

John Jones Surgical Society NEWSLETTER

Alumni News of the NewYork-Presbyterian Hospital/Columbia Department of Surgery



Third Annual John Jones Surgical Society Day

At NewYork-Presbyterian and Morgan Stanley Children's Hospitals

May 19, 2006

This time it really was just one day, on a Friday, and it was indeed a full, enjoyable, and edifying day. It began with breakfast at the Faculty Club, followed by options to observe surgical procedures, visit the inanimate skills lab on PH 12 (a chance to see a familiar old ward put to good use), or tour the Morgan Stanley Children's Hospital of New York (MSCHONY). As explained by Nancy Hogle, RN, NYPH's Skills Lab uses the McGill Inanimate System for Training and Evaluation of Laparoscopic Skills (MISTELS) program, comprising 5 tasks: peg transfer, pattern cutting, placement of a ligating loop, and extracorporeal and intracorporeal knot tying. The program was originally developed by Gerald M. Fried in the 1990s and recently validated for both its rating consistency and positive impact on clinical operating performance.^{1,2} Dennis Fowler has shown progressive incremental achievement among our surgical residents and is in the process of exploring similar relationships between inanimate learning and clinical performance in open operations.



The NYPH's Skill Lab tour from left: Dr. Dennis Fowler, Nancy Hogle, RN, Drs. Karen Horvath, Theodora Budnik and Anne Larkin.

The MSCHONY tour was conducted by R. Peter Altman, MSCH's Vice President of Medical Affairs and Surgeon-in-Chief, who aptly described this magnificent children's care center as a precious treasure, so appreciated by patients, health care professionals, and all of its workers, that everyone looks after its cleanliness. Viewing a display of the treasured old book collection of the Armand Hammer Library, which includes a 1597 volume by Tagliacozzi, the father of Plastic Surgery and the originator of western

civilization's "Nose Job," completed the morning activities. At the end of the session, Ken Forde presented its curator, Steve Novak, with handwritten Presbyterian Hospital Surgery Case Logbooks, Volumes 6 (1882) and 27 (1892) that had been residing among the not quite as well organized JJSS memorabilia. Look for Steve Novak's article on the Hammer Archives collection, and Peter Altman's report on MSCHONY's first 1000 days of operation in the Fall, 2006 JJSS News Letter (JJSSNL).

After a rainy dash back to the Faculty Club, and a sumptuous lunch, Karen Horvath, Associate Professor and Director of the Surgical Residency Program at Washington University, and NYPH Chief Resident, in 1997, moderated an afternoon symposium entitled, "Looking Back To Look Forward - What Shall We Tell The Residents?"

- Larry Jordan, Columbia Presbyterian Hospital (CPMC) Chief Resident, in 1988, and now practicing with Princeton Surgical Associates, in Princeton, NJ, spoke on how the Columbia Residency Program prepared him for his present practice. On the whole, the answer was "well." He is doing procedures such as radiofrequency endovenous obliteration that he did not do in residency, but he believes that he finished training well equipped to take on new procedures as they inevitably come along. The

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Newsletter Information

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¹ Vassiliou MC, Ghitulescu GA, Feldman LS, et al. The MISTELS program to measure technical skill in laparoscopic surgery : evidence for reliability. Surg Endosc 2006;20:744-7.

² Vassiliou MC, Feldman LS, Andrew CG, et al. A global assessment tool for evaluation of intraoperative laparoscopic skills. Am J Surg 2005;190:197-13.

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- shortcoming: business matters.
- Phil Caushaj, Surgeon-in Chief at Western Pennsylvania Hospital in Pittsburg, Professor and Vice Chairman of Surgery at Temple University, and CPMC Chief Resident, in 1984, addressed, "How Surgery and Residency is Changing - Is this what I signed up for?" and Anne Larkin, Assistant Professor and Director of the University of Massachusetts Surgical Training Program, and NYPH Chief Resident in 1999, discussed "Future Training of Surgical Residents." Both spoke about accommodating to 80-hour-week training and the coming of "Pay for Performance" reimbursement and their affect on postgraduate surgical education, as well as on attending workloads.
 - Henry Spotnitz, George H. Humphreys, II Professor of Surgery, Vice Chairman, Research and Information Systems, and Chief Resident in Thoracic Surgery in 1975, all at Columbia University, discussed the vicissitudes of grantsmanship, under the rubric "How to Obtain and Sustain NIH Funding." He had three primary take-home messages: 1) new grantee applicants need a higher priority score to succeed than those with a proven track record, 2) if asked to serve on a review section, do it, and 3) accept all reviewer suggestions, even if they might at first seem a little "off the wall."
 - José Guillem, Associate Professor of Surgery, Cornell University, and Attending Surgeon, Memorial Sloan-Kettering Cancer Center, gave his views on "Clinical Practice and Research - How To Do Both," and Steve Libutti, Senior Investigator, Surgery Branch, National

Cancer Institute (NCI) spoke on "The NIH and the Surgical Trainee." These presentations were the inspiration for the principal theme of this JJSSNL, "Academic Surgical Career Development at Columbia" and are incorporated in that section.

