

A Legacy of Caring
AAST 75th Annual Meeting
Presidential Address

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Introduction

In a live interview with renowned film critic, Gene Siskel, Oprah Winfrey was asked: “What do you know for sure?”¹ Oprah was unsure as to how to answer the question, but, since then, she has devoted the last page of her magazine “O” to a commentary about what she knows for sure.² I believe that to know something for sure, it should be rooted in passion, and come straight from the heart. And so I will share with you something that I know for sure, something that I believe will make a difference in the care of our patients and, hopefully, become a part of our surgical legacy.

It has been a remarkable year. Having the opportunity to serve as President of the American Association for the Surgery of Trauma (AAST) is the single greatest academic honor of my career and I am deeply grateful. And, this year has also been remarkable for another reason as I turned 65 years old and became eligible for Medicare, placing the words “near retirement” in my lexicon for the first time ever. Having been a doctor for 36 years, I reflected on my career and the many changes that have occurred during the decades of my clinical practice. These include the rise in surgical subspecialization, the decline in the number of general surgeons, the blessing and burden of the electronic medical record, the popularity of minimally invasive surgery, and the implementation of duty hour restrictions leading to more handoffs and fragmented patient care. It became clear to me that my generation of surgeons, the baby boomers (1946-1964), have successfully transitioned our surgical practices through a unique time in healthcare.³ As technology immigrants, we learned to use the electronic medical record to document and bill for patient care, took courses to learn laparoscopic surgery and ultrasound, and

developed the Acute Care Surgery fellowship to train future surgeons to handle what we generalists have always done—take care of any elective or emergent surgical condition at any time.^{4,5,6} Yes, our General Surgery training was different as it was characterized by intense, often around-the-clock immersion in the care and ownership of the patient. There may have been some downsides to this type of training, but the long-term upside was that it allowed us to accumulate extensive knowledge about our patients and a well-developed “gut sense” that served us well as we tackled complex surgical problems. This intense immersion in service to the patient was analogous to seeing a movie over and over and over again until the lines were memorized and the next scene easily anticipated. The resultant wisdom was value added and patient centric allowing us to offer superior patient care and earn the respect of our colleagues. We were dependable, knew our stuff, and fulfilled most of the “A’s” in spades, as we were able, always available, and accountable. This “know how” took persistent dedication and hard work. It is what the corporate world refers to as “deep smarts”, an intangible and timeless asset that takes years to develop, requires patience and reflection, and is not easily duplicated or transferrable, thus lending a unique competitive advantage.⁷ These features make this wisdom distinctive, as it became an integral part of the core upon which we developed as authentic leaders who could “walk the talk.” Hence, this intellectual capital or wisdom has special value and should not be lost. It is essential that we transfer it to the next generation of surgeons and, in fact, our impending retirement brings urgency to this concern. According to the Association of American Medical Colleges 2014 Physician specialty data almost half of all general surgeons in the United States are ≥ 55 years old and there are 3.3% fewer general surgeons (in 2014) than there were five years ago.⁸ Hence, there is a continuing

decline in the numbers of senior practicing general surgeons and along with that decrease goes the wisdom. Our patients need this expertise and judgment now more than ever as many have complex injuries and, often, extensive comorbidities. For example, a 50-year-old obese woman was ejected from a motor vehicle and sustained numerous injuries including the herniation of the right lobe of her liver, small bowel, and cecum through her right hemidiaphragm and chest. (Figure 1) The injuries presented a unique set of challenges, as did her abnormal physiology. Her base deficit was 12 and her International Normalized Ratio was 3.5 as she was taking warfarin related to a diseased aortic valve. Decisions to be made at the initial operation included how and when to reverse her coagulopathy, how to temporarily cover the herniated area, and the timing and type of the permanent reconstruction of her abdominal wall. (Figure 2) So, there is no doubt that the transfer of wisdom is important, but what is not clear is what to transfer and how best to do so.

Interviews/qualitative research

Based on the premise that senior surgeons have long-standing experience in leadership, clinical practice, and education of trainees, I conducted phone interviews from May through July, 2016, with a select group of colleagues to determine their insights, advice, and practical suggestions on how to transmit the wisdom of our generation. Surgeons were selected to participate in the interviews if they had > 30 years in clinical practice and held leadership positions in Surgery. The questions were crafted to cover the following areas: 1) leadership; 2) knowledge/wisdom transfer; 3) judgment; and, 4) perceptions about generational differences. (Table 1) Additionally, there was an opportunity for each participant to add comments after answering the eight questions.

Participation in the interview process was initially requested by email and by a telephone call, if needed. The eight questions and a comment section were included with the interview request. The office of the AAST provided a toll free number and administrative assistance prior to and during each recorded call. The interviews were conducted and recorded individually by phone and later transcribed verbatim.

The interview itself was the unit of analysis. Responses were analyzed for a set of independent and exhaustive themes using content analysis. Separate theme-based coding categories were iteratively identified as an indicator of inter-rater reliability and discrepancies were settled by discussion. The software used for the analysis was NVivo11 for Windows, QSR International. (Burlington, MA)

Results and practical suggestions

The 62 surgeons who were interviewed had over 1,800 years combined leadership and clinical experience. Included among those interviewed were three Presidents (past and current) of the American College of Surgeons, the Executive Director of the American College of Surgeons, the Executive Director of the American Board of Surgery, two deans of medical schools, and 23 Past Presidents of the AAST. Of the 62 surgeons, 54 (87%) were members of AAST. Surgeons were located throughout the United States with a slight predominance (26%) from the northeast. Only two of the participants were recently retired from clinical practice, and all were currently in or had recently held major local and national leadership positions. Most commonly, this was as chair of a department of Surgery. The average interview time was about 26 minutes with a range of 8 to 51 minutes. Within this context, presented here are the most frequent

answers to the questions and some practical suggestions to address concerns about the transfer of knowledge and wisdom.

Question #1: Creating a culture at work

The development of core values was considered the most important element in establishing a culture. (Figure 3) The core values needed to be specific, clearly communicated to faculty and trainees, and drive decision making through good and challenging times. Recognizing that the formation of a culture takes time, the leaders emphasized the need for consistency of purpose and persistence of the message with regular assessment of milestones to ensure that the core values remained relevant and were embraced.⁹ The surgeon leaders recognized the importance of integrity, transparency, optimism, and the determination to stay the course to achieve a lasting culture that would help develop the potential of junior surgeons. Further, they underscored a commonality of purpose among all levels of leadership so to avoid value dissonance.¹⁰

Practical suggestions:

1. Dr. Brent Eastman quoted the Chinese proverb, “Tell me and I will forget, show me and I may remember, involve me and I will understand.” With this philosophy, he developed a peer-selected Physician Leadership Cabinet whose members were a united voice working collaboratively and transparently with the hospital’s CEO to solve problems and improve patient care.¹¹
2. Dr. Gary Dunnington, Chair, Department of Surgery at Indiana University School of Medicine, gives an annual State of the Department address. Within the context

of the Department's core values, some of the highlights include clinical practice data, recruitment updates, leadership changes, and progress in research. Also, it is a good time to remind the faculty how the core values are centric to the operations of a department and how they guide its growth and development.

Question #2: Most valuable quality

“Leading by example” was the most frequently cited quality that allowed surgeon leaders to advance or be more effective. (Figure 4) Leading by example embodies professionalism, character, and integrity, is present 24/7, and is part of the leader's DNA. It is especially important that a leader build trust and operate from a strong moral compass to ensure that actions reinforce the right behaviors. Further, the leaders felt strongly that being an operating surgeon was an essential responsibility of a surgeon leader regardless of the demands of administrative duties. In addition, the interviewees cautioned that words and actions have consequences and that true character is revealed in the choices made and in promises kept.

