I Am Not Comfortable with This: 2020 Scudder Oration on Trauma

Gregory J Jurkovich, MD, FACS

I will begin with my thanks to the Committee on Trauma for the honor of this oration. I am fully aware of the historical significance of this lecture and humbled to be included with the list of past honorees. It is anxiety provoking to be given this platform, and as such, I prepared my remarks with the greatest respect and admiration for the American College of Surgeon and its legacy, for all my colleagues in surgery, and in particular, for those of you in our chosen career as trauma surgeons.

I must acknowledge the profound influence others have had on allowing me, or any Scudder orator, this special honor. My past and my influences are deeply rooted in my family, the faith we were all raised with, the legacy of immigrants and education as a priority, a true family physician, and the sacrifices it takes to get there (Fig. 1). My father died a few years ago, and I miss him daily, as much as a reminder of what it takes to be a man with a family as for any other number of reasons. My mother is a sparkly 89 years young, but unfortunately, a bit of a technological luddite, so I will have to show her this talk later. My 3 brothers and I are close, best friends really, and part of a much larger network of family that brings identity and grounding.

My education and training legacy is a source of great pride for me, as are the notable figures who have populated that journey. Northwestern and the University of Minnesota set the stage. The University of Colorado and Denver Health, research fellowship at Duke, and jobs at The University of South Alabama, the University of Washington, and now my home at the University of California Davis in Sacramento. I once had an inexplicable dream to live in all corners and regions of the US, and this journey has nearly afforded me that reward.

I must call out a few, of course at the risk of missing many. I nearly became a transplant surgeon because of the influence of Drs John Najarian and Tom Starzl. I gravitated to trauma and acute care surgery because of the influence and mentorship during my residency of Drs Ben Eiseman and Gene Moore, and I flourished in this field because of surgical leaders spawned by Dr G Tom Shires: namely, Drs Bill Curreri, Jim Carrico, and Ron Maier.

I found my home at Harborview in Seattle, where I was blessed with wonderful friends and partners, and a community that simply suited me and rewarded me. Part of that reward was the amazing academic cross departmental affiliations with many, notably, Dr Fred Rivara, a pediatrician and Editor in Chief of JAMA open, Dr Ellen MacKenzie, an epidemiologist and Dean of the School of Public Health at Johns Hopkins, Dr Doug Zatzick, a professor of psychiatry at the University of Washington, and Dr Avery Nathans, a consummate academic surgeon, now in Toronto, whom many of you know as leading the Trauma Quality Improvement Program (TQIP), but to me, represents the long line of immensely successful fellows we had a Harborview who always were a joy.

Two chairs have been particularly influential: Drs Carlos Pellegrini and Diana Farmer. Quite different people, but both consummate academic surgeons, kind, thoughtful, and honest leaders, with qualities too numerous to name, which reflect the best of all of us. And to be sure, I have loved the friendship and family so many of my colleagues have blessed me with over the years in academic trauma and acute care surgery, including the sharing of my hobbies and family events outside the hospital setting. It is my true wish and hope that you all can find this same strong sense of belonging. I cannot thank you enough for the friendship, the collaboration, the laughter, and the discussions on the philosophy on life.

COVID AND 2020

Past orators have covered a wide variety of topics in the field of trauma surgery, and I hope I will call some of them to mind during my presentation. But I begin this talk with some comments on the most unusual situation in which we find ourselves this year, in the midst of a pandemic infection striking 30 million people worldwide, caused more than 1 million deaths, and sparing no corner of the world[1] (Fig. 2). The sheer volume of information about the epidemiology, clinical course, and biology of

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From the Department of Surgery, University of California Davis Medical Center, Sacramento, CA.

Correspondence address: Gregory J Jurkovich, MD, FACS, Department of Surgery, UC Davis Health, 2335 Stockton Blvd, North Addition Office Building, Room 6017, Sacramento, CA 95817. email: gjjurkovich@ucdavis.edu

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this virus is at once breathtaking and overwhelming. Enough!, we scream almost daily with the onslaught of input on the pandemic, societal woes and polar political objectives, historical and deadly fires in the West and hurricanes in the South and East, and other disasters; and that abbreviated list only represents the American aneurysm of pain, and skirts the global problems of pollution and waste, overpopulation, famine, and armed conflicts.

