Impact, Insight, and Innovation: Our Legacy of Learning

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Good morning everyone and thank you, Dr Potts, for that very kind and generous introduction. It is something my family and I will always remember and appreciate. To our friends and families, welcome to the Western Surgical Association (WSA), one of the finest surgical organizations in America; known for its strong science, excellent surgeons, and genuine friendship and fellowship among its members. To those members, a very succinct, but very sincere, "thank you" for this year as your president. It is certainly the highlight of my academic career. As is usual and customary, let me take a few moments to acknowledge and thank some very important people in my life and to express my appreciation for all that you have done and continue to do for me.

To my faculty members and teammates at NorthShore University HealthSystem: I remain honored and privileged to lead such an outstanding group of clinical and academic surgeons, and I so genuinely appreciate all the lessons you have taught me about leadership and genuine partnership with each other. I would like to thank the 3 surgical chairmen from my years at Northwestern: David Nahrwold, my first academic chairman as a medical student, resident, and early faculty member; David Winchester, my predecessor as surgical chair at NorthShore and Evanston, and the first role model I had as an academic surgical oncologist, and to Jimmy Yao, one of my all-time favorites, who taught me the most valuable lesson about leading surgeons—that first and foremost you must lead from the operating room and you must never forget that. From my years at MD Anderson, I would like to acknowledge Charles Balch and Raph Pollock, who taught me the value of preparation and planning for a career in academic surgery, and to Steve Curley, an extraordinary surgeon and professional colleague and the best friend I have made in 30 years in academic surgery. To all of you I say a most sincere and genuine "thank you" for all you have done and, continue to do, to shape and guide my career and my life.

I would like to thank Leigh Neumayer, our secretary; Karen Brasel, our recorder; and Margo Shoop, our treasurer. It has been an honor to serve with you on our executive council this year. You are extraordinary surgeons and leaders, and you are remarkable role models, and not just for women in surgery, but for all of us. Thank you for all you have done for our organization this past year.

To my daughter Brittney, you are without a doubt the most dedicated, determined, and enthusiastic young woman I have ever met. Your care and compassion for your students with special needs is so admirable, and I am truly humbled to call you my daughter. Every child should be so lucky to have a teacher like you in their lives. To my son Jason, adventurer, explorer, outdoorsman, and writer, you have hiked across Europe, kayaked the Mississippi River from Minnesota to New Orleans, and just finished biking more than 3,500 miles from Colorado to Alaska to raise funds and awareness for Alzheimer's disease. You are the strongest and most independent man I have ever known, and I am so proud of your strength and spirit. You keep doing your thing and I will continue to live vicariously through your journeys and writings. And to both of you, thank you for the balance and equilibrium you have given my life and thank you for teaching me the true purpose of fatherhood. To my wife Anne, hard to put into words what this extraordinary lady has meant to me. She is my best friend, a terrific mother to our children, and an incredible partner for the last 35 years. Without her love and loyalty, support, and understanding, there is absolutely no way I would be standing here today.

I have entitled my address, "Impact, Insight, and Innovation—Our Legacy of Learning." It is really the story of our sharing and learning from each other as surgeons in this organization for the last 127 years. Let me explain how I arrived at this topic by sharing an experience I had last October, when Anne and I traveled to the towns where my father's and mother's families were from. It was a trip to learn how and why my family immigrated to America.

My grandfather, Alessandro Talamonti, was born in San Benedetto del Tronto in 1895. That town now is

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an absolutely gorgeous seaside resort in northern Italy, with the Apennine Mountains as a spiny background to the west, and the blue, rolling Adriatic Sea on its eastern coast. As we explored the town, I kept wondering why anyone would ever leave such an idyllic and beautiful place. But Italy in 1895 was not as beautiful and tranquil as it is now. The country was torn and fractured by civil wars during the process of national unification. Decades of internal strife had left a legacy of violence, social chaos, and widespread poverty. Diseases and natural catastrophes swept through the new nation. There was essentially no central government to aid the population, the agricultural and fishing economies had completely collapsed, and little progress had been made toward industrialization.