Practical suggestions:

1. David Feliciano and Gene Moore reiterated that spending time in the operating room contributes to the leader's credibility, as it is an opportunity to learn firsthand about preoperative screening, perioperative services, and the capabilities of the operating room staff including anesthesiologists and nurses. Surgeon leadership in this area creates a competitive advantage that can be used to influence multiple specialists.

2. During their long tenure, surgeon leaders Dave Hoyt and Peggy Knudson noted that there has been an increased need for and value placed on emotional intelligence, namely, patience, good listening skills, and the ability to collaborate. To address those needs, some leaders recommended an “open door” policy to encourage faculty to drop by for advice. Other suggestions included casual quarterly lunches, inter-departmental/inter-school research meetings, and a journal club that focused on the facets of emotional intelligence.

Question #3: Helping young surgeons become good leaders

An effective leader provides young surgeons an opportunity to learn the nuances of leadership through mentoring. (Figure 5) Mentorship provides special insight, understanding, and wisdom that are not easily obtainable through the “usual” learning channels. The areas where mentorship is most needed for junior faculty include the following: 1) outlining goals; 2) managing time and effort, and 3) learning the essentials of research, especially how to generate a sound hypothesis. The leaders expressed the need to direct the junior faculty to a defined project or role with clear expectations and with enough independence to make decisions. Further, regular meetings with them were needed in order to assess their progress, encourage goal-directed discipline, and potentially prevent them from making irrevocable mistakes. The leaders saw this process as a critical factor for faculty retention.

Practical suggestions:

1. “Chip” Souba and Gary Dunnington keep a collection of leadership books from the business sector and share their “top pick” with the junior faculty.

2. Barbara Bass and David Feliciano suggested leadership courses for junior faculty to attend. These may be local or national such as the American College of Surgeons Leadership Course or the Program for Chiefs of Clinical Services sponsored by the Harvard T. H Chan School of Public Health.^{12,13}
3. Tony Meyer keeps a list of the societies that junior faculty should join. Becoming a member of a non-specialty surgical society may be particularly helpful to the young surgeon's career. Benefits of membership include the opportunity to present research work, network with leaders outside of a specialty in American Surgery, and position themselves for national recognition by serving on committees.
4. Bill Schwab introduces junior faculty to local leaders in the hospital or medical center and encourages them to schedule a lunch session to learn about leadership topics such as strategic planning, problem solving, and time management.
5. Surgeon leaders should grow surgeon leaders and, based on the wisdom of those interviewed, this is a key factor to ensure the continuation of a culture. It validated what we are doing under the leadership of Dr. Gary Dunnington in the Department of Surgery at Indiana University School of Medicine. We have designed and implemented a tiered approach to leadership development whereby faculty are placed in one of four tiers of leadership based on the number of years on faculty, interest in leadership development, and recognition of leadership skills. (Table 2) Each Tier has a custom designed curriculum with assignments that target a specific level of leadership. The unique aspects of these monthly sessions include the following: small group environment, sharing of personal

experience and wisdom by senior leaders, carefully selected readings from outstanding authors to complement and underscore the lessons to be learned, and the opportunity to network with colleagues. Also, the participants are encouraged to create a personal journal that leads to introspection and self-awareness. Outcomes to be measured include the results of a 360° evaluation and the academic promotion of the participants.

Question #4: Passage of clinical knowledge/wisdom to the next generation

Most interviewees were challenged with this question as clinical and administrative demands have eroded teaching time. But, they recognized that our generation has many pearls of wisdom to pass on to the next generation of surgeons. Many emphasized that Surgery as a specialty allows for learning in multiple venues, including the emergency department, the trauma bay, operating room, the surgical intensive care unit and conferences. They placed the highest value on patient case-based learning and one-on-one teaching. (Figure 6) Others emphasized the value of graded responsibility in the operating room with the endpoint of autonomy.

Practical suggestions:

1. Gene Moore suggested that senior surgeons take the opportunity to introduce his/her clinical experiences into conferences to add value beyond what is found in textbooks and journals.
2. Frank Lewis, Barbara Bass, and Gary Dunnington suggested that teaching and the evaluation of trainees should be more strategic so as to provide knowledge

tailored to the trainee's level. Examples include the graded procedures taught in the surgery skills laboratory and the Clinic Assessment and Management Examination for Outpatients or CAMEO, which is designed to evaluate the trainee's performance in the outpatient setting with input from the patient.¹⁴ Additionally, evaluating the trainee immediately after the performance of a procedure can be accomplished with SIMPL, the System for Improving and Measuring Procedural Learning. This smart-phone based evaluation technique allows almost "real time" assessment of the trainee making learning more meaningful.¹⁵

3. We recently designed some of our clinical rotations for senior residents at Indiana University to be apprentice-based. The purpose of this all-encompassing experience includes learning clinical judgment, technical skills, and perioperative care from one experienced attending surgeon at a time. It is anticipated that this process will likely build trust between faculty and resident.
4. Len Jacobs emphasized the importance of courses such as the American College of Surgeons Advanced Trauma Operative Management (ATOM),¹⁶ the Advanced Surgical Skills for Exposure in Trauma (ASSET),¹⁷ and hands-on cadaver workshops. All three allow for the interactive exchange of knowledge about trauma operations and procedures.
5. Andy Peitzman suggested the "Gray hair/no hair rule". Junior faculty in his hospital must notify a seasoned surgeon if they are going to perform a complex operation not frequently done. Further, the junior faculty surgeon is encouraged to

- ask the senior surgeon to come into the operating room for hands-on advice before performing the difficult portions of the procedure.
6. Morning Report and Morbidity and Mortality Conference offer opportunities for case-based learning with follow up for decisions made and input from experienced surgeons.
 7. Other opportunities for case-based learning include a dedicated weekly General and Trauma Surgery Conference that covers surgical topics based on a patient from operative case logs. (Table 3) During this conference, General Surgery residents are asked to address the pertinent history and physical examination, diagnostic tests, preoperative discussion with the patient and family, the details of the operation, and the management of potential complications. This conference format mimics the American Board of Surgery Certifying Examination.
 8. Rick Greene and Mary McCarthy suggested taking advantage of the time at the scrub sink to discuss an operation.¹⁸ Lasting only a few minutes, this ritual is unique to surgeons and serves as an opportunity to transfer wisdom.
 9. Tom Scalea emphasized the importance of including patient-based panels by senior surgeons in postgraduate courses.

Question #5: Leadership succession planning

Over half of those interviewed admitted that they had not devoted a great deal of effort to leadership succession planning for their own positions. But, most surgeon leaders agreed that the early identification of potential leaders among junior faculty was an important first step in

this process. (Figure 7) They also emphasized that junior faculty desire leadership roles and, with their “buy in”, the desired culture is more likely to thrive. But, along with titles come responsibility, and L.D. Britt cautioned that the leadership journey is a marathon, not a sprint.

Practical suggestions:

1. Wayne Meredith identifies a junior faculty member with leadership potential and appoints him/her as an associate director of a division or section. Fred Moore added that the associate director’s responsibilities should include assisting the director with writing a business plan for that division or section.
2. And, to guide succession planning, Fred Moore, Julie Freischlag, John Morris, and Steve Stain posed the following insightful questions that each leader should consider:
 - What major changes does the department anticipate in the next three to five years and what skills or attributes will be required to respond to those shifts?
 - What are the best practices associated with succession planning?
 - How does succession planning help identify gaps in expertise and skills?
 - How can succession planning contribute to diversity?