As of this writing, we are not yet over this deadly worldwide pathologic disease that has now dwarfed other health problems[2] (Fig. 3). It has struck within our own circle of course, likely close to you. The frequent advice from our own College and the deluge of academic articles from throughout the world serve to emphasize the deadly nature of this disease. To be sure, surgeons are not at the forefront of this pandemic, other than providing invaluable support with ECMO, but we certainly have our roles that continue, particularly in trauma centers across the world.

Unfortunately, as an editorial by Michaels and Wagner in JAMA[3] noted, the US is facing an unprecedented, massive healthcare worker crisis, with thousands of us exposed to the virus as we provide care for others. Estimates are that more than 150,000 hospital and nursing home staff have been infected with the SARS-CoV-2 virus, and more than 700 have died, but the federal Occupational Safety and Health Administration (OSHA), has simply and unequivocally failed in its responsibility to even accurately track the numbers.

I am not comfortable with this. Are you?

It is an amazing fact of biology that a virus known as SARS-CoV-2 can have such a profound effect on virtually all aspects of contemporary life. Coronaviruses are a large family of enveloped, nonsegmented, single-stranded RNA viruses that circulate among animals including camels, cats, and bats. Coronaviruses derive their name from their electron microscopic image, which resembles a crown—or corona[4] (Figs. 4 and 5). They have 1 strand of RNA and 4 structural proteins: spike, envelope, membrane, and nucleocapsid.)

The single strand of RNA consists of nearly 30,000 nucleotides; one-third are genes for building the 4 structural proteins, the rest are for replication, except for 8 specific genes for proteins that inhibit host defenses. Eight. The viron attaches to human cells via the spike protein attaching to the human angiotensin-converting enzyme 2 receptor, the viron releases RNA into the infected cell, where it is replicated at the rate of 100 to 1,000 new virons per day per cell infected. Six strains of coronavirus have infected humans, 4 of which together are responsible for about one-third of common colds.

While the virus is small, it can be filtered by the appropriate mask. Those of you who live in the West will recognize the size of fire smoke pollution at 2.5 microns, and other industrial smog at 10 microns (Fig. 6). Yet mask wearing is not universal, social distancing is ignored, parties and the modern-day Roman colosseum of college and professional sports must go on, and so the spread continues, now with more than 233,000 deaths in the US and yet another current curve spike in progress all across the country. But as is human nature, there must be some humor in this darkness, and so the memes and cartoons lampooning 2020 and the lifestyle it has destined us for are numerous, and as I do, I am sure you have your favorites.

Many states and communities have been able to "bend the curve" of the infection rate, allowing hospitals to adapt to the unprecedented onslaught of those with the most severe form of this respiratory illness, but as a society, our attention to this advice and these warnings wanes. As this graphic from my own hospital shows, 2 spikes in admission and positive test rates, 1 early in March, and 1 again in July, and almost certainly a "fall season" spike to happen (Fig. 7). The predictions are spot on. It is, after all, simply math and biology.

We have had warnings about the lethality of pandemics. In the past 2 decades, there have been 2 other global coronavirus outbreaks. SARS (sever acute respiratory syndrome) CoV in 2003, beginning in China, likely from bats, civets, and raccoon dogs, and spread by people. It had an R_0 of 4 (meaning 1 person infects 4 others) and a case fatality rate of 10%. The second warning was MERS-CoV causing the Middle Eastern Respiratory Syndrome. It began in Saudi Arabia, and was spread by camels and people. The MERS syndrome had a very high case fatality rate of 35%, but a very low R_0 of 1, meaning it would be difficult to eradicate, but will not cause a pandemic.[5,6]

As best is known, SARS CoV-2, the virus, or Covid 19, as the disease is called, has an overall case-fatality rate of 3% (US and worldwide), but may be as high as 10% in some countries. Its infectivity, or R_0 is best estimated to be a distressing 5.7, but good data have been difficult to determine, and the R_0 in 3 specific settings was determined to range from 1.3 to 7.1—hence the pandemic it is causing.[7]

So here we are as trauma surgeons, exposed to a large number of patients every day, from every walk of life, and at the highest risk of getting infected. I don't want to get infected. I don't want to infect my family. I don't want to get sick. I don't want to be a vector. I don't want to die. I am not comfortable with any of this, but how can we just walk away?

Who is comfortable in today's trauma centers?