Our President, Ken Forde began the business meeting, after a short break, by noting that JJSS members pay no dues, thanks to departmental support of all of its activities through the generosity of the Chairman, Dr. Rose. Ken thanked David Kinne for his good service as JJSSNL Editor, since 2001, and announced that Jim Chandler has agreed to take over the editorship as of this meeting. Elections to the following committees then ensued:

Nominating Committee: Ken Forde, Karen Horvath, and Philip Caushaj

By-Laws Committee: John Schullinger, Anne Larkin, and Henry Spotnitz

Program Committee: José Guillem, Jeffrey Cohen, Arthur Lee, Stephen Libutti, plus an appointed member, Dennis Fowler, as the Surgical Department's representative

The business meeting concluded promptly at 5:00 PM, leaving the attendees an hour of leisure before the 6:00 cocktail hour, to be followed by a lovely dinner at the Terrace in the Sky, adjacent to the Columbia University main campus. ■

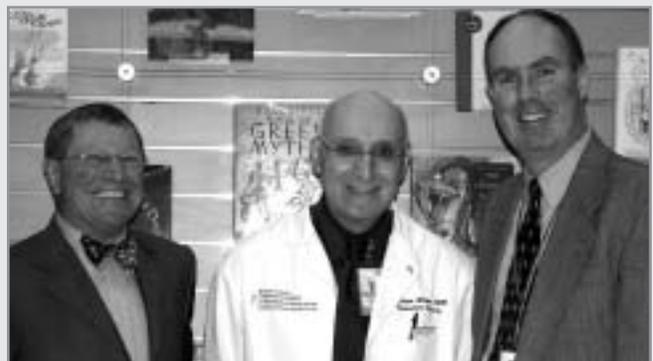
John Jones Day 2006



Symposium presenters from left: Drs. José Guillem, Lawrence Jordan, Karen Horvath, (moderator) Philip Caushaj, Anne Larkin, Henry Spotnitz and Steven Libutti.



Dr. Kenneth Forde presenting Stephen Novak (right) with the PH Surgery Case Logbooks.



Dr. Peter Altman (center), seen here with Dr. James Chandler (left) and Bill Horan (right) in the Morgan Stanley Children's Hospital.



Dr. Tracey Arnell, seen here with Dr. Steven Xydes (center) former Chief Resident ('05) and Dr. Eric Liu.

Dr. John Kinne creating a striking resemblance to the portrait of a Bolognese surgeon as he speaks with Dr. Marianne Wolff.



Whipple Society of P&S students (left) Beth Hochman, Matthew Tomey & Christopher Reverte (right), meeting Drs. Jaretzki and JB Price(center).



Dr. Eric A. Rose.



Surgical Residents, (left) Drs. Avital Harari & (right) Abbas Rana .



First year surgical residents, from left; Drs. Morgan Stewart, Dave Rosow and Benjamin Wei.



Surgical resident Dr. Cory Van Hove (left) and former Chief Resident, Patricia Sylla.

Dr. John Allendorf (left) seen here with Clayton Peterson P&S ('07).



Academic Surgical Career Development at Columbia

Prestigious university surgical departments want to train first-quality clinical surgeons but also both desire and have a societal obligation to nurture future academic leaders. By far, most of the impetus to pursue academic excellence has to be internally generated, but good people in the right institutions are the most successful. As an example, the daunting “Decade with Dave” surgical program at Duke University, under Dr. David C. Sabiston, Jr., which produced many surgical leaders, was not so long as it appeared in comparison to others, if the starting point was entry and the finishing point was being Associate Professor somewhere, or receiving a NIH, KO-2, Independent Scientist Award.

We begin our examination of the process with José Guillem and Steve Libutti's concepts drawn from their own commendable career paths. José finished his CPMC surgical residency in 1990, and Steve finished in 1995. They are well qualified to give guidance and clearly practice what they preach. Their “Zl's,” are notable, respectively 3.3 and 4.1. Robert M. Zollinger³ the charismatic and tough-acting, Professor and Chairman of Surgery, at Ohio State University, from 1947 to 1974, contrived the Zollinger Index, (ZI), a productivity measure, arrived at, by dividing ones number of publications by ones age to spur young surgeons to publish early and often. It is somewhat tongue-in-cheek, as it neglects quality assessment, a criticism most often leveled by those with ZI's substantially less than unity.

José's presentation stressed getting proper training in both clinical surgery and research. Six years of clinical training and a year in the lab is an unrealistic basis for a dual career - just think about it in the reverse. You need to identify a self-sustaining niche with plenty of room for exploration both in clinical practice and in the lab. His niche is colorectal cancer, focusing on familial colorectal cancer in the laboratory and on achieving better control of rectal cancer with total mesenteric excision and nerve- and sphincter-sparing procedures in the clinic. He said, “You need mentoring in both arenas: surround yourself with talent, great mentors and bright associates.” He, himself, credits a long list of mentors: including Ken Forde, the late Paul LoGerfo, I. Bernard Weinstein, Michael Treat, and Mark Hardy at Columbia.