Question #6: Choosing trainees and hiring faculty

Many of the surgeons stated that the core values were the focal point of choosing surgical residents and recruiting faculty. And, once “on board” as members of the department, they expected the trainees and faculty to fully embrace the core values and to emulate them, as well. Relative to choosing trainees, the surgeon leaders said that they preferred to choose

residents who had demonstrated a skill or acted as a leader outside of medicine. (Figure 8) This was thought to require perseverance and grit which they believed to be a good indicator that the trainee had the “makings of a surgeon” and would stay the course to become a good one. From the leaders’ perspective, this selection criterion carried more weight than academic achievements and they used their own work experiences to validate this belief. In retrospect, the surgeon leaders viewed such experience as an opportunity to develop character and relate to future patients from all backgrounds.¹⁹ As for hiring faculty, Gil Cryer and Ron Maier sought faculty with a special talent or niche who would contribute to the mission and enhance the culture. Examples include faculty with expertise in prehospital care, ultrasound, business, or clinical research. Having the wisdom to hire good people not only contributes to the longevity of the department or division, but also to that of the leader.

Practical suggestions:

1. Dennis Vane suggested that a workforce assessment should be performed at least annually to address the following: a) anticipated changes in the number of faculty (for e.g., clinical needs and impending retirement) and expansion of the operation; b) resources to achieve quality patient care, financial targets, and a fair faculty workload; and c) budget implications of the changes.
2. Gary Dunnington shared his Department’s recruitment policy with some salient points listed in Table 4.

Question #7: Qualities of the Millennials

While our generation struggled to become “computer adequate”, the Millennials seem to have been born “tech savvy”. Also, they place a high value on family, “life/work balance”, collaboration, and they seem to be less judgmental, more progressive, and just

plain smart. (Figure 9) Bob Mackersie and Mark Malangoni noted that these traits allow the Millennials to reach out to the patient with compassion. Further, these trainees embrace outcome data to answer questions and improve patient care.

Practical suggestions:

Millennials learn through technology. Whereas we had pockets full of cards and lists, they have apps on their I-phones and have a world of information at their fingertips. They may be experts with the “how” but we must guide them through the “where” and the “what”. Examples of such guidance include the following: 1) set guidelines for the case presentations at Morbidity and Mortality conference so that junior faculty and residents access the best journals and the most appropriate articles from them; 2) teach them the “anatomy” of a journal article and how to read it critically; 3) provide them with the basics of research principles including how to formulate a hypothesis that follows the FINER criteria; i.e., is the hypothesis feasible, interesting, novel, ethical, and relevant?²⁰ 4) assist them with the grant writing process;²¹ 5) examine patients with the trainees and emphasize the subtleties of physical examination and how they tie in with the patient’s history of present illness; and 6) involve them in patient discussions especially those related to the delivery of bad news and admission of errors.

Question #8: Strengths of our generation

An undying work ethic that puts the patient first was the quality that led the list. (Figure 10) Many interviewees credited their parents, the “greatest generation”, as having a profound influence on them especially with respect to a strong work ethic, loyalty, and humility.²² As our generation spent so many hours in the hospital, many surgeons

recognized the value of learning from nurses, as well. Many stated that they owed a debt of gratitude to the nurses, especially those in the intensive care unit who were an indispensable part of their training. Interactions with the nursing staff were different for us as there was no intravenous or wound care nursing team, no intensive care unit service, and no rapid response team. Hence, as surgical trainees, we followed our patients from day one and worked closely alongside the nurses to care for the patient. In his book “The Making of a Surgeon”, the late William Nolen tells the story about making dressing rounds during his General Surgery internship at Bellevue Hospital. He asked the nurse if he could borrow her scissors and she replied “no”. Instead, she handed him a pair of scissors on which his name was engraved. He was so touched with this expression of respect; he wrote “I damn near cried.”²³ Earning the respect of a good nurse was a highly sought after badge of honor. Finally, Barbara Bass, Basil Pruitt, and Dave Livingston said that our generation appreciated surgical history and those whose contributions helped to build our profession. This is especially true for military surgeons whose sacrifices and wisdom helped to define and develop many new paradigms for field care, resuscitation and transfusion, hemostasis, and long-range transport.

#9: Comments:

Additional comments offered from some of the interviewees included the following:

David V. Feliciano: “On day one, each Surgery resident should receive the book, “Forgive and Remember”, because Surgery is about being accountable.”²⁴

Barbara Bass: “Build a group that values others for their differences as well as their strengths.”

Andy Peitzman: “Always do the right thing for the patient.”

David Richardson: “Transparency creates trust.”

Steve Shackford: “We need to convey the tribal wisdom... We have been trying to do this for years with our course, *The Doctor-Patient Relationship*.”

Len Jacobs: “What can we (the leadership) do now to ensure that we will be successful in 15 years? We need to think about the future.”

Tom Cogbill: Amidst all of our successes, gratitude should also go to those who support us at work, i.e., administrative assistants, advanced practitioners, trauma program managers and so many more who make it all happen.”

Anna Ledgerwood and Charlie Lucas said to treat the patient like a member of your family.

Susan Briggs, MD, MPH: “Stop talking about the ‘good old days’. Let’s move forward and build something together.

Reflections and Conclusions

On the basis of this shared wisdom and practical suggestions from senior surgeons, I want to emphasize the following two points:

The reasserting of core values by today’s surgical leaders is the first step in the transfer of knowledge and wisdom to the next generation of surgeons. Core values have staying power and, emblematic of those timeless values is my alma mater, Misericordia University. Founded in 1924 by the Sisters of Mercy to educate the daughters of coal miners, their core values of mercy, service, justice, and hospitality have transcended

generations.²⁵ (Table 5) Those values are as relevant today as they were nearly 100 years ago. Hence, the core values shape a culture that has thrived through generations.

The second step is that the leader sets an example by living these core values, communicating them, and holding him/herself accountable to the highest standards especially those relating to patient care. When we live core values and share them with our team, we form trust. I learned this during my 19 years at Grady Memorial Hospital in Atlanta, Georgia. Since its opening in 1892, Grady has held fast to its mission to care for the underserved, and it has withstood the test of time to evolve as a safety net hospital with a rich heritage despite adversity. Through a commitment to the underserved, Grady built community trust, established new capability and capacity, and evolved as a trainees' "classroom" for generations—another example of the transfer of wisdom.

Subsequent generations of surgeons will be different than we baby boomers, but, through our calling and a culture that is patient centric, our destinies are shared. The wisdom that we have to offer does add value and makes a difference in others' lives. What validates this for me is an email that I received from AAST member, Dave Notrica, former Emory General Surgery resident and current Trauma Medical Director at the University of Arizona College of Medicine's American College of Surgeons Level 1 Pediatric Trauma Center at Phoenix Children's Hospital. Dave wrote the following to me after reading my Oriens Address delivered at the 27th Meeting of the Eastern Association for the Surgery of Trauma: "Thank you SO MUCH for everything you did to train me. I still remember... moments that were life-changing for me...The day you taught me ultrasound; the day I took a patient with a stab wound to the chest with pericardial tamponade to the OR based on the FAST alone ...I was worried about being

wrong...You never doubted me; the day we had a patient with a gunshot wound to the abdomen and you took us straight down onto the aorta via the diaphragm; the day you asked me to teach the ultrasound course at the American College of Surgeons; and the day you took us deep sea fishing in San Diego.” I was very touched to receive this communication as it made me realize that the transfer of knowledge and wisdom has an impact beyond generational differences. It gives us a way to measure our lives by gauging the difference we make in the lives of others. And, most importantly, it is about caring for our patients.