The conflict of this perspective is captured in an essay in the *New England Journal of Medicine* by a young internal

Figure 1. Pictured from left to right: Dr Albert Sullivan, Monsignor Jerome Quinn, Dr G "Jerry" Jurkovich, Dr Ben Owens, the "real" Gregory J Jurkovich (1984). Photo courtesy of the author.

medicine resident. Written during the spring peak of the pandemic and capturing the initial montage of opinions and suggestions for slowing the spread of the virus. I loved the line, "After 22 years of education to the tune of hundreds of thousands of dollars, after finally grasping a basic understanding of the sodium balance and the

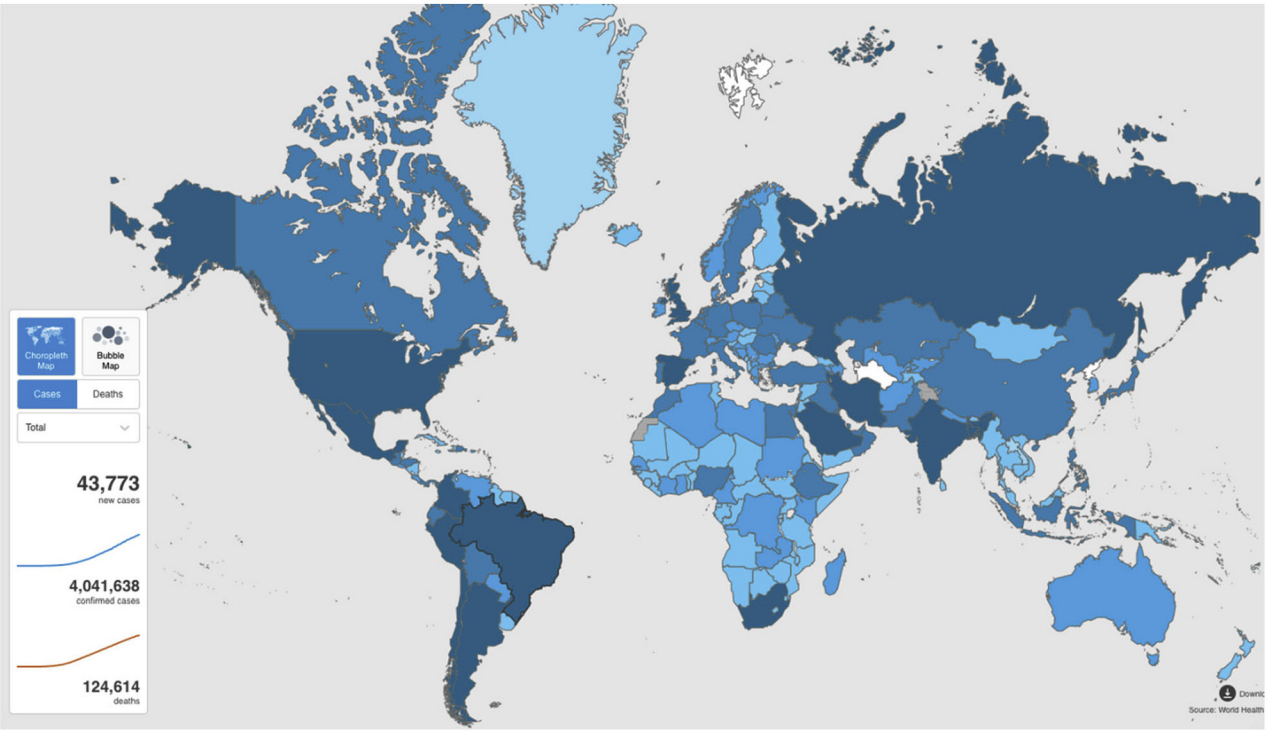

Figure 2. COVID cases worldwide as of September 5, 2020. Reprinted with permission from the WHO.[1]