San Benedetto del Tronto was not immune to this political unrest, poverty, and hopelessness. The male population was severely reduced as the young men were drafted or conscripted to fight in the doomed armies and navies of the time. The beautiful ports and bays, which sustained the fishing industry, were clogged and polluted with shipwrecks and remnants of war. With their fishing economy in ruins, the people of the region were destitute and suffered staggering malnutrition and disease. Two cholera outbreaks in the 1890s reduced the region's population by more than 50%.

Conditions like this all over Europe led to the mass immigration of the early 20th century. Between 1890 and 1920, more than 12 million European immigrants left their homes and came to the land of hope and opportunity. These immigrants made up the main labor force for the industrialization of the US economy in the early 20th century. But their life was hard. The United States was ill-prepared to absorb so many new immigrants in such a short period of time. They were met with poor living conditions, hard labor at low wages, and resentment, ultimately leading to restrictive legislation limiting immigrant flow to the United States. Nonetheless, few gave up and returned home.[1]

All 4 of my grandparents came over from Italy on those boats, some legally, some illegally. They had children, raised families, and became part of America. My grandfather, Alessandro, was 7 years old when his family put him on a boat to America. Alone, with no passport and very little money, the plan was for him to be met in New York City by relatives who would then send him on to Chicago, where other family members would care for him until his father and brothers could join him in America. Alessandro achieved fame in the Roaring Twenties, as Sonny Talamonti, a champion race car driver, before his death in a racing accident in 1926. My parents, John Talamonti and Alice Zarlengo, met, married, and together did a fabulous job raising and educating my sister, Sharyle, and me. And they lived all the dreams and experiences that Tom Brokaw wrote about so beautifully in his wonderful book, *The Greatest Generation*.[2] So why do I share this immigrant tale with you? Because soon after returning from that trip, a few weeks later I received this honor to be your president, and just as I had spent time after my trip to Italy trying to understand the immigrant experience of the 20th century, I would spend the year leading up to this presentation learning not just about the history of the WSA, but also the forces and factors that have shaped the spirit and personality of the Western Surgical.

Interestingly, at the same time that the mass European immigration was happening, 100 years of westward expansion across the Great Plains and over the Rocky Mountains were peaking, between 1860 and 1920. This was driven by the population expansion in the eastern states and the availability of cheap, fertile land and the opportunity for individual land ownership. And often understated in the history books was the political freedom for those seeking to avoid the discord of slavery and the taxation and loss of life to fight against it. The California Gold Rush of 1849 offered the dream of riches in the land west of the Rocky Mountains. Completion of the first Transcontinental and Union Pacific Northwest Railroads made transportation of the masses west not only feasible, but also sustainable. But nothing energized westward expansion more than the Homestead Act of 1862, which made 270 million acres of public land available for those brave enough to make the journey. And more than 1.6 million homesteaders took this challenge and headed west in their enduring symbol and our organization's proud emblem—the covered wagon. But their life was hard too, and these settlers required the same courage and strength as those European immigrants. And they were met with the same hardship and pain. And amidst all that uncertainty and deprivation, there was an undeniable and relentless calling for more and better medical care.[3]

Therefore, our society initially began as the Western Obstetric and Gynecologic Association in 1891, with 42 charter members. The American Surgical Association had already been founded 11 years earlier in the populous, industrial North, and the Southern Surgical Association had been founded in 1887 in the resurgent South. In contrast, the West, empty of people but brimming with energy, was culturally isolated. Hospitals were rudimentary, and scientifically trained nurses were rare on the frontier. Postoperative care was given by whomever was available, and the surgeon was kept informed as well as possible. Medical journals were sparse, communications difficult, and opportunities to attend meetings rare. Milo S Ward was elected our first president in 1891,

and in his Presidential Address in Topeka, KS he wrote, "We are so much cut off from the East and South that it is imperative that we create for ourselves a society that will foster the true scientific spirit and give us a better knowledge of each other. Let us not despise the day of small things, although we are few in number and as yet unrecognized by the medical surgical world."[4] By 1895, the association was known as the Western Surgical and Gynecologic, and in 1909 we became the Western Surgical Association.