He endorsed “Zollingerism,” saying, “Begin writing early and often. Establish a balanced portfolio; get into the JCI and AJP, become involved in a prospective randomized clinical trial, but don't neglect retrospective case reviews and book chapters.” Become a “household name” at your IRB. “Time management and perseverance, always keeping the BIG PICTURE in mind, are essential. Don't sacrifice your family life: [I] never met a man who, on his dying bed, said he wished he had spent more time in his office.”

Steve Libutti went directly from NYPH to the Surgery Branch of the NCI, a renowned surgical scientist incubator, especially since Steve Rosenberg became its Chief. He entered as a clinical associate and transitioned to NCI's clinical investigator tenure track, culminating in his recent appointment as head of the Tumor Angiogenesis Section of NCI's Endocrine Surgery Service. He outlined the current, basic two-year fellowship as comprising four 6-month clinical rotations on thoracic oncology, surgical oncology,

endocrine surgery and a general consult service. These clinical rotations dovetail with an 18-month commitment to translational research, in a laboratory selected by the fellow during his or her first six months. Steve's laboratory interests have ranged broadly, encompassing intracellular messaging as it relates to therapy susceptibility, immuno-modulation, and genetic markers of malignancy, as well as tumor angiogenesis. His clinical interests have focused on endocrine surgery, tumor debulking, and excision of metastases. “No 80-hour week at the NCI; it's a fellowship, not a residency.” Steve, like José, emphasized that the developing surgeon scientist needs role-model mentors and an integrated clinical and laboratory experience in an environment that allows for translation of new discoveries, and added that it must be one that rewards success.

There are several nurturing organizational elements in Columbia's Department of Surgery that bear on academic development. Most of these were instigated on Eric Rose's, watch and probably reflect his personal experience as a product of Columbia and the NIH. A leading example would be Ann Marie Schmidt's presence in the Department, as an internist-scientist interested in glycation. When José spoke of seeking great mentoring and a spacious niche, her name came immediately to mind. The burgeoning 21st-Century data supporting inadequate glucose control as a root cause of vascular disease and all sorts of poor surgical outcomes in non-diabetics, as well as diabetics, promise a durable, broad field for inquiry, well beyond cardiac-procedure, surgical-site infections, in which it was first documented.^{4,5}

Departmental guidance and encouragement begins early, as it should, with the Whipple Society of P & S, an organization of medical students interested in surgery. We get an overview of preclinical year interactions with the Department from two Whipple Society, third-year students, Joe Shonkwiler and Rob Neely, who are just beginning to grapple with the issues of clinical practice and an academic surgical career. NYPH surgical resident, Eric Liu regularly interviews a Presbyterian Hospital residency graduate as an ongoing feature of the JSSNL, entitled, “Where Are They Now?” This time, the answer to his rhetorical title is, “Right Here.”

Tracey Arnell, Assistant Professor in the Department's colorectal surgery section, who trained at Harbor-UCLA and completed a colorectal fellowship at the Lahey Clinic, finishing in 1999, will share her thoughts about the institutional component of academic surgical development. She brings an enlightening perspective from these other training sites, as well as from her own academic development, as a work-in-progress, to her position as the Department's Vice Chairperson for Faculty Development. Next, Henry Spotnitz, Vice Chairman, Research and Information Systems will outline the translational research opportunities within the Department and the involvement of younger faculty in mentored relationships. Finally, we will look at a revitalized JSS fellowship and how easy it is for JSS members, and all interested parties, to participate at the very point where an important departmental function can jump start a nascent academic career, namely, the resident research years. ■

³ Festschrift for Robert M. Zollinger, Sr., M.D. *Am J Surg* 2003;186:203-44.

⁴ Furnary AP, Zerr KJ, Grunkemeyer GL, Starr A. Continuous intravenous insulin infusion reduces the incidence of deep sternal wound infection in diabetic patients after cardiac surgical procedures. *Ann Thorac Surg* 1999;67:352-60.

⁵ Yan SF, Naka Y, Hudson BI, et al The ligand/RAGE axis: lighting the fuse and igniting vascular stress. *Curr Atheroscler Rep* 2006;8:232-9.

Two Years Into The Process

Rob Neely and Joe Shonkwiler

We came to Columbia P & S, intending to pursue surgical careers, and considered ourselves fortunate to be accepted at a school with a renowned surgical faculty. During our preclinical years, one or both of us have attended all events for medical students sponsored by the Department of Surgery and the Whipple Surgical Society, including group meetings, a suture course, and the laparoscopic skills lab, as well as one-on-one chats. These venues have allowed us to become acquainted with several members of the surgical faculty and to observe them at work in the operating room. In short, we and our surgically interested colleagues, appreciate the Department's efforts to introduce us to the field, and most of us feel that we have come to know at least one or two surgeons well enough to seek personal advice.

