From the New England Society for Vascular Surgery

A modest proposal

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Although to those sitting in the audience the traditional gratitude toward the society, mentors and family can seem at times hackneyed and repetitive, I can tell you that it is by no means so. In preparing for this talk, which has frankly been one of the more difficult endeavors of my career, gratitude and humility are a constant accompaniment.

I am grateful to the New England Society for Vascular Surgery for helping nurture my early academic and clinical career and for introducing me to an outstanding group of professional colleagues of the highest caliber, many of whom I cherish as personal friends. The honor of having been elected to serve on the Executive Committee as Secretary, and now as I reach the end of my Presidential year, will serve as my highest professional achievement. When I look at the list of those who have held those offices before, I am grateful and humbled.

I count many individuals as critical mentors over the years, and acknowledging each would take us into the early morning hours, but I wish to single out a few, all of whom, ironically, had ties to New England vascular surgery before I even contemplated a move here.

As a third-year medical student on a Navy scholarship, I spent two clinical rotations at Portsmouth Naval hospital, where my love of surgery and my passion for vascular surgery were cemented. I had the honor of working on the Vascular Surgery Service, whose attending was a bright, energetic, inquisitive, and skilled surgeon who had just completed his fellowship at the Peter Bent Brigham Hospital, Past President Andy Whittemore (Fig 1). His influence through example has attended my entire career.

I obtained fellowship training at the University of Cincinnati under the leadership of Dick Kempczinski (Fig 2), a Harvard-trained surgeon who was making a mark in academic vascular surgery but never lost his Massachusetts General Hospital roots. He taught me precision and perfection in technique, a rigorous adherence to scientific method, and a strict intellectual honesty, even when subsequent investigations called into question theories we thought we had proved. As many of you know, he was the victim of an unfortunate bodysurfing injury that left him paralyzed in 1994. We remain in touch, but it is the memories of his presence in the operating room and in the laboratory that continue to shape my thinking.

When I accepted a faculty appointment at Brown in1991 and began my academic career at the Miriam Hospital, I met Past President Bob Hopkins (Fig 3), whose unfortunate passing this year is commemorated in your program. Bob was a compendium of Brown and Rhode Island surgical history, a true gentleman, and shared my love and interest in the vascular laboratory and hemodynamics. He is the only surgeon I know who would recalculate the velocity obtained in a stenosis if he felt the insonation angle theta was incorrect. He is sorely missed.

Brown does not have a fellowship program, but we have a robust medical school and surgical residency, and I have been privileged to work with some incredibly bright and challenging students and house staff over the years. We have placed many in some of the most prestigious training programs in the country, and it always gives me pleasure to hear of their success from their program directors, fellow faculty, and partners.

My family and extended family, children, and grandchildren, which Patty and I have brought together in a far flung and constantly evolving opera, are a constant source of pride, wonderment, and joy. In particular, my daughter Kate and her husband Mike, living in D.C. and raising Sebastian and Natalie through the wonder years, and Charles and his wife Leslie, moving most improbably to New Orleans, where he pursues a residency in plastic and reconstructive surgery, keep me grounded and honest. Patty's daughter Jesse and her husband Robb get the family award for farthest traveled, having come from North Carolina to attend.

My wife Patty is the most amazing person I know—loving, humble, firm, intelligent, professional, and most of all, tolerant of her continuous improvement project, me.

As you learned from Roger's overly complimentary introduction, I was an English major during my undergraduate years at Emory, with a particular interest in 18th and 19th century British and American authors. Thus I turned to some of my favorites for inspiration.

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Fig 1. Anthony Whittemore, 24th President of the New England Society for Vascular Surgery.

Fig 2. Richard Kempczinski, Professor Emeritus, University of Cincinnati.

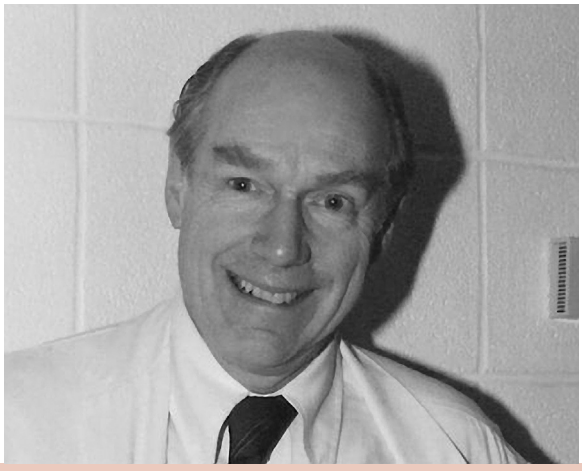

Fig 3. Robert West Hopkins (1924-2016), Professor of Surgery Emeritus, Brown Medical School.

With a direct descendant of Melville as our 24th Society President, it would be inappropriate to use *Moby Dick* as a template. *Middlemarch* is too obscure, and although a *Tale of Two Cities* is a useful metaphor for the difference between cardiac surgery and vascular surgery, that also seemed too facile.

Therefore, I have turned to Jonathan Swift, and more specifically to his brief essay, "A Modest Proposal" (Fig 4) for my theme. Swift published the tract, the full title of which is "A Modest Proposal for Preventing the Children of Poor People From Being a Burthen to Their Parents or Country, and for Making Them Beneficial to the Publick" anonymously in 1729.[1] In it he outlines several logical proposals to deal with the plight of the starving Irish, population control, economic hardship, and improving the lot of the upper class.

Along those lines, and in keeping with my lifelong professional interest in the management of claudication, I have reviewed what I see as the current state of affairs in the treatment of patients with claudication, also known as the assault on the superficial femoral artery (SFA). We have been inundated by numerous strategies to deal with that pesky vessel—drug-eluting balloons and stents for stenoses, lasers, atherectomy devices, crossing wires for chronic total occlusions, retrograde pedal access for the most stubborn lesions. And for what?

Patency rates of 73% at 1 year and 64% at 3 years, with a dismal 33% at 7 years.[2] Early reintervention rates for secondary patency of 38%, amputation rates as high as 8%.[3] For a patient who has undergone laser recanalization of a chronically occluded SFA, followed by atherectomy with a distal protection device, balloon angioplasty in preparation for drug-eluting balloon therapy, with a drug-eluting stent as a bailout for dissection, all guided by intravascular ultrasound imaging, the cost of such a primary procedure in devices alone exceeds $10,000.00.