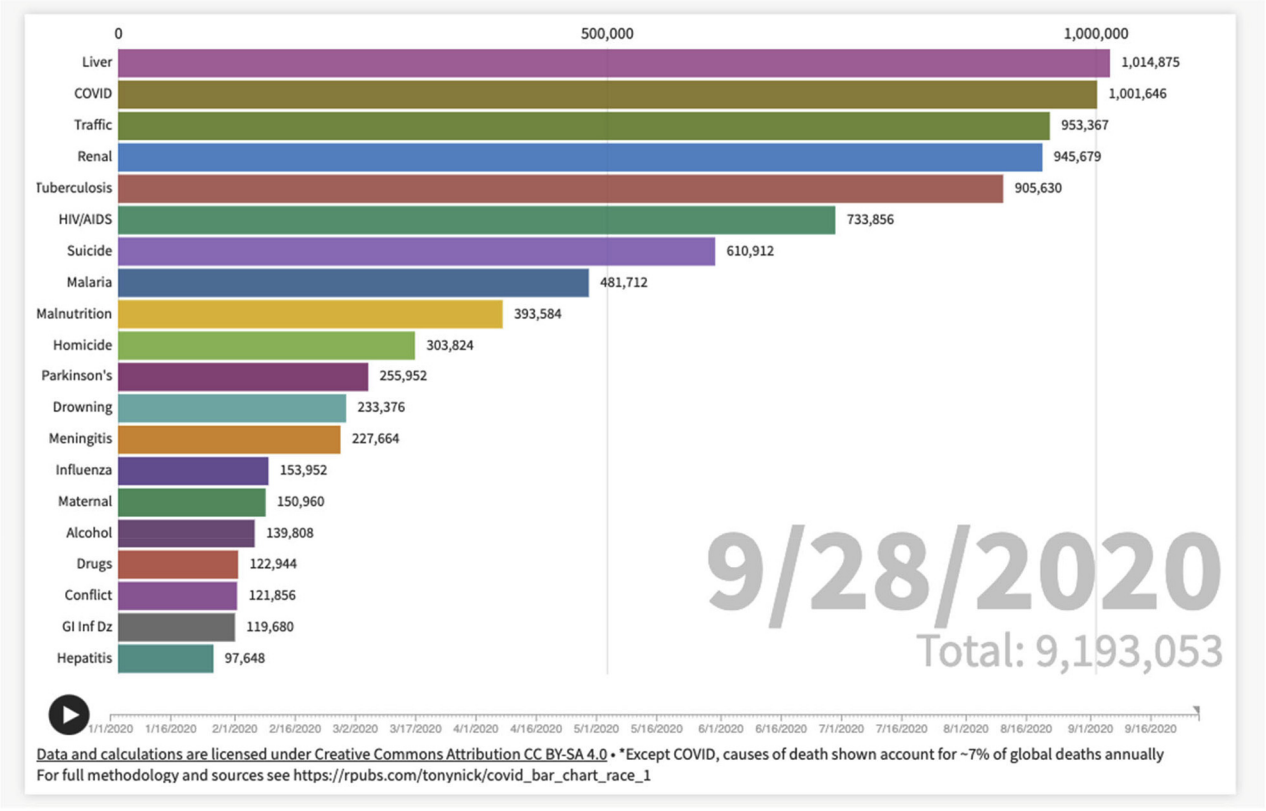

Figure 3. Global death due to COVID and other major diseases, as of September 28, 2020. A bar chart race, reprinted from by Flourish team and Tony Nickonchuk,[3] with permission.

management of hyponatremia, after all this work, will I be undone by a savage, single-stranded piece of RNA?"[8] Indeed, as the essayist goes on to say, "I am not immunosuppressed or pregnant or chronically ill or elderly. In the absence of these conditions, does my profession now demand that I embark on a fearless

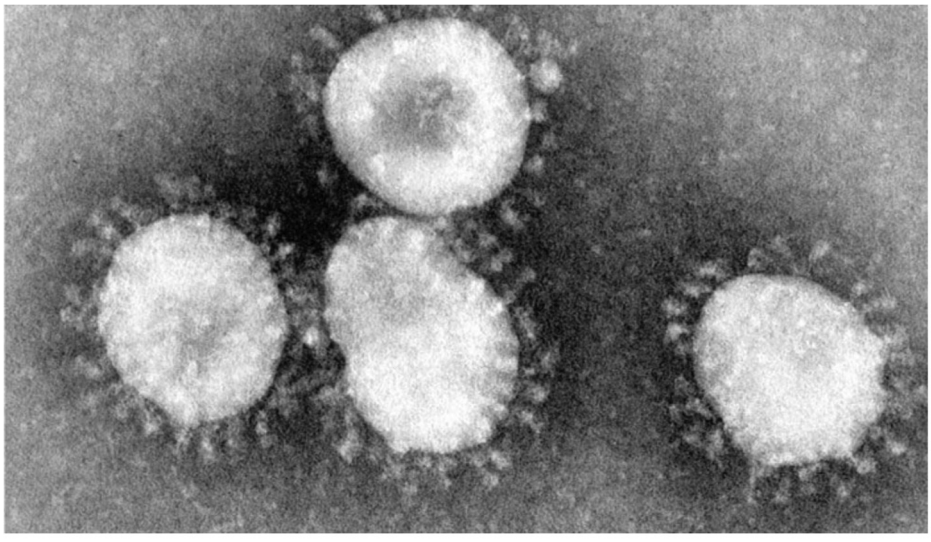

Figure 4. Coronovirus electronmicroscopy images, courtesy of CDC/Dr Fred Murphy.