What could be done better? We have two constructive criticisms. The surgical faculty is conspicuously absent from the preclinical curriculum compared to the exposure students have to internal medical and pediatric specialties and subspecialties. For example, there should have been small group sessions, or at least one lecture, about Cardiac Surgery during the introductory Cardiology course and a presentation from a general surgeon during the GI course. Surgeons need to be involved at this level, describing how decisions to elect surgical intervention are made and its potential to impact on the various diseases presented in the second year. This void leaves an unbalanced impression that is not compensated by the Department's extracurricular activities because students without a particular interest in surgery are unlikely to attend them. The second

criticism is not as specific and certainly comes with notable exceptions. We have been dismayed to hear surgeons commonly speak to us about why Surgery is better than other fields, which are rarely presented in a positive light, rather than describing their own passion and love of Surgery. This is value misplacement, telling us less about Surgery and more about the individual's personal priorities. When there is an opportunity to share a passion with eager acolytes, it is far more effective to say why it is so meaningful, rather than why everything else is not.

The decision whether to pursue academic medicine or enter private practice is a perplexing one for medical students. We encounter academic physicians almost exclusively in medical school, and our experience with private physicians is essentially limited to friends and family members. Student exposure at Columbia is predictably academic. Moreover, the rising financial challenges facing surgeons in private practice, from insurance coverage to basic overhead, enhance the apparent practicality of an academic career. Although Columbia educators never explicitly conveyed this point of view, the general understanding of medical students is that private surgical practice is on the decline.

Our preclinical experiences have laid the foundation for our introduction to Surgery. We anticipate that our surgical clerkships will further shape our opinions and allow us to investigate such topics more completely. In particular, we're looking forward to building relationships within the Department of Surgery and will give you an update next year. ■

John Jones Day Dinner at the Terrace



Dr. Julius Jacobson III (left) and his wife Joan with Dr. Mark Hardy.



Dr. Jeffrey Cohen (left) with Dr. Larry Whelan.



From left, Ruth Hardy, Andrea Ratner and Kay Forde.



Dinner at the Terrace.

Where Are They Now?

Eric H. Liu, MD



Richard Whelan, MD

Richard "Larry" Whelan is associate professor of surgery, chief of the colon and rectal surgery section, and director of the laparoscopic physiology and oncology laboratory at Columbia University, New York-Presbyterian Hospital. After graduating from P&S and finishing his general surgery residency at Columbia Presbyterian, Dr. Whelan took a two-year fellowship in colon and rectal surgery at the University of Minnesota. His first

faculty appointment was at SUNY Downstate, in Brooklyn, where he stayed for three years, before returning to Columbia, in 1991. His activities in the intervening 15 years have brought him international recognition as a leader in education and basic research in minimally invasive surgery for the treatment of colon and rectal diseases. I had the opportunity to ask him the following questions:

How would you compare your experience at Columbia with that at other institutions?

It is important to determine what is clinically available at your hospital. When I was at SUNY Downstate, penetrating abdominal trauma was very common. So, fresh out of my colo-rectal fellowship, the first clinical study I did was to look at diversion colitis in gunshot patients with colostomies. Now my focus is on elective surgery for diseases of the colon and rectum. Our Department's resources and facilities are exceptionally research friendly. It's hard to imagine not being able to find supportive and knowledgeable collaborators here. The Department's unique core research facilities are available to all, allowing those with little infrastructure of their own to gear up and be productive in short order. The environment is remarkably tolerant and actually encourages "out-of-the-box" thinking. We started twelve years ago, with John Allendorf, doing studies in an old bathroom (early recognition of my specialization) on the 17th floor, which led to at least seven papers. Thankfully, we got an actual lab a few years later. Our group has survived on departmental start-up funding and small grants from surgical societies, philanthropic sources, and industry. This, along with hard work and some luck have allowed someone like myself, with a meager research background, to develop a program in which our group takes justifiable pride. The residents and medical students at Columbia are important elements in faculty life. Being surrounded by bright, innovative, well-motivated people, often with prior research experience, makes life as an attending surgeon and researcher easier and more interesting. I revel in the accomplishments of the post docs, students, and residents who have spent time in our lab and have learned far more than I have taught them.

How are you balancing research, your clinical work, and life, itself?

You need Excedrin® and Prozac®. When you start, you have to be

very focused, and it's easier to begin with in-vitro and small animal work, rather than clinical research, which requires substantial infrastructure. You also need dedicated time, at least one day a week in the lab, just to get things going. After that, provided you have sufficient money, hire a PhD to run the lab and to help the residents in doing bench research. This allows you to build your clinical practice while participating fully in research. One downside is that your income will suffer a bit when you combine a research career and clinical practice, but the economic gap compared with clinical practice alone might be diminishing. As for me, I would not change a thing: I am very happy and enjoy my life. Contributing to the literature in a way that affects the practice of others, exploring new exciting ideas, and having the chance to work with bright, young people are rich rewards that more than compensate for the monetary short fall.