From the very beginning, our founders and our members understood the absolute necessity of an annual academic meeting to exchange clinical experiences, present ideas and innovative approaches to the surgical problems of the day, and hear from distinguished colleagues with acknowledged expertise in a given specialty or surgical approach. Annual meetings were 2 days long, lasting from 9:00 AM to 9:00 PM with morning, afternoon, and evening sessions. The President's Address and case discussions took place during a modest dinner banquet. Not unexpectedly, the content reflected the diseases, concerns, and perspectives of the times. The programs of the first decades were uniformly clinical, reflecting the professional needs of the founders and the paucity of medical schools and academic clinics in the region. What was crystal clear was an undeniable and unrelenting need to communicate with fellow surgeons, to exchange new technical approaches, and to share experiences and outcomes of these early and rapidly evolving procedures. And it was the Western Surgical Association that met this vital need.

For more than 127 years, the WSA has been a shining example of how surgeons learn and share information with each other and how they have advanced this extraordinary profession of ours. From the time of pioneers like Charles Mayo at beginning of the 20th century, when advances in clinical surgery had a tremendous impact on the surgeons and ultimately, on the patients they cared for, to the middle of the 20th century, after the country had survived 2 consecutive world wars and was led by surgeons like Warren Cole, when the introduction of the scientific method provided scientific insight into our most vexing clinical and chronic problems, and on to the end of the 20th century, and as we turned the corner on the new millennium, leaders like Claude Organ ushered in an extraordinary era of innovation in technology, informatics, and personalized surgical care.

IMPACT

The impact and inspiration of new knowledge could clearly be felt in the early years of the organization. Presentations by the senior surgeon had the look and feel of a modern day Grand Rounds presentation given by a surgical resident. This was clearly the era of "how to do" surgery, when the emphasis was on making the clinical diagnosis with rudimentary testing and the critical technical maneuvers guiding surgical strategy. What followed next was probably the most important component of the presentation, discussion by the other surgeons in attendance. These were often lengthy, serious, vigorous, and passionate, and given to add another surgeon's personal experience or perspective with a similar problem. I chose 1 example from the 1899 meeting that was of obvious interest to me, as a surgeon who operates on the liver and pancreas: a presentation by Dr Byron Davis, professor of surgery at Omaha Medical College, later to become the University of Nebraska Medical School. Davis' presentation was entitled, "Surgical diseases of the biliary passages."[5] His talk was 20 minutes long and highlighted 3 challenging cases of cholangitis, cholangiocarcinoma, and a traumatic injury of the biliary tract. The discussion was 25 minutes long and the entire discourse filled 21 pages in the annual publication of the meeting's transactions!

Today we would deride these case presentations as single institution reports, statistically underpowered, lacking in hypothesis-driven scientific methodology, and with questionable clinical conclusions. But back in the day, those were the lifeblood of this meeting and they emphasized the profound impact of emotion on learning. During our daughter Brittney's academic journey, majoring in Elementary and Special Education at the University of Arizona and later in her Master's degree program in Infant and Early Childhood Intervention at the University of Denver, she would share journal articles and books she thought I might find interesting as a surgical educator. One such book was entitled, *Descartes' Error* by Antonio Damasio, PhD. A scientist who studies the neurobiology of learning, Damasio describes how emotions affect learning by creating an enduring or nontransient memory, unique in its intensity and therefore not requiring the usual need for repetition and reinforcement to assure sustainability of the memory.[6] That's how surgeons learn. And this emphasizes one of the most profound ways we surgeons learn from each other, and that is the intense experience of a single patient or a single surgical encounter that is so powerful and so impactful that it imprints an indelible learning moment, never to be forgotten. Descartes would say that surgeons need only repetition and cognitive awareness to function as surgeons. But Damasio would counter that repetition and cognitive awareness only give us the tools necessary to function as surgeons, but it is the impact of emotional and intense memories that gives us the knowledge of

how best to use our surgical skills. Therefore, Damasio would argue that surgery is the ultimate cognitive specialty in medicine. I would hope that every surgeon in the room right now can recall that singular experience gained from a single patient or an encounter with a senior attending that was so powerful and so impactful that it is embedded in their surgical DNA forever.