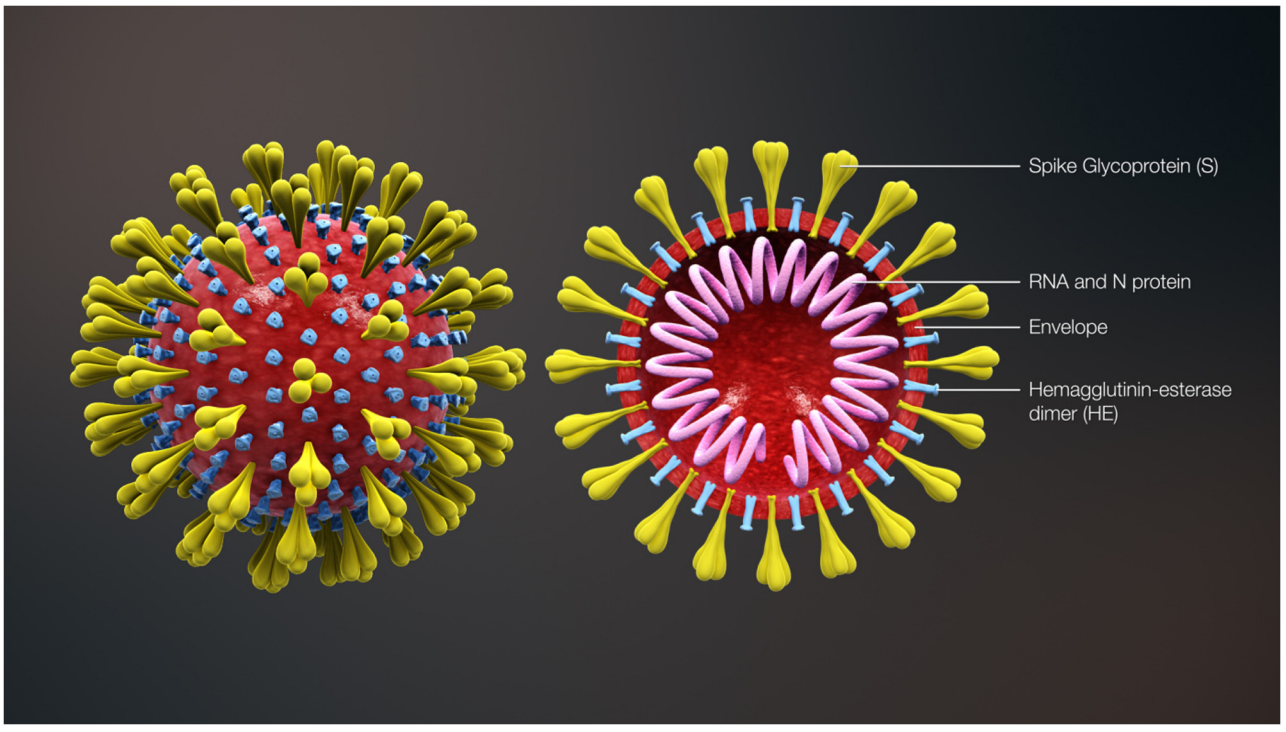

Figure 5. Coronavirus cartoon depiction.[4] Reprinted courtesy of Scientific Animations.

unwavering sense of duty—but I don't want to be a tragic hero. I didn't sign up for that."

I am not comfortable with this. . . .

But like this author, we have found a way to manage these anxieties, fears, and guilt, and bob along through the flood of information on this pandemic. Some may try to find a profound meaning in this anxiety, but most will simply try to survive, one step in front of the other.

This pandemic has reminded us all of our responsibility as physicians and healers, and brings home the common theme of medical school applicants saying, " I want to help people" as justification for entry into our profession. Lisa Rosenbaum, the well-known correspondent for the *New England Journal of Medicine,* has written, with sincere angst, about the heroes that will shelter in place, including herself.[9] Acknowledging her lupus and immunosuppressive therapy for that disease, and following the pleading of her mother, and the admonition of her family, she stepped aside. As she beautifully writes, "Clinicians on the sidelines must confront not only shame and guilt, but also the loss of their primordial story. Who are you, if you can't be the hero you imagined yourself to be?"