You've built your reputation on a technological sea change: what are the pitfalls of working with new technology?

You have to be very careful when investigating a new surgical method. Be very selective for your early cases and do them under an IRB-approved protocol. Resist the temptation to use a new method on high-risk patients or in less than optimal circumstances. Complications will happen, and even though they may have nothing to do with the new technique, they will cast a shadow on it. I strongly recommend doing objective studies to assess a new surgical technique before going on stage as its champion. Michael Treat, Marc Bessler, and I decided, in the early 90's, to study the physiologic effects of laparoscopic versus open surgical approaches. A decade and a half later, we have learned quite a bit and come a long way. If a new approach is truly better, you should be able to prove it, and your institution and chairman will embrace such research. It is important to set up a long-term database up right at the start, especially for cancer patients. Paul LoGerfo kept beating this into us, and he was right. You need only look at the massive yield from Murray Brennan's superb database at Memorial-Slone-Kettering, initiated almost before he unpacked.

What is on the horizon in surgery?

The next two decades in general surgery will see the development of perioperative drugs that will substantially mitigate negative physiologic and immunologic affects of major surgery and improve its outcomes. With respect to oncology, I predict that, in 20 years, a newly diagnosed cancer patient will be given one or several drugs both preoperatively and immediately after the operation that will make tumors less likely to recur by enhancing host ability to deal with residual disease. Surgeons who care for these patients should, and will, lead this effort. To do this, we need to participate in the incredible pharmacological and immunological discoveries that are being made, in the model set by Steve Rosenberg at the NCI. We just finished a prospective randomized trial in fifty-two cancer patients that involved perioperative administration of the immuno-modulator, GM-CSF (Granulocyte Macrophage Colony Stimulating Factor). As surgeons, we are perfectly positioned to enroll cancer patients in trials because we are the gatekeepers. ■

John Jones Day



Dr. Frank Gump



Dr. David Carberry



Dr. Theodora Budnik



Dr. Richard Edie

A Job Description for a New Vice Chair

Tracey D. Arnell, MD

The newly created position of Vice Chair for Faculty Development had no precedent at Columbia and essentially a blank slate. I first needed to define what constitutes a successful and nurturing environment within a productive academic surgical department? Then, within this context, what are the individual aspects of a surgeon and career progression that are critical to develop? Clearly not every surgeon has the same aspirations or abilities, in terms of type of practice, area and interest in research, and non-direct-care activities.

To answer the first question, I spoke with leaders in our own Department and also those in other US surgery departments, as well as leaders in other medical specialties. The answers varied in detail, but conceptually, they were impressively consistent:

The clinical environment should encourage critical assessment of individual practice and aid in learning and adapting new advances in surgery. This should include mentorship and practical support in and out of the operating room in an institution with up-to-date equipment, adequate ancillary services and an entire compliment of well-developed medical specialties. The consensus was that neither all departments, nor all members of a department can share the same research paradigm. More competition for relatively stable funding, limited space, and willing qualified mentors all impose constraints that particularly impact the novice investigator. The traditional physician scientist approach of achieving full NIH support, which demands 75% dedicated research time, is a daunting commitment for a young surgeon with a strong interest in developing an exemplary clinical practice within an academic institution. This person also perceives increasing demands for clinical production and ever more documentation and committee work.

Fortunately, this is not a true dilemma: there are many satisfactory solutions and a variety of ways that an individual can contribute to an academic surgical department's success and renown. Sources of financial support from surgical academic societies, charitable funds, and industry often focus on beginning researchers and, typically, offer much more flexibility than NIH funding. Development of large-scale, programmatic research domains, such as the one directed by Dr. Schmidt, raise many specific questions for investigation, provide a mutually enriching intellectual environment, and notable efficiency through sharing of space and equipment. These advantages are not lost on the NIH, and there are larger project program grants (PPG) specifically available for this type of collaboration.

The Department has a long history of productive research that continues to flourish; yet there is a wide diversity of interests among our faculty. Many of us are involved in activities, aside from research, which add substantial richness and depth to our Department. These include resident and student teaching, participation in American College of Surgeons and specialty society programs and courses, medical informatics, and surgical missions to underdeveloped countries. Although not as easily quantified as grant dollars and

number of publications, these pursuits deserve formal recognition in evaluating a faculty member's productivity.

Meeting with individual junior faculty members to better understand their interests and direction was the first step in deciding what the Department can and should do to enhance their development. A major theme emerged: provide information. The faculty development position needs to be a fountain of information, a purveyor of opportunities for research funding, career enhancing courses, and a coach, identifying faculty that may be eligible for awards and society membership and facilitating their applications. We now have a Faculty Development Section on the Department's website that includes grants, awards, society membership requirements, and application deadlines.