What I know for sure...

So, what do I know for sure? I know for sure that Surgery is deeply rooted in the past with knowledge and wisdom that transcends generations. We baby boomer surgeons have leadership, clinical, and educational “deep smarts” that are an integral part of our generation and a part of our commitment to the service of others. I also know for sure that it is the core upon which we developed as authentic leaders who “walked the talk” and built a lasting culture that helped to make Surgery what it is today. I know for sure that this wisdom has potential to improve patient care and enrich the lives of others far beyond what can be gleaned from the literature. And, I know that by serving others we carry this wisdom forward, make it part of the next generation’s life, and earn our part of a heritage that will create a lasting *legacy of caring*.

Finally, I am profoundly grateful to have served as your President. Much of the joy for me was having the opportunity to serve the members and the organization. You have honored me more than I could ever have imagined as the daughter of two parents

who worked in factories and raised me in a small coal town in northeastern Pennsylvania.

I am deeply grateful for the confidence and trust of the members and for what all of you friends, colleagues, mentors, trainees, have given to me. And, for myself, I quote from the Hippocratic Oath: “May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.”²⁶

Thank you.

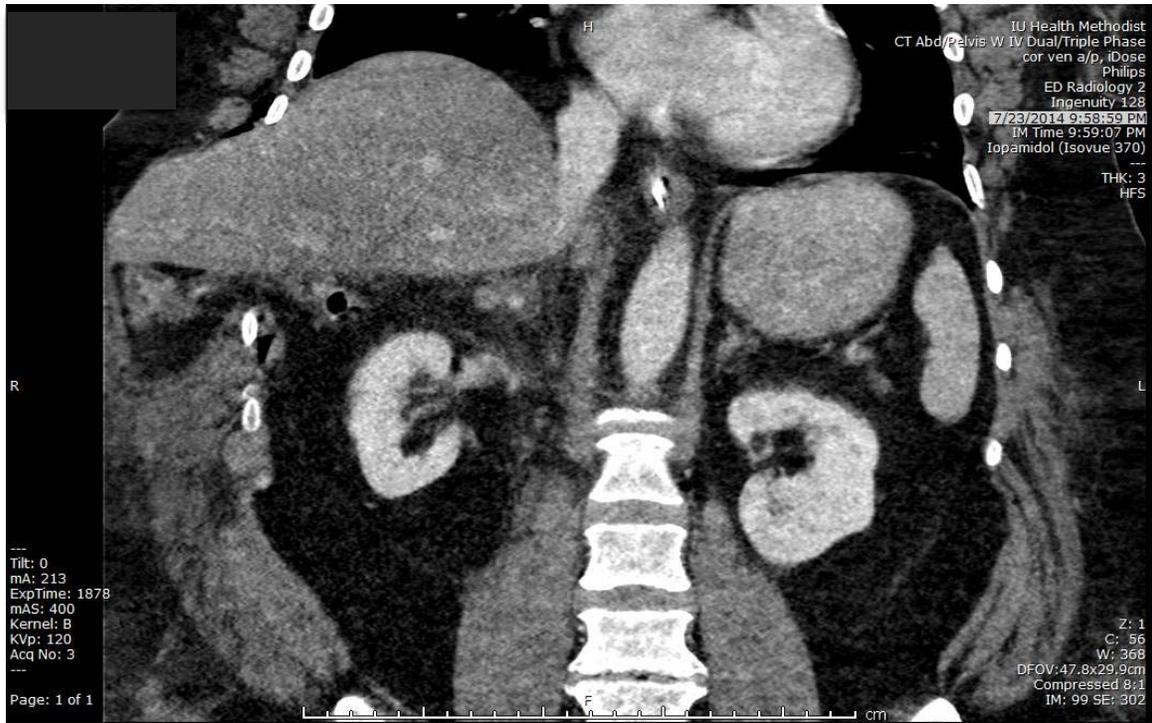
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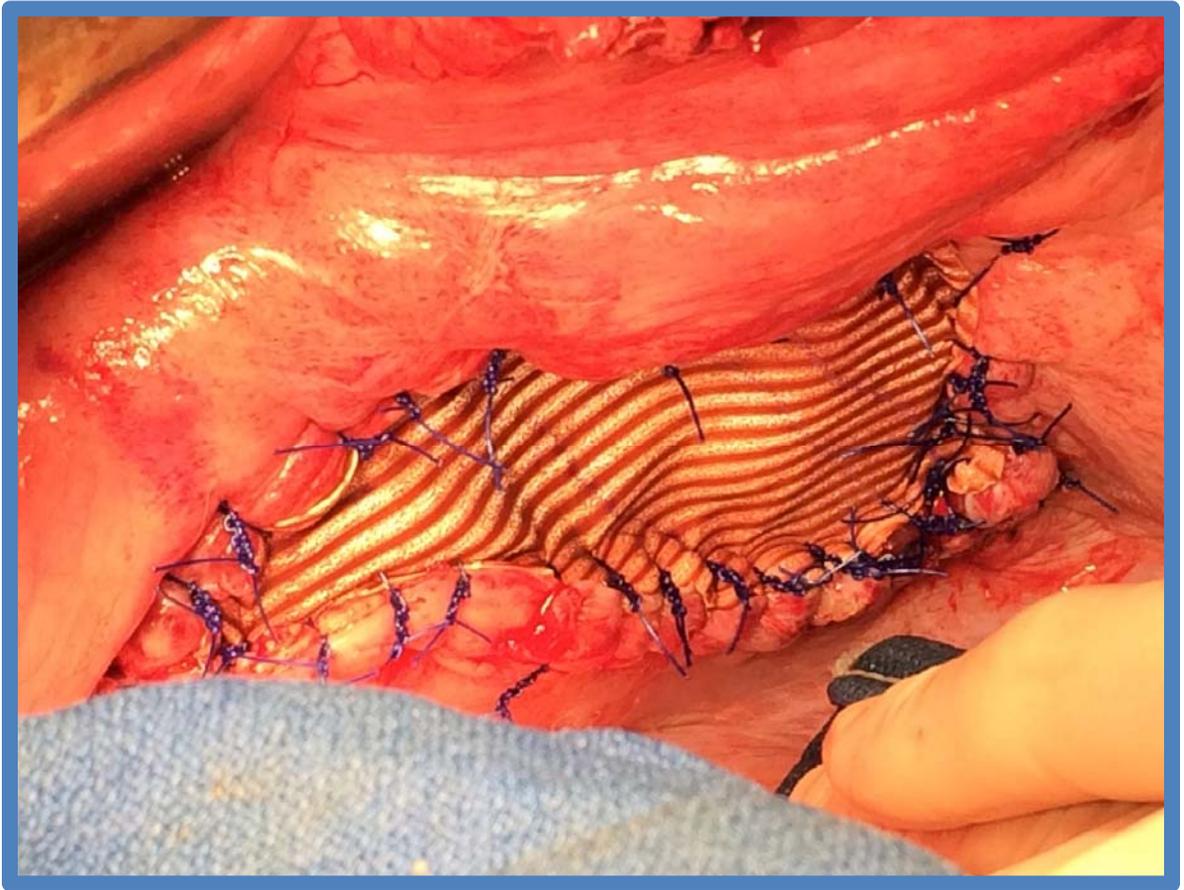
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Figure 1



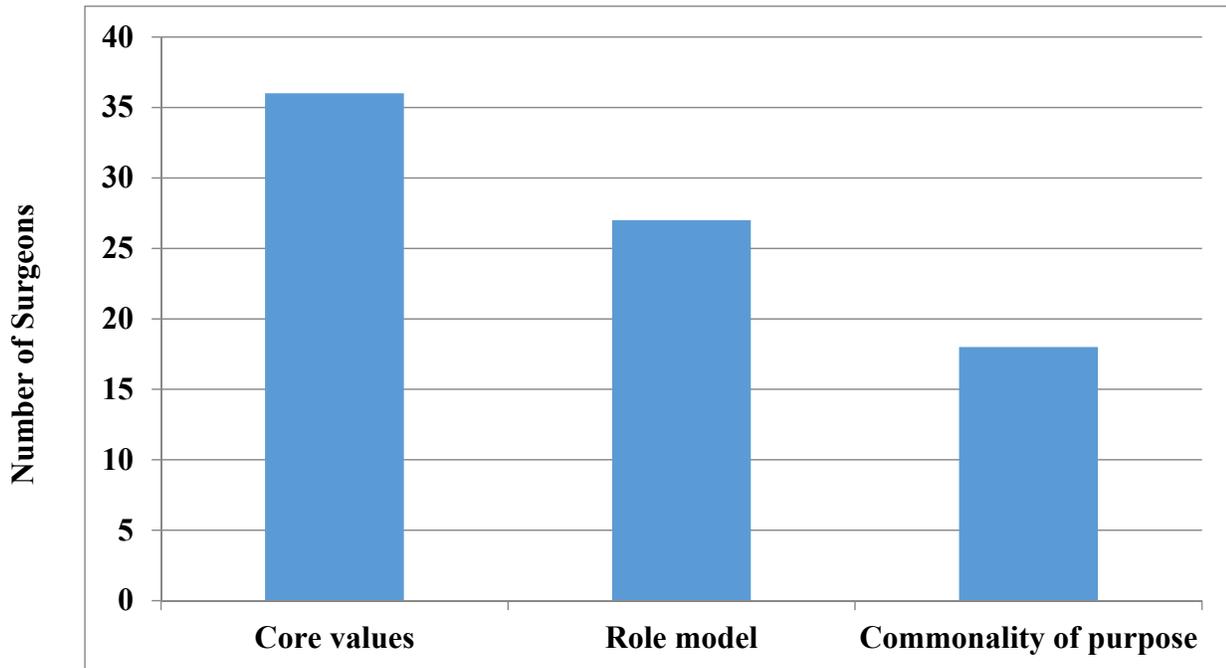
Coronal view of computed tomography scan of abdomen showing herniation of portions of liver, right colon, and small bowel through the right hemidiaphragm and chest wall.

Figure 2



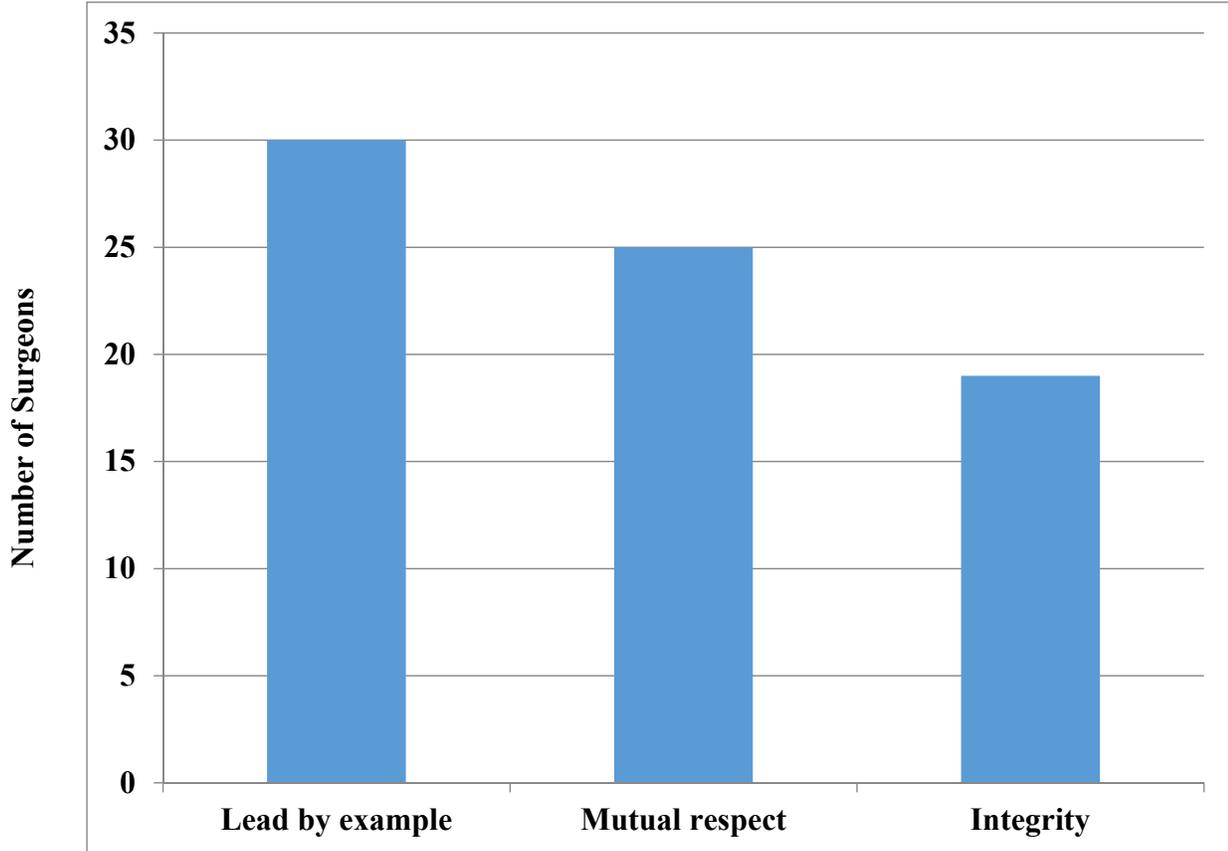
Abdominal wall repair with dual mesh polytetrafluoroethylene.

Figure 3



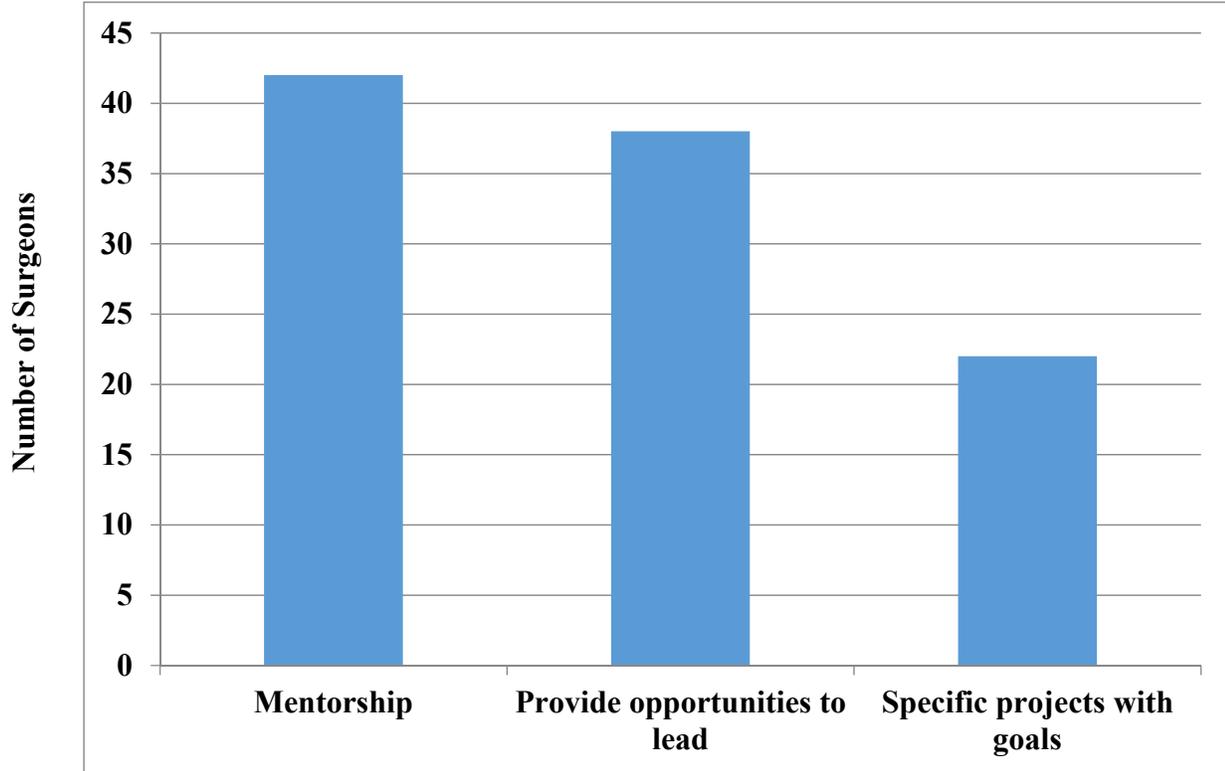
Question #1. What have you learned about trying to create a culture at work that is in alignment with the values, norms, and practices of your division or department?

Figure 4



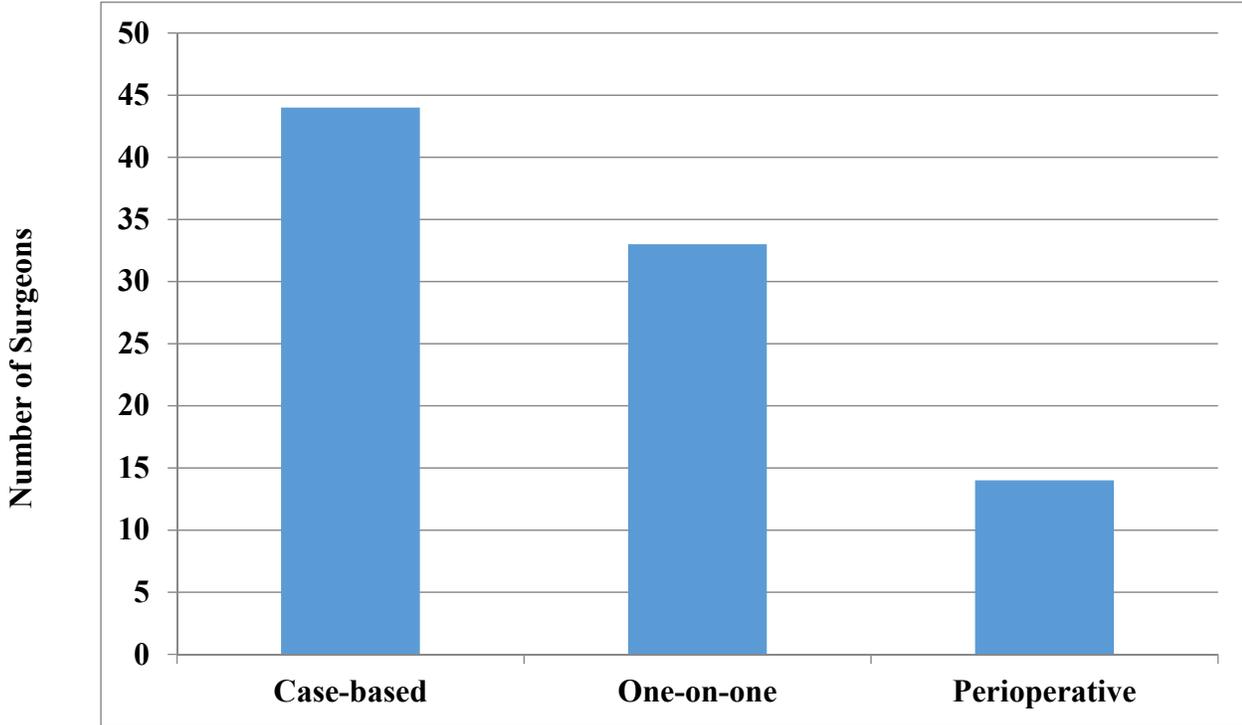
Question #2. What is the most valuable quality that you have learned over the years that has allowed you to advance in leadership and/or enhance your effectiveness?

Figure 5



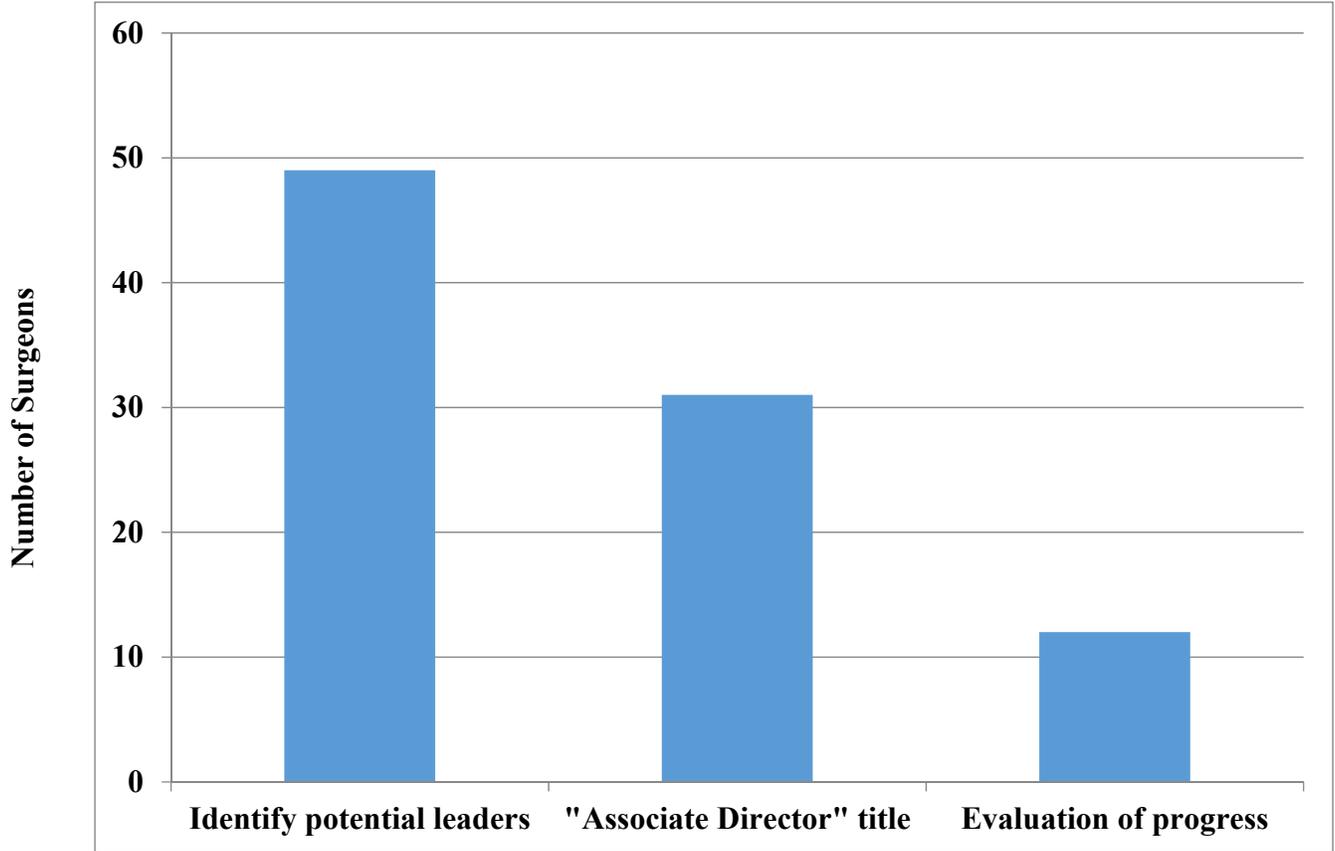
Question #3. What are some ways that you can help young surgeons to become good leaders?