Howard Bauchner, editor of the *Journal of the American Medical Association*, recently commented that 2020 will be a transformative year of the 21st century.[10] Like 1776, 1865, 1941, all of the 1960's, and 2001, it is a year that will be written about, taught in school, and become part of the collective memory of the people who lived through it. It has already reached into our vernacular as a response to the simple question of the greeting "Hi — How are you?" to which I can relate to the response: "I am 2020," meaning: lonely, depressed, isolated, angry, anxious, on edge, thankful, grateful, worried, unsure, unsettled, and restless and bored—all at the same time.

The 18th century philosopher, Immanuel Kant (1724—1804), is widely considered the central figure in modern philosophy; he wrote of the need for societies to have "the moral law within." Without a common sense of what is "right" or "just," groups will fracture, and the fragments will wander, and the basis for a just society will be lost.

Our chosen field of medicine is defined by the sense that we are committed to promoting the science and art of medicine and improving the health of the patient, and the public. Within the background of the tumultuous events of 2020, we are forced to acknowledge that the traditional lane of medicine must be much wider and must encompass our role in the fabric of society. As Don Berwick noted in a recent essay in *JAMA*: "Healers are called to heal. When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so."[11]

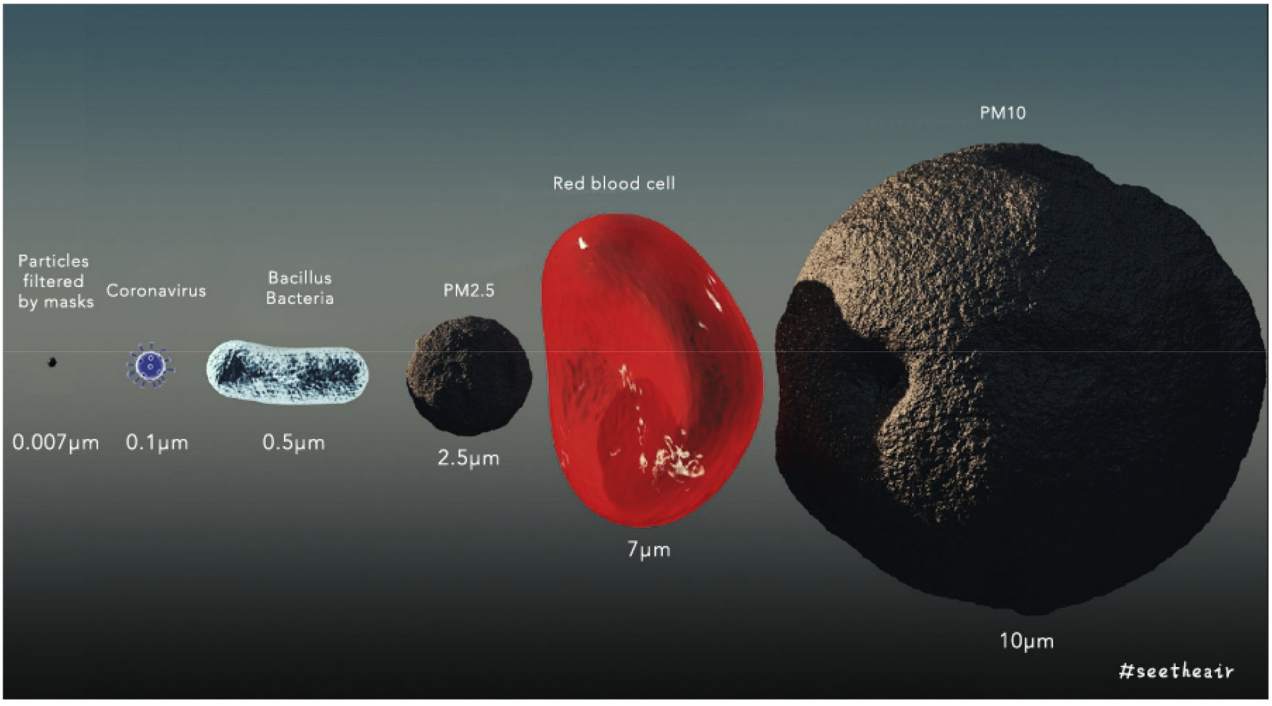

Figure 6. Particular matter and corovirus size. Printed courtesy of the artist, Sotirios Papathanasiou; #SeetheAir.