Undoubtedly, the greatest need is for good mentoring. Historically this has occurred informally and generally quite successfully. As the Department has grown, though, this informal arrangement has become less effective in reaching everyone for whom mentoring should be available. "Matchmaker, Matchmaker, Make me a match, Find me a find, Catch me a catch" may be the greatest challenge, yet, is potentially the most lucrative innovation in faculty development.^{6,7} Applying Yente's role in Joseph Stein's 1964 "Fiddler on the Roof" to academic medical mentoring in a systematized manner is a timely issue in several departments of medicine and family practice, but Wiley "Chip" Souba,⁸ Chairman of Surgery at Penn State University seems to have achieved a seven-year lead in his own institution, with his aptly titled, 1999 article in the *Journal of Surgical Research*.⁹ As potential new faculty become apparent among our residents and fellows, or join the Department from outside, our plan is to identify a mentor who shares common interests and is already demonstratively successful. These mentors will be encouraged to meet regularly with their juniors and develop career plans including involvement in societies, committees within the hospital, and academic growth. The ultimate goal is to establish lasting mentor relationships for our entire junior faculty in accord with Dr. Souba's outline of seven essential behaviors that sustain a mentor's credibility:

- M**otivate,
- E**mpower and encourage,
- N**urture self-confidence,
- T**each by example,
- O**ffer wise counsel,
- R**aise the performance bar, and
- S**hine in reflected light

Our Department has a tradition of having a successful and respected faculty that has met and surmounted new challenges throughout its history, frequently being on the leading edge of change. Establishing a Vice Chair for Faculty Development is another step in this continuum, which is unique to Surgery among Columbia's clinical departments. "Times are a changing" and once again, so must our strategies. ■

⁶ Hoover EL. Mentoring surgeons in private and academic practice. *Arch Surg* 2005;140:598-608.

⁷ Thorndyke LE, Gusic ME, George GH, et al. Empowering junior faculty: Penn State's faculty development and mentoring program. *Acad Med* 2006;81:668-73.

⁸ Souba WW. Mentoring young academic surgeons, our most precious asset. *J Surg Res*. 1999;82:113-20.

⁹ Bussey-Jones J, Bernstein I, Higgins S, et al. Repaving the road to academic success: the IMERGE approach to peer monitoring. *Acad Med* 2006;81:674-9.

The Clinic, the Laboratory Bench, and Mentoring

Henry M. Spotnitz, MD

Translational research, bringing clinical problems to the bench and laboratory discoveries to the bedside, is a vital component of our faculty development program. The Surgical Science division, directed by Ann Marie Schmidt, is focused on RAGE, the Recceptor for Advanced Glycation End products. RAGE is a cell surface immunoglobulin that engages a broad spectrum of intracellular ligands, which interact with protein and lipid non-enzymatic glycation-oxidation products that accumulate in diverse settings, such as diabetes, inflammation, renal failure, pro-oxidant states, atherosclerotic lesions, and natural aging. In laboratory studies, blocking or decoying RAGE-ligand interactions is effective in tumor suppression, wound healing, liver regeneration, Alzheimer's disease, myocardial infarction, neuron degeneration and many other disease states. Remarkably, no fewer than six junior faculty members work on RAGE-related research projects under Dr. Schmidt's direction.

In oncologic research, Jessica Kandel's laboratory is centered on the role and control of tumor angiogenesis, Howard Kaufman's studies are focused on immunotherapy, and Larry Whelan's group is defining the anti-neoplastic benefits of laparoscopic surgery. In all, about five junior faculty members are collaborators in these laboratories. My own interests, and those of my colleagues in cardiac surgery and cardiology, include optimization of biventricular pacing, atrial fibrillation, myocardial protection, circulatory support, and stem cell treatment of heart failure, and currently involve five junior faculty members. Mark Hardy's work

with islet transplantation has regularly included one or more resident or junior faculty associates since 1975. Alumni of Mark's laboratory, who subsequently made important, independent contributions to the surgical treatment of diabetes mellitus include among others, Professors Collin Webber, at Emory University; Henry Lau, at Johns Hopkins; Mark Stegall, at the Mayo School of the Health Sciences; Piotr Fiodor, at the University of Warsaw; and Soji Oluwole, of our own faculty.

Clinical trials are supported by 24 departmental research coordinators and by our clinical evaluative research division, INCHOIR (The International Center for Health Outcomes and Innovation Research), directed by Annetine Gelijs. These trials involve such disparate therapies as RAGE blockade, unique anticoagulants, transplantation, wound healing, and innovative approaches to cancer, cardiovascular surgery, and minimally invasive surgery. Dr. Gelijs' group is a well-funded, independent research division that conducts its own outcomes studies and also serves as consultants to other Department investigators, providing statistical expertise, grant writing skills, regulatory compliance assurance, and Data Safety Management Board services.

As Tracey Arnell has discussed, faculty development and mentoring are among our Department's fundamental objectives. Fulfilling this objective in the face of competitive academic funding, declining professional fees and increasing clinical pressure is critical to the future of our Department and to academic departments in general. ■

John Jones Day Dinner at the Terrace



Drs. Arthur Lee (left) and Kenneth Forde.



Dr. Kinne, outgoing editor of the JJSS Newsletter, seen here with his wife Kathleen.



From left; Jody King, Drs. Carey Dolgin, Henry Spotnitz & Thomas King.



Dr. E. Foster Conklin and his wife Carol.

JJSS Needs a Presence in this Vital Process

James G. Chandler, MD

When a new friend or a patient asks you "Where did you train?" do you mumble "Columbia Presbyterian?" No, you say "Columbia Presbyterian in New York" or "New York Columbia Presbyterian Hospital" with overtones implying a badge of honor and fond remembrances. Last December a letter was sent to the JJSS membership soliciting money for a resident research fund, suggesting that at some future time, when it had accumulated sufficient capital it would be used to fund resident research and that residents receiving monies from the funds would be designated John Jones Research Fellows. It pretty much bombed, or put in a nicer way, did not evoke contributions consonant with our collective regard for the institution.

No one would question successful resident research as being a vital jump-start for an academic career. Dabbling in research for a year or less, on the pretense that it is a good discipline for every surgeon to have tasted, is nonsense, and for someone interested in academic achievement, it can be a discouraging debacle without good mentoring. The laudatory extent of NYPH resident participation, as shown in the table, suggests that funding from multiple sources is already available. However, the extent of commitment and the eventual career follow up are less well known.

2005-2006 Resident Research Projects

Resident/Mentor

Avraham Belizon/Richard Whelan
 Dmitri Belov/Yoshifumi Naka
 T. Alexander Quinn/Henry Spotnitz
 Joey C. Papa/Jessica Kandel
 Timothy Martens/Silviu Itescu
 Christian Petruccio/Howard Kaufman
 Rashida Jefferson/Darrell Yamashiro
 David Sternberg/Joshua Sonett
 Anand K. Khakhar/Lloyd Ratner
 Teresa Kim/Marc Bessler
 Alejandro Ruiz-Elizalde/Marc Arkovitz
 Juliet Park/Jeffrey Ascherman
 Catherine S. Forster/Faisal Cheema
 Sharone Jacobs/June Wu
 Mark Russo/Michael Argenziano
 Kimberly Hong/Jonathan Chen
 Robert Gray/Ralph Mosca
 Isaac George/Mehmet Oz
 George Comas, MD/Craig Smith

Project

PPAR α -agonist inhibition of perioperative tumor growth
 Vascular-derived progenitors in post-traumatic arterial remodeling
 Automated biventricular automated pacing after cardiac surgery
 Vascular recovery during sustained anti-angiogenesis in hepatoblastoma
 Biaxial loading's effect on mesenchymal progenitor cardiac gene expression
 Regulation of TNF- α -induced increases in lung endothelial cell permeability
 Alternative path rescue of neuroblastoma angiogenesis with VEGF blockade
 Epithelial mesenchymal transitioning & lung cancer's metastatic potential
 BK nephropathy as a cause of recipient renal failure of non-renal transplants
 Gastric restriction & duodenal exclusion in non-obese diabetic animals
 Bone protein genetic receptors in murine congenital diaphragmatic hernia
 Wound healing in Notch-deficient mice
 Genetic determinants of heart transplant rejection
 Long Acting VEGF analogue to reverse impaired healing in diabetic mice
 Atrial fibrillation and drugs that interfere with the loss of TASK-1 function
 TEG based transfusion in heart transplantation and VAD implantation
 Acute overload's effect on ventricular compliance & new tech development
 Myostatin expression in heart failure & after LVAD mechanical unloading
 Local delivery of amiodarone with a tissue adherent hydrogel patch

The aims of JJSS members are no different than those of Mr. Black, or Morgan-Stanley; we are just way less affluent and certainly cannot afford a building. We are equally eager to help, within our means, and although focused specifically on the Department of Surgery, we have similar desires for immediate and durable identity, a continuing say about how our money is disbursed, and outcomes evidence that it is indeed being well spent. Thanks to President Ken Forde's efforts these things are all coming into being this year. The Society will now endeavor to support a single John Jones Research Fellow, who will have committed to two research years and competed successfully based on the merits of his or her project, having a supporting letter from a committed mentor willing to support a second year of research, and evidence of personal scholastic achievement and exceptional performance in the early residency years. The competitive process and the requirement to convince a mentor, in effect, to supply matching funds should make the John Jones Fellowship sufficiently distinctive to merit a line in every recipient's curriculum vitae. It should also be distinguished by offering flexibility as to where, and with whom, the work is to be done. After all, John Jones, himself, left Kings College for Philadelphia and returned to New York to consult on George Washington's thigh abscess.¹⁰ One can easily envision John Jones Fellowship selection evolving into a marker of likely faculty appointment after completing clinical training, which would provide a tangible link to the JJSS and ensure our continuing support for the fellowship.