Figure 6



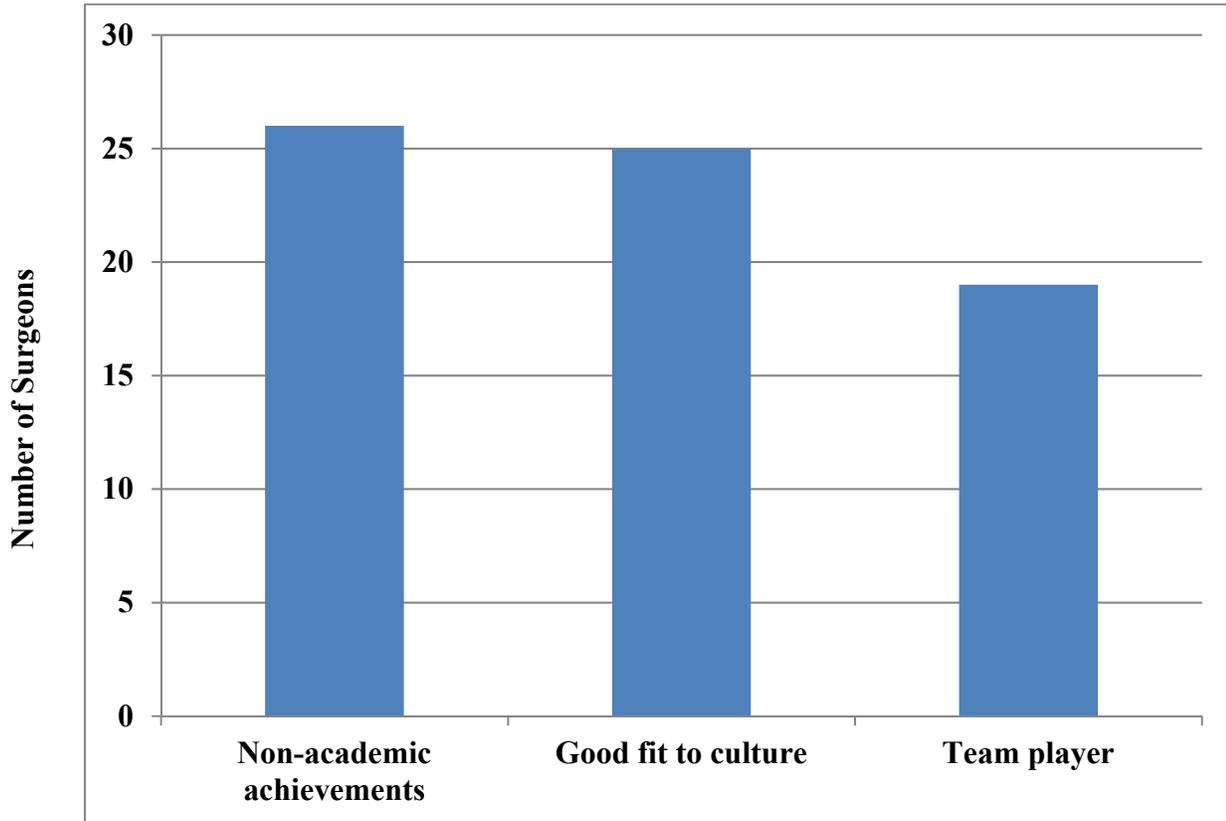
Question #4. In addition to teaching conferences, courses, journal clubs etc., what process or processes do you have in place or suggest should be in place to ensure the passage of clinical knowledge to the next generation?

Figure 7



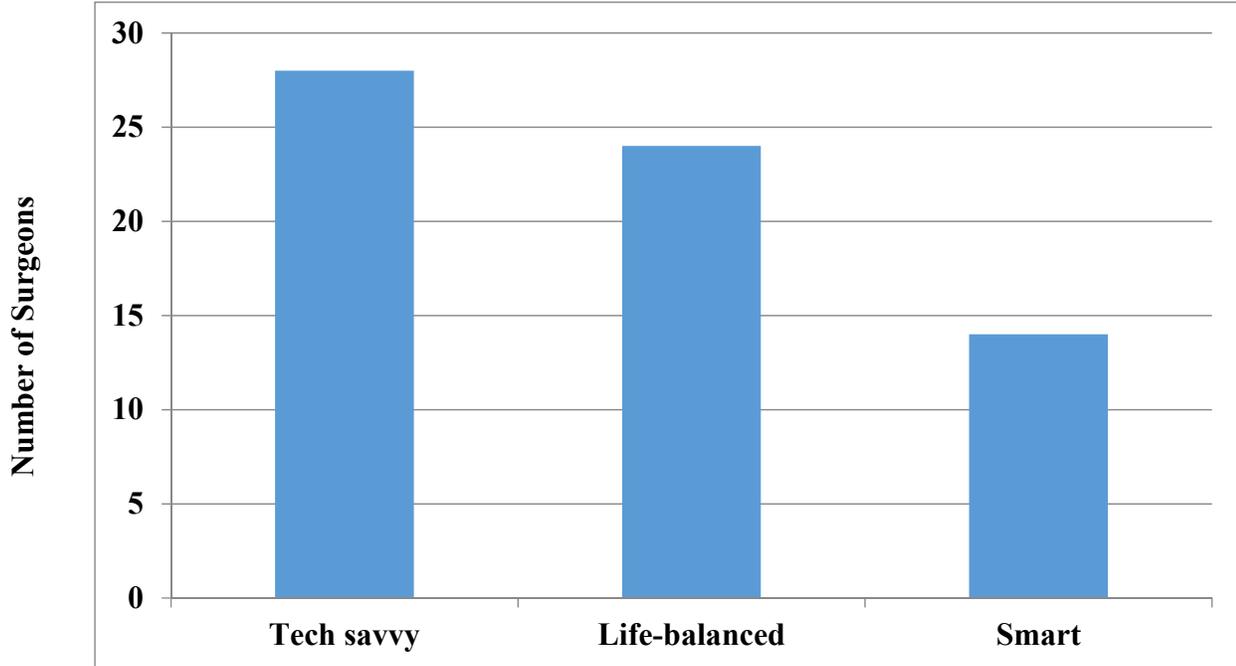
Question #5. What process do you have in place for leadership succession planning?

