and how to stay relevant. You never want to feel devalued, but you have to figure out how to keep providing value and learning how to value yourself. You need to keep the fire and the passion for coming to work every day.

Q: But you can’t do everything. While you need to have a deep profile to stay relevant, not everyone is going to be a basic science researcher, clinical researcher, outstanding clinician, educator, and administrator.

A: That’s very true. Most people can’t do all those things themselves, so it’s important as a leader to recognize those qualities in others and make sure that you bring in the right people. Everyone has strengths and

weaknesses, so you have to identify those and then bring in people who have complementary areas of strength.

Q: Training has changed a lot and you have been very involved in this with both the APDVS and the ABS. Where is this going?

A: The 0-5 vascular residency is here to stay, and those programs have done a great job training vascular surgeons. However, the independent (5+2) pathway remains a critical option for training because not everyone knows they want to be a vascular surgeon when they enter residency. I believe both options will be around for the foreseeable future. Both are necessary, and both are critical; keeping them both is important. The real question with training will be how to train people to do complex open surgery in an era of endovascular techniques. That’s an issue that the APDVS is dealing with as open aorta numbers are getting lower. It may be that we will see mini-fellowships in open surgery as we used to see when endovascular surgery became common. The good news is that the vascular educational community is very active and forward-thinking in how to train the best surgeons. I think with the leadership of the APDVS and the incredible vascular educators we have in this country, we are going to continue to see innovations going forward.

Leadership continued on next page

It's a Pivotal Time; Please Donate to PAC

Dear colleagues,

We, the SVS and its members, stand at a pivotal time in our history. Health care policy will be at the center of the debate in next year's elections. It is apparent that vascular surgeons need to have a voice in our future or be swept away in others' ideas for how health care should be delivered and reimbursed in our country. The battle lines are now being drawn.

Our challenge at this time is very clear: Get our voice and message out to as many candidates and elected officials as possible so that we can have an impact on their decisions that affect our specialty and our ability to care for our patients. We will only be successful if we support and utilize the most important tool in our arsenal — the SVS Political Action Committee (SVS PAC).

Why give to the SVS PAC? Because PAC donations provide the ability to have direct access to the candidates and elected officials involved in the health care policy debates. Contributions to their campaigns are vital to their success. Without them, these candidates and officials have little chance of winning. It is here that the PAC has its greatest influence because a donation provides us access to discuss our issues with the candidates.

While these candidates have political skills, their knowledge and understanding of the health care needs of patients and physicians is often lacking, especially in the field of vascular surgery. To candidates' credit, they often welcome input, so the SVS uses their political and fundraising events to educate them about our patients' needs, our specialty, and our ability to do what we do in the most cost-effective and quality-driven manner possible.

As a result of past PAC activities, discussions are currently taking place regarding areas vital to us, such as:

- The future of surgical payments
- Removal of restrictive regulations
- Stopping the expansion of prior authorization requirements that impede our ability to offer timely vascular services

Other issues will surely appear on the horizon and new candidates will always surface, so the PAC's work — being vigilant to protect and advocate for our specialty — is an ongoing mission.

The SVS PAC is in the process of identifying those candidates who embrace our values — quality and cost-effective patient care, the importance of physician input into health care policy debates, and appropriate reimbursement for services rendered — and that will be the

PAC's criteria for campaign contributions.

We will keep the SVS membership apprised of our meetings in articles that will appear in Vascular Specialist and the new SVS enewsletter, "DC Update."

As for fundraising, the SVS PAC Committee has two goals: to raise at least \$200,000 this 2019-20 election cycle and to get greater SVS member involvement in our PAC.

In the past, we had not had more than 17 percent of the membership donate, a paltry and anemic figure when compared to other PACS. Currently, we are only at 3 percent member involvement for 2019.

When one considers what is at stake for our specialty in the upcoming elections, it is time for all members to get on board and contribute to the SVS PAC. Even a small, monthly amount donated by credit card will help us reach our goal. Any contribution is an investment in vascular surgery's future.

Sitting on the sidelines and expecting others to carry the load is no longer an option. Please become an SVS PAC supporter. There is no better way to secure your future.

SVS members, please donate at vsweb.org/PAC.