Now it is time to ante up. The cost of a fellowship is currently \$60,000 per year. To fund this from endowment earnings alone, would require a capital accumulation of \$1.2 million, a long way from the \$14,000 currently in the fund. The JJSS has 900 reachable members. If 60% of us contribute this year, a mean donation of just \$200 would provide funding for a 2007 John Jones Surgical Fellow and have \$48,000 go towards the goal of a \$1.2 million corpus. To avoid living from year to year, we should also look for creative matching to hasten the capital accumulation and assure fiscal stability. Many of us have relations with industry or generous patients, who might be interested in working with us, if the fellowship's competitive qualities and pivotal role in igniting an academic career were made known to them. This should be an attractive appeal, if framed with your personal enthusiasm for the legacy of John Jones and indebtedness to your surgical training, especially when you are talking with a patient who was an indirect beneficiary. Checks should be made out to the Department of Surgery, Columbia University, with JJSS Fellowship noted on the memo line, and sent to William J Horan, Senior Director of Development, Columbia University College of Physicians and Surgeons, 100 Haven Avenue, Suite 29D New York, NY 10032. Appreciated stock would, of course, be welcomed, effectively gaining a partial match, going back to you from the IRS. Bill Horan can provide the details for making stock gifts and charitable bequests. He can be reached by phone at 212-304-7203, by fax at 212-544-1920, and at wjh2104@columbia.edu. ■

¹⁰ Rogers BO. Surgery in the revolutionary war: contributions of John Jones, MD (1721-1791). *Plast Reconstr Surg* 1972;49:1-13

Obituary of George F. Crikelair, MD



George F. Crikelair

Dr. George F. Crikelair, Professor of Surgery and Chief of Plastic Surgery at Columbia Presbyterian Medical Center (CPMC), from 1959 to 1977, died following a stroke, at age 81, in Fort Lauderdale, FL on February 23, 2005. He is survived by his loving wife of 60 years, Eleanor (Hoesli), six children and 15 grandchildren. Their eldest son, John, a heroic Army officer, was killed in Vietnam in 1969.

Dr. Crikelair received his medical degree from the University of Wisconsin, his general surgical training at the Detroit Receiving Hospital, and his plastic surgery training at CPMC, under Jerome P Webster, in the first formal US plastic surgery training program, joining Webster's faculty in 1952. Seven years later, Dr. Crikelair assumed the program's helm, after the untimely death of William Stevenson, who had directed the service after Dr. Webster's retirement. Crikelair immediately set out to establish strong subspecialty sections, appointing William Littler to head hand surgery, David Ju and Carl Feind in head and neck surgery, Robin Rankow in cleft lip, palate and maxillofacial surgery, Joseph Tameren in cosmetic surgery, and Melvin Moss to head the division's research efforts.

I first met Dr. Crikelair, in 1952, when I was a surgical intern. I found him to be consistently amicable, comedic, devoted to teaching and research, and endowed with exceptional manual dexterity. I returned to CPMC, after military service for general and plastic surgery training and then stayed on, along with Frank Symonds, as part of the General Plastic Surgical faculty.

Dr. Crikelair published more than 90 clinical and scientific articles, most of which focused on prevention of childhood burn injuries and on cleft palate repairs. His research and prodding resulted in Congress passing the Flammable Fabrics Act, in 1953, which mandated flame retardant night wear for children and

established the US Consumer Products Safety Commission. He supported my attempts to develop a vaccine against homograft rejection, which dovetailed with gynecologist, Vince Frida's pursuit of a vaccine to control fetal Rh disease. We were able to show that simultaneously administering blood group A substance to stimulate antibodies in a severely burned, group O volunteer allowed a son-to-father, group A, skin homograft to survive for more than a year. But the real payoff, largely supported by Crikelair-engineered private funding, was Dr. Frida's development of a vaccine to prevent erythroblastosis fetalis, which received a Mary Lasker Award.

Nationally, Dr. Crikelair chaired the American Board of Plastic Surgery and was president of the American Society of Plastic & Reconstructive Surgeons. He was a founding member of the Clinical Society of University Plastic Surgeons and the American Trauma Society, as well as an honorary member of the American Academy of Pediatrics, the latter, in recognition of his work in diminishing childhood burns. Internationally, he was an honorary member of the Turkish Plastic Surgery Society, and consultant to the Queens Hospital for Burns and Reconstructive Surgery in Tehran, Iran, as well as a much sought after visiting professor.

Dr. Crikelair had many outside interests. One that we both shared was support for the Boy Scouts of America. As a former scoutmaster and Eagle Scout, I envied his Silver Beaver award. In retirement, he published several short stories and poems and two books: "The Pleural of Coffee Should Be Tea" and "Port Watching At Port Everglades." Dr. Crikelair's mantra embodied a wholesome blend of innovative and courageous leadership with tolerance for those in all walks of life, guided by his Christian ideals.

George, thank you for being part of CPMC and for being an influential part in so many of our lives.

Cadvan O. Griffiths, Jr., M.D., L.L.B., F.C.L.M., D.D. (Hon.) ■

SAVE
THE
DATE

2006
ACS Reception
Tuesday,
October 10, 2006
Fairmont Hotel
Chicago, IL



For more information & reservations contact Trisha at 212.305.2735 or Email: jh2104@columbia.edu