For me, it happened while I was a student and a resident at Northwestern on the general surgery rotation with Drs Gerald Ujiki and Stuart Poticha. Both were proud members of the Western Surgical Association. They were magnificent in every regard. Dr Ujiki's quiet confidence and professionalism, his incredible knowledge about the breadth and depth of general surgery, and his technical gifts in the operating room (OR) were so exquisite and breathtaking that I knew after 1 day as a student in his OR, I was destined for a career in surgery. His partner, Dr Poticha, was also an extraordinary surgeon, a charismatic personality, totally in command, in and out of the OR. A former military surgeon in Vietnam and an absolutely gifted technical surgeon, he could transform any operating room into the most magnificent center of learning imaginable. Whenever we were doing a complex pancreatic resection or a major liver procedure, Dr Poticha would pause in the middle of the operation and ask me, "What would you do if that right hepatic vein tore and we had a hole in the vena cava?" or "How should we handle a posterior laceration of the portal vein?" Admittedly, I usually had no clue. I would stop operating and begin to mumble and stumble through some inane response about sutures and shunts and vascular clamps. And when he was done shaking his head after saying, "No, no, no," then Dr Poticha would pause and look at me and proceed to tell me stories from his time in Vietnam that were so impactful in his training. And whether it was a through-and-through gunshot wound in the liver or a shrapnel injury to the posterior head of the pancreas, the stories of massive life-threatening hemorrhage were so vivid and told with such an emphasis on poise under pressure that I knew those maneuvers were embedded in my memory as if they had happened to me. And those residents who have operated with me for the past 27 years can attest that there is never a major liver or pancreas resection that I do not think of Dr Poticha and his lessons of poise under pressure when managing life-threatening trauma and share with my residents his legacy in my learning.

Such were the value and the impact of those case reports and discussions by our forefathers at the turn of the 20th century. It was truly a time when our meeting emphasized the emotional and inspirational part of surgical learning. And I would tell our younger surgeons that your presentations at these meetings need not be a mindless or unemotional recitation of statistics and outcomes and the limitations of my data. It is indeed the most impactful and profound presentation that stirs our imaginations and inspires us to take better care of sick patients, which is held in highest esteem.

INSIGHT

By the conclusion of World War I, American leadership had ascended onto the international stage, and that was certainly true in surgery. American surgeons assumed a leading role in the extraordinary surgical advances of the 20th century. And without a doubt, the surgeons of the WSA were as important as any group in the country in terms of the importance and impact of their contributions to this new science of surgery. Advances in the basic sciences of microbiology, pharmacology, endocrinology, physiology, and cancer biology provided scientific insight and enlightened our "craft." Large institutional clinical reports provided the wisdom of experience and directed relevant scientific research like no other field in medicine. Taken together, these new surgeon-scientists unified the profession and turned what had been an art and craft into a scientific specialty, attracting the best and brightest of the day. Quite simply, it was no longer about how to stop the bleeding, drain the pus, or cut out the lump, and more about how to think about the body's physiologic responses to hemorrhage, sepsis, and cancer, which could thereby improve and optimize clinical outcomes. No better description of this progress can be found than the Presidential Address of Joseph Rilus Eastman from 1916 entitled, "The old art and the new science of surgery.[7]" Eastman wrote: "Surgery must still be heroic.

Gross anatomy cannot be abridged. Pathology is still a great basal factor in rational surgical practice. But it is the biologist surgeon, standing upon all the proved knowledge of the art and his experience, and of the science as well, whose viewpoint is highest and whose impact is greatest."

As I read through the archives of the Western Surgical Association, there were countless examples of surgical scientists who used the scientific method to advance our profession, but 3 stood out to me. One was J Bradley Aust, president of the Western Surgical Association in 1989. An extraordinary clinician and a true scientist, this man contributed scientific advances in transplant immunology, cardiac physiology, and surgical oncology. Then there were others like Basil Pruitt, president of the Western Surgical Association in 1994, who had a laser beam focus on burns and trauma. He made seminal discoveries in wound sepsis, skin grafting, fluid resuscitation,

and nutritional support of severely burned patients. And one of my all-time favorite academic surgeons was Ray Joehl, president of the Western in 2012 and someone who taught many of the residents at Northwestern the need to incorporate the scientific method into their clinical training. Dr Joehl began his career studying the basic science of acute and chronic pancreatitis; later, with the introduction of laparoscopy, he studied surgical education, and later in his career, when he moved to the VA system, he applied the scientific method to his research on quality improvement and patient safety. Trust, there were many, many similarly gifted and dedicated surgeons who made such important contributions and who were so dedicated to the organization that is meeting today. But these surgeons are wonderful examples of how insight and remarkable and relentless curiosity moved the field forward and made for better care of patients. Each is an extraordinary example of the surgical biologist and scientist described and celebrated by Eastman.

INNOVATION

All of our surgeons at NorthShore have academic appointments and faculty positions in the University of Chicago Department of Surgery. So periodically I head down to the Hyde Park campus for meetings with Jeff Matthews or Mitch Posner or Kevin Roggin to discuss mutual interests in the training program. And as I walk through the halls of their hospital, I always pass a picture of Charles Huggins on the wall leading to the surgery department. Charles Huggins was a famous University of Chicago surgeon who won the Nobel Prize for Medicine in 1966 for his pioneering research on the hormonal regulation of prostate cancer. Above his picture is the plaque that once hung above the doorway to his lab and reads, "Discovery is our business." Whenever I see his picture and read that sign, I am reminded that innovation and creativity are our highest forms of academic accomplishment and contribution to our profession. But these require not only the insight of science and the wisdom of clinical experience, but also the inquisitiveness, conviction, and courage to take risks in the pursuit of improving care for the sick and suffering. Yet our greatest challenge to innovation and creativity is our own willingness to change.

Studies investigating the neuroscience of learning would suggest we are biologically programmed to avoid change and innovation. In her book, *Wired to Resist*, Britt Andreatta, PhD, describes the basic biology and neuroscience of how humans are genetically wired to resist change and innovation and seek safety in constancy and predictability.[8] It is part of our DNA. Which one of us, as a surgeon, hasn't either uttered these words or heard them: "I have done this operation hundreds of times. I know exactly every step. I know exactly how it is going to turn out and I'm not changing a thing. This is how I do it." We do not want to give up that sense of control and consistency. We are working against human biology and almost every natural instinct to change and be creative. Change also requires not only energy but risk without immediate reward. And what surgeon in this room doesn't love the exhilaration and the immediate reward when they pick up a scalpel and slay a dragon for a patient and that patient is better almost immediately? It's so exciting to see those patients get better so quickly. Why would you change that? And surgeons achieve mastery with repetition as we seek consistent quality for our patients. Yet these same behaviors retard growth and innovation and progress.

No one has described better these challenges to change than Charles Lockwood in his presidential address of 1921 entitled, "The general surgeon — past, present and future." In 1921, Lockwood wrote that repetition and consistency lead to technical mastery. And we must incorporate scientific advances into clinical practice with speed and efficiency while never compromising patient care and safety. Yet the accelerating turnover of medical knowledge and incredible technologic advances mandates a willingness to change and adapt.[9] Ladies and gentlemen, you know if that was true in 1921, it is even truer now in the 21st century, when the turnover in medical knowledge is so rapid and often so radical.