Yours truly,

Carlo A. Dall'Olmo, MD, Past SVS-PAC chair

Michael Dalsing, MD, SVS-PAC chair

SVS: W.L. Gore & Associates Block Grant Will Support Vascular Quality

W.L. Gore & Associates, Inc. will support a new Society for Vascular Surgery initiative to advance patient safety programs and the quality of vascular care.

Through a general block grant, Gore will help fund SVS quality initiatives designed to improve vascular patient surgical outcomes. These related projects will address key practice factors influencing quality care, including new care delivery and payment models, patient education, costs, surgeon wellness, and the value of vascular surgery services.

First-year funding support will focus on several initiatives including:

- Analysis of an advanced payment model that may improve care for patients with PAD
- A summit and a call to action for SVS leaders focused on appropriateness of care
- Data analysis of vascular surgeon well-being
- Data collection and analysis to address valuation of vascular surgery services

Gore is committed to two additional years of funding pending progress evaluation of years one and two.

"At the highest strategic level, SVS and Gore share an important mission goal to improve the quality

of lives of vascular patients," noted SVS Executive Director Kenneth M. Slaw, PhD. "This is a new and innovative model that transcends the traditional society/industry relationship and provides an opportunity for SVS and Gore to collaborate more deeply on key quality program initiatives that matter

at a mission level."

"Gore is committed to improving the quality of health care and outcomes for all vascular patients," concurred Eric Zacharias, vascular business leader of W.L. Gore & Associates. "Innovative collaborations such as this with the SVS reflect our shared, value-based goals."

Leadership

continued from previous page

Q: What do you think has been your greatest strategy for success?

A: I really have never said "no" to anything. That's not necessarily a great strategy, but it's worked for me! My recommendation to junior faculty is to take the opportunities that come their way and make the most of them. Do it on time, do it well, and do exactly what you promised to do. When you do a great job, more opportunities come and one thing

leads to another. If you are offered a presentation opportunity, even if it is not exactly what you want to speak on, I recommend doing it anyway and do a great job. Then the next time someone has an opportunity, you will be seen as someone who can deliver. This opens a lot of doors. You keep your mind open, and say yes to every opportunity that you are given.

Dr. Rossi is an associate professor of surgery, radiology and orthopedic surgery, Chief, Division of Vascular and Endovascular Surgery, Medical College of Wisconsin, Milwaukee.

Education: Submit Research Abstracts for VRIC, VAM

Calling SVS members: Your research is wanted, whether the topic covers EVAR follow-up, how to perform celiac artery decompressions with a supra-celiac aorta to celiac bypass, or the biology behind vascular smooth muscle cell responses.

Submission sites are now open for two annual SVS meetings in 2020, the Vascular Research Initiatives Conference and the Vascular Annual Meeting.

VRIC: The VRIC submission site will close Jan. 7. The conference, on Monday, May 4, 2020, in Chicago focuses on emerging vascular science. VRIC is held in conjunction with the American Heart Association's Vascular Discovery Scientific Sessions,

May 5 to 7, 2020, also in Chicago. Visit vsweb.org/VRIC20 for more information.

VAM: The VAM abstract submission site will close at 3 p.m. Central Standard Time (4 p.m. Eastern, 2 p.m. Mountain, and 1 p.m. Pacific) Wednesday, Jan. 15, 2020.

Submission categories and guidelines are available at vsweb.org/Guidelines20. Learn more about VAM at vsweb.org/VAM2020.

The meeting will be June 17 to 20 at the Metro Toronto Convention Centre in Toronto, Canada. Scientific sessions are June 18 to 20 and exhibits will be open June 18 to 19. Registration and housing will open in early March.

Looking to Retirement

BY RUSSELL SAMSON, MD

It is quite depressing to reach the age when people start requesting your perspective on retirement. In fact, for me, it's even more disheartening since some patients question whether I will still be present at their next visit. I used to share my lamentations with medical colleagues in the doctors' lounge, but many of my referral doctors have retired (or worse!). That my age is apparent is confirmed by new doctors in town addressing me as "Sir"! So, I guess by now I should have made plans for my eventual retirement, but I remain in a quandary as to when and how. However, I do have some insight gained by my intimate association with three vascular surgeons who have retired from active practice.

My brother Ian did his vascular training with Dr. Emerick Szilyagi in the early '70s. He became the senior surgeon in a five-person General/Vascular practice and then retired at the age of 65 years. He is still a vibrant participant in life at the age of 80. Despite the rigors of a hectic practice, he was active as President of the County Medical

Society, the New Jersey Vascular Society, and Chairman of the Medicare Multi-Specialty Advisory Committee working to improve legislation that handicapped medical practice in that state and improving patients access to



DR. SAMSON

quality medical care. Further, he maintained a keen interest in hobbies. He also loved motorcycles and was a founding member of the Motorcycling Doctors Association. When he retired from practice, he went cold turkey. Moving to a new state and an adult retirement community, he has followed all of his hobbies, and now has only a cursory interest in vascular surgery. He tells me he has never been happier.

My first partner, David Showalter, was the consummate vascular surgeon. Patients and fellow physicians recognized David as an extraordinarily gifted surgeon. He devoted every waking moment to ensuring excel-

lence in every aspect of his practice. Dedicated to his two children, he would drive his daughter, a nationally recognized swimmer, to lessons at 5 in the morning, ride 20 or so miles on his aerodynamic bike, and still be in the OR punctually at 7 a.m. At 61, he retired abruptly. Like Ian, he also tells me he has never been happier. He still wakes early, exercises, and now partakes in all aspects of what others would call "normal" life.

And, of course, having been Frank Veith's second fellow, I have had ample opportunity to watch this most driven workaholic "retire" from active surgery yet continue working well into his supposed 80s (no one truly knows how old Frank is!). I am sure every vascular surgeon is familiar with all that Frank has done to further vascular surgery even after he gave up direct patient care.

So, let me tell you what I have learned from these exceptional vascular surgeons that will help me if, and when, I retire. Maybe I am overstating but, as the lyrics to the song "War" goes ... "Absolutely Nothing." That is because after ending direct patient care, one's lifestyle is often tailored to the individual's proclivities. I personally still have no idea how or when to retire nor how to occupy myself when I do. I guess that's why I'm still working at 69. I have come to realize that vascular surgeons are a uniquely driven and tireless

group. Accordingly, most will need to continue to be active at a similar pace. Some will continue to be involved in other aspects of vascular medicine or other ventures. Others will participate for the first time in the life that total involvement in the practice of our specialty prevented us from enjoying.

My indecisiveness makes it presumptuous for me to offer any counsel. But I do have a few recommendations. First, if you are of two minds as to whether it's time to retire, then don't. It means you have still much to offer and more to enjoy. Retire if you are no longer enjoying the work or are overly stressed by the pressure of taking care of your very ill patients. But first spend time evaluating and plan the replacement endeavors because, if well chosen, you will have an exhilarating life ahead.

Further, this need not be an all or none decision. Despite our gung-ho, full speed ahead mentality, there are usually opportunities to cut back or slow down without leaving the profession entirely. Whatever path you choose do not go forego spending time with your loved ones because by now, you probably will have learned, it is the moments you have spent with them that have been, and forever will be, the most worthwhile.

Dr. Samson is a physician in the practice of Sarasota Vascular Specialists in Florida.

PASSPORT NEEDED FOR VAM 2020!



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U.S. members, start your passport process at vsweb.org/USPassports.

SVS | Society for Vascular Surgery

Roles

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of the operating room for the last time. Besides the loss of camaraderie of other vascular surgeons, some of whom are my closest friends, the biggest challenge and fear is not having another goal to strive for. Not having a goal or purpose in life, not feeling enthusiasm and urgency to accomplish something that day, and not having a good reason to get up in the morning can be depressing, especially for goal-oriented people like vascular surgeons.

So, what do I recommend when the end of a surgical career is on the horizon, even if its 5-10 years away? I can only speak for myself, and my approach to the future may not appeal to many vascular surgeons. I still find teaching and writing to be rewarding and both keep my mind fresh. I can continue to participate in academic projects, teach our vascular fellows, serve on the *Journal of Vascu-*

lar Surgery editorial board, coordinate our annual vascular symposium, and most importantly, participate in other projects that raise the visibility of vascular surgery as a specialty. The older, or rather, the experienced vascular surgeons among us can devote their time to ensuring our specialty's future. I still get upset when patients or friends don't understand what a vascular surgeon does, or is, and when other physicians, who are not nearly as capable as we are, hold themselves out to be experts in vascular care. I still feel as passionate about our specialty as I did 30 years ago, but now years of experience help me to be considerate of all solutions. In a few years I will certainly slow down or stop operating because I don't want a third cervical spine operation – but not yet. And even before then, I expect I will still find time to hang out on my patio with a good cigar.

Dr. Calligaro is a vascular surgeon in Philadelphia.

Hospitalist Comanagement Reduced Odds of MI, Shortened Vascular Surgery Stays

BY RICHARD MARK KIRKNER
MDEDGE NEWS
REPORTING FROM MIDWESTERN VASCULAR 2019

CHICAGO – A care model that uses hospitalists to comanage vascular surgery patients cut myocardial infarction rates by more than half and reduced hospital stays by about 12%, according to results of a study of the hospitalist comanagement model from Loyola University Chicago, Maywood, Ill., presented at the annual meeting of the Midwestern Vascular Surgery Society.

“Hospitalist comanagement was associated with decreased length of stay without affecting readmission for patients undergoing amputation, embolectomy, and infected graft,” said Kaavya Adam, a third-year medical student at Loyola University Chicago. “In the overall population, there was a reduction in cases of MI, 30-day readmissions, and overall length of stay.”

In 2014, Loyola implemented a program that used 11 hospitalists to rotate through the vascular surgery service. The hospitalists call on any patient who stays more than 24 hours on the non-ICU floors. Mr. Adam said hospitalist duties include evaluating patient comorbidities, adjusting medication, talking with family about medical man-



KAAVYA ADAM

agement, seeing patients on the day of surgery, ordering preoperative labs, and meeting with the anesthesiology and vascular surgery teams.

The study compared outcomes in 866 patients admitted during 2007-2013, before the comanage-

ment model was put into place, and 572 admitted during 2014-2017.

Rates of diabetes, hypertension, chronic kidney disease, coronary artery disease, hyperlipidemia, and malnutrition were similar between the groups. However, the pre-comanagement group had significantly higher rates of ischemic pain (27.8% vs. 10.7%), gangrene (21.3% vs. 13.6%), and ulceration (30.6% vs. 21.9%), while the comanaged group had significantly higher rates of claudication (34.3% vs. 13.2%). The statistical analysis accounted for these variations, Mr. Adam said.

“We did find significant results for the reduction in the odds of MI at 30 days; there was a 61% reduction,” he said.

The reduction in hospital stay was even more pronounced for patients with complex cases, Adam said. In amputation, the length of stay was reduced by 3.77 days ($P = .01$); in embolectomy, by 7.35 ($P = .004$); and in infected graft, by 8.35 ($P = .007$).

Continuing research will evaluate the cost effectiveness of the hospitalist model and define a comanagement model that is most beneficial, Mr. Adam said. He had no relevant financial disclosures.

SOURCE: Adam K et al. Midwestern Vascular 2019, Abstract 14.

FDA Approves Rituximab To Treat Children With Rare Vasculitis

BY MARK LESNEY
MDEDGE NEWS

The Food and Drug Administration approved rituximab (Rituxan) by injection to treat granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA) in children 2 years of age and older in combination with glucocorticoid treatment, according to an FDA news release.

These rare forms of vasculitis damage small blood vessels through inflammation and can lead to serious organ failure, including lungs and kidneys.

The Genentech drug received priority review and an orphan drug designation based on the results of a pediatric clinical trial of 25 patients aged 6-17 years with active GPA or MPA who were treated with rituximab in an international multicenter, open-label, uncontrolled study. Patients in the trial were also given methylprednisolone

prior to starting treatment.

The trial consisted of a 6-month remission induction phase where patients were treated only with rituximab and glucocorticoids. In addition, patients who had not achieved remission could receive additional treatment, including other therapies, at the discretion of the investigator, according to the FDA. By 6 months, 14 of the patients were in remission, and after 18 months, all 25 patients were in remission.

Rituximab contains a boxed warning regarding increased risks of fatal infusion reactions, potentially fatal severe skin and mouth reactions, hepatitis B virus reactivation that may cause serious or lethal liver problems, and progressive multifocal leukoencephalopathy, a rare, potentially lethal brain infection.

The trial was conducted and sponsored by F. Hoffmann-La Roche, which owns Genentech.

mlesney@mdedge.com

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