Not my responsibility

Within that context then, where does the phrase, "I am not comfortable with this" fall? How many times have you answered a transfer center call from a sending "provider" from another hospital with the statement, "Our surgeons are not comfortable taking care of this patient"? thereby justifying transferring to yet another hospital, with family dislocation and patient expenses ignored. Or how many times has your emergency room tried to find an admitting physician for a patient and heard the response, "No, not my service, I am not comfortable with that," prolonging the emergency department stay, searching for an admitting team, and creating infighting within your hospital staff?

Who **is** comfortable in 2020? Where did this phrase come from? What does it mean? Where does it fit in our role as physicians? Did Halstead, Cushing, or Osler ever utter this phrase? Many of you, I am sure, have seen this phrase taking hold in the clinics, hospital corridors, and the halls of medicine. It seems that whenever confronted with the challenging, the inconvenient, the undesirable, the underinsured, or maybe just when overwhelmed with a new-found anxiety, our colleagues and peers have begun to utter the phrase: "I am not comfortable with. . . . ."

Jackson Salvant, a neurosurgeon in Virginia, penned a piece on this topic last year on social media that caught my eye, and made me realize I was not the only one peeved by this statement.[12] As Dr Salvant noted, upon utterance of this simple line, all responsibility to the patient, or the honorable practice of medicine is immediately and completely absolved, and the responsibility and burden, however small or large, must come to rest on someone else. The phrase, "I'm not comfortable with this" has become so powerful that it leaves no room for question. Instead of the phrase explaining a lack of ability, knowledge, or training, we now deftly wield this phrase and produce an impenetrable shield against all that is unwanted, difficult, unpleasant, or just inconvenient. It absolves responsibility.

Of course, this is not a shield raised only by fellow physicians. It is the perfect defense for anyone who is stressed, burnt out, or doesn't wish to be bothered with a difficult problem or additional work. It is now heard from nurses to the super-specialist who, perhaps, may be using it as a way to avoid caring for the most challenging, common, and least rewarding conditions in medical practice—at least at night, on weekends, and for the uninsured patient.

Perhaps this is a matter of defensive medicine. Defensive medicine may motivate doctors to request more consultations to limit liability and responsibility, referring to different specialists for each symptom, with the thought that once a referral is made, responsibility is pardoned.