Figure 8



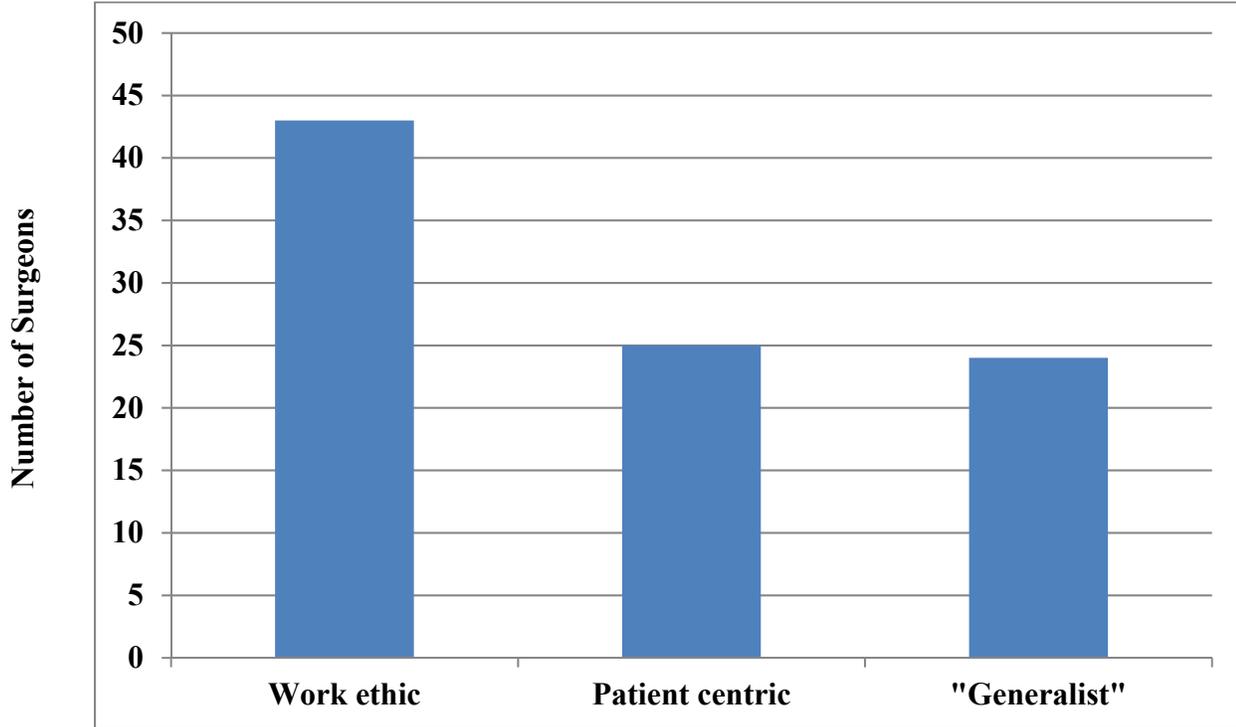
Question #6. What have you learned about choosing surgical residents/fellows and hiring faculty that is important to pass on to your junior faculty surgeons?

Figure 9



Question #7. What are the strengths of the next generation (Millennials or Gen Y, born about 1980-2000) of surgeons that will make them good doctors?

Figure 10



Question #8. What are the strengths of your generation of surgeons that have made them good doctors?

Table 1 Interview Questions

1	What have you learned about trying to create a culture at work that is in alignment with the values, norms, and practices of your division or department?
2	What is the most valuable quality that you have learned over the years that has allowed you to advance in leadership and/or enhance your effectiveness?
3	What are some ways that you can help young surgeons to become good leaders?
4	In addition to teaching conferences, courses, journal clubs etc., what process or processes do you have in place or suggest should be in place to ensure the passage of clinical knowledge to the next generation?
5	What process do you have in place for leadership succession planning?
6	What have you learned about choosing surgical residents/fellows and hiring faculty that is important to pass on to your junior faculty surgeons?
7	What are the strengths of the next generation (Millennials or Gen Y, born about 1980-2000) of surgeons that will make them good doctors?
8	What are the strengths of your generation of surgeons that have made them good doctors?
9	Comments: _____

Table 2 Tier Levels for Leadership Training from the Indiana University School of Medicine Department of Surgery, Indianapolis, Indiana

Tier Level	Description
Tier 1	New faculty during their first one to three years
Tier 2	Junior faculty with leadership skills identified and placed in junior leadership roles
Tier 3	Faculty who have demonstrated success in junior leadership roles and are in preparation for major leadership roles
Tier 4	Senior leadership in roles such as Division Chief, Medical Director, and Vice-Chair

**Table 3. General Surgery and Trauma Case-based Teaching Conference from the Indiana University School of Medicine Department of Surgery, Indiana University Health-Methodist Hospital, Indianapolis, Indiana
Courtesy of David V. Feliciano, MD**

August 3	General Surgery - "Papillary Thyroid Cancer of Thyroid Gland"
August 10	Trauma - "Gunshot Wound Zone II of Neck"
August 17	NONE
August 24	General Surgery - "Graves' Disease"
August 31	Trauma - "Blunt Carotid Artery Injury"
September 7	General Surgery - "Primary Hyperparathyroidism"
September 14	NONE
September 21	Trauma - "Hole in the Esophagus"
September 28	General Surgery - "Zenker's Diverticulum"
October 5	Trauma - Gunshot Wound to Lung"
October 12	General Surgery - Gastroesophageal Reflux Disease
October 19	NONE
October 26	Trauma - "Mediastinal Traverse"
November 2	General Surgery - "Paraesophageal Hernia"
November 9	Trauma - "Emergency Room Thoracotomy"
November 16	General Surgery - "Barrett's Esophagus"
November 23	Trauma - "Big Hole in Right Ventricle"
November 30	General Surgery - "Achalasia"
December 7	Trauma - "Blunt Rupture of Descending Thoracic Aorta"
December 14	General Surgery - "Adenocarcinoma of Gastroesophageal Junction"
December 21	Trauma - "Gunshot Wound of Subclavian Artery"
December 28	NONE

**Table 4. Recruitment Policy from the Indiana University School of Medicine
Department of Surgery, Indianapolis, Indiana**

Screen candidates by telephone prior to scheduling the recruitment visit
Send itinerary to the candidate in advance of the visit
Schedule a recruitment dinner for a maximum of six faculty with dinner guests appropriate for candidate's life stage when spouses attend
Meet with the department chair for at least 45 minutes during the first visit
Include residents in candidate visits
Provide a staff escort for the candidate during the visit
Arrange for a brief exit interview and plan for follow-up phone call within seven to 10 days
Offer a Memorandum of Understanding once the decision is made to hire the candidate

Table 5 Misericordia University Values

Mercy through	Service through	Justice through	Hospitality with
Compassion	Selflessness	Fairness	Dignity
Love	Sacrifice	Acceptance	Respect
Caring	Action	Advocacy	Openness

I wish to express my appreciation to the following talented individuals for their valuable assistance:

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LeRanna Hatcher, Medical Student

Jernica Smith

Kyle Posego

Miguel Gutierrez

Nanette Redmond

Victoria Dodge