Another important friend and mentor in my career has been Rich Prinz. Dr Prinz came to NorthShore in 2009 after 15 years as chair of surgery at Rush Medical College. He was also president of the Western Surgical in 2003. We have had many conversations about what it takes to be a successful academic chair and leader and how to build an academic department at a hybrid place like NorthShore. He has always told me to recruit surgeons with "an academic heart"; to build around them a culture of investigation, scholarship, and curiosity; and to have the courage and confidence to change things myself. As I reflected on those conversations with Rich and as I read the more recent proceedings of the Western Surgical Association, I realized we have the most extraordinary profession on the planet. We can learn something new every single day if we keep an open mind. And if we do that we will spend every single day of our lives and our careers never bored! What a wonderful thing to say about a career.

For me, an eye-opening experience like this has played out over the last decade and began in 2008 at the Western Surgical meeting in Santa Fe. I came to our meeting and

heard a gifted young surgeon, a truly innovative mind named Michael Kendrick, present a paper on his early experience with total laparoscopic pancreaticoduodenectomy at the Mayo Clinic.[10] He showed that a minimally invasive Whipple was feasible and that he could do it safely and efficiently, but I will tell you, I was "wired to resist." I was 50 years old, and I had done hundreds of Whipples. I sat in that audience and I said, "I'm not changing! I'm stubborn and I'm skeptical and I know how to do a Whipple safely and quickly and effectively and why should I change?" Then he put the video up and I was awestruck and inspired. It was a challenge I knew was coming.

A few years later I heard Melissa Hogg present at an international symposium the structured curriculum she and her partners at the University of Pittsburgh had developed for learning robotic pancreatic surgery. Melissa had been a medical student and surgery resident at Northwestern and then went on to do extraordinary things at UPMC. She presented a paper entitled, "Training in minimally invasive pancreatic resections—a paradigm shift away from 'see one, do one, teach one.'" She had created a formal curriculum with progressive skill acquisition accompanied by intensive feedback and a graded evaluation process.[11] So I knew then that all those wondrous things that Michael Kendrick had shown me years earlier, that were feasible and doable in his hands, could be learned using the curriculum developed by Melissa Hogg. And that maybe even a surgeon, now in his 60s, could train and learn to perform a robotic-assisted Whipple procedure. So I took a 3-week sabbatical in February, 2017 and went to the University of Pittsburgh, and I was fully immersed in their robotic surgery program and care pathways. And after a great deal of preparation, practice, and proctoring, we did our first robotic Whipple procedure at NorthShore in May 2017.

But I am not here to talk about the pros and cons of minimally invasive surgery for pancreatic cancer versus traditional open surgery. And I am not about to debate robotic vs laparoscopic vs open surgery. That is not the point I want to make. But I will tell you something. When I did that first robotic Whipple procedure, it was simultaneously the most intimidating, exhilarating, terrifying, and exciting experience I have had in the last 20 years. And when that first robotic Whipple was done, I couldn't wait to do the next one! So I would challenge every surgeon in the room to go home this year and learn something new. Try a new technology, change a technique you have not changed in decades, and see if you can get better. And if you don't want to do that then participate in a national quality database and compare your outcomes against an external national benchmark, and see if you are as good as you think you are. And if you're not, then change. It will make you a better surgeon and it help you take better care of your patients. And as my son, Jason, has taught me; every grand adventure begins with a bold first step!

In conclusion, our scholarship affects our patients in the most profound way and inspires our trainees. Our research is unique in its combination of scientific insight and clinical wisdom, and it helps to save lives more directly than in any other field in medicine. Our ability to innovate and create is simultaneously our greatest challenge, an immense responsibility, and an awesome opportunity to change the way sick people are cared for. Our generation of new knowledge is a noble calling and the Western Surgical Association has been, and continues to be, a valuable resource for our surgeons and the patients they serve. Thank you all for this year as your president.

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