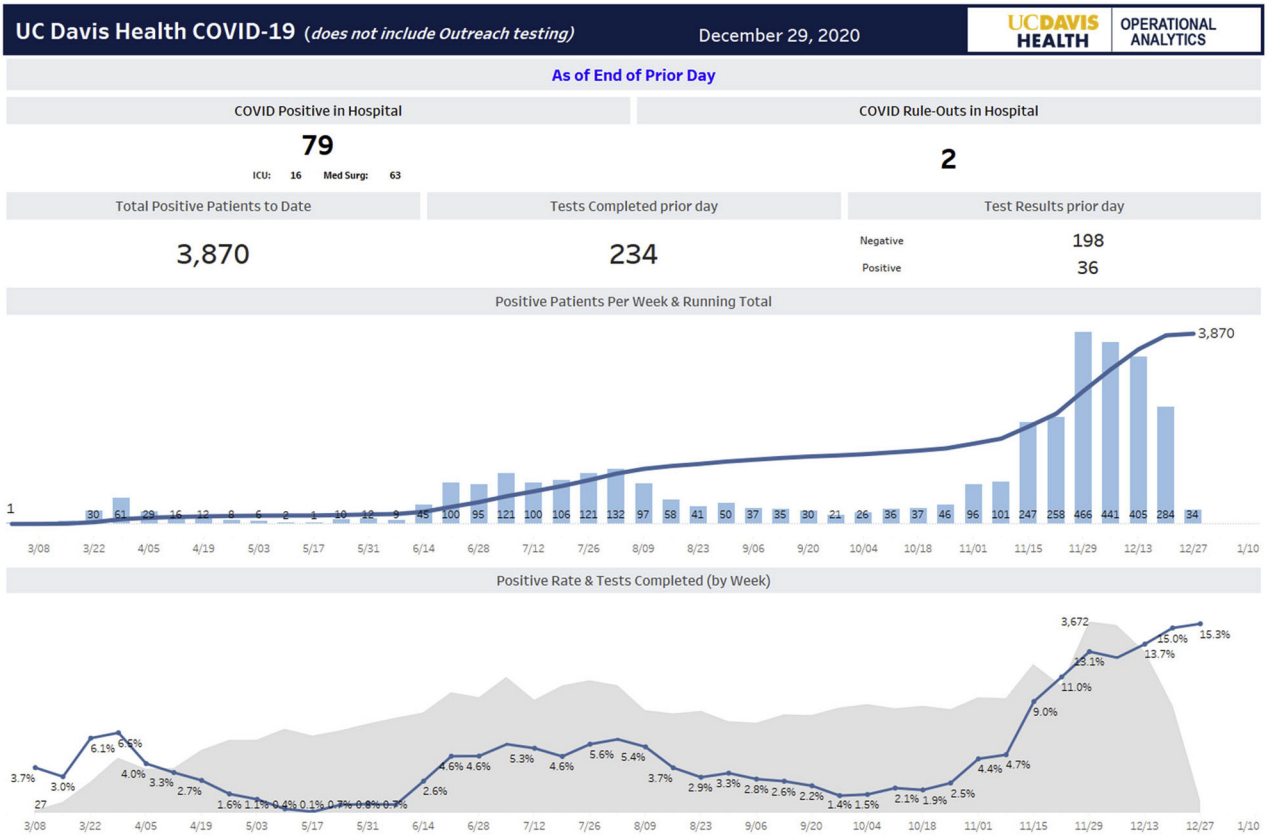

Figure 7. University of California, Davis COVID monitoring system as of Dec 29, 2020. Reprinted with permission from UC Davis Medical Center.

Difficult patients are placed on a referral merry-go-round, seeing one specialist after another without any clear plan or treatment. To be clear, I don't think this the primary driver of the ubiquitous use of this phrase, but it might be a component.

Perhaps it is the demand or expectation for perfectionism, or a fear of making an error, or even succumbing to the demand of some patients that if a super specialist exists in this area, then that care must be sought out. Every symptom must be assigned to a specialty, and consultation must be obtained for each item on the problem list. The hospitalist or emergency room physician or indeed, the modern acute care surgeon, becomes little more than a triage specialist. It is little wonder that medical care has become so disjointed and expensive.

Loss of professionalism

Can it be that no one is comfortable anymore, and the net effect has been an insidious growth of apathy among doctors? This may be our professional example of the behavioral science of risk aversion. Drs Collins, Shin, and Hanley, congenital heart surgeons writing an op ed in the *Annals of Surgery* recently, celebrating the risk-taking innovation by intrepid surgeons in the development of congenital heart surgery.[13] But they likewise decried the loss of risk taking by modern hospitals, brought on by grading systems and rankings, and spilling over into surgeons avoiding risk to maintain the status quo and excellent score cards. They argue convincingly that this will eventuate in the loss of skills, loss of innovations, and eventually, loss of lives.

Marylene Gagné and Ed Deci, well known Canadian and American psychologists, who have largely defined motivation and education theory, posit that there are 3 pillars that support a professional's intrinsic motivation and psychological well-being: autonomy, competence, and relatedness or sense of belonging.[14] Many have argued that all 3 have been stripped away as a direct result of the restructuring of the healthcare system.[15]

Perhaps the phrase, "I am not comfortable with this" is a direct result of the loss of these 3 pillars. Are we no longer autonomous? Are we no longer competent? Can we no longer relate to a system or feel like we belong and have personnel attachments to our patients and our workplace? Doctors used to want to give patients the

time and support they needed, and they want the system to value and recognize their efforts to provide this kind of care. While much lip service is given to the phrase "patient-centered care," many doctors feel that the system is increasingly driven by money and metrics, with rewards for those who embrace these priorities rather than the patient-doctor relationship.

Well, I am not comfortable with that.

To be sure, there have always been physicians who found ways of avoiding extra work and unpleasant patients, but the change we are experiencing today is much more widespread, in my opinion. Examples abound in the creation of boutique medical practices that are, in essence, simpler and more profitable. We bandy about the descriptor as a "more balanced lifestyle," but at times, that simply seems like code for "an easier job." And when all physicians opt for "easier," we surely have a problem. And perhaps that is what we are seeing. Medicine is now a job, not a profession, not a calling

Carl Hauser expounded on this risk in his most eloquent Western Trauma Presidential address in 2017 entitled, "Ownership."[16] In that address, he outlined the corporatization of healthcare and the loss medicine as a profession—a profession honored and loved by the public and idealized in the heroic images of Ben Casey and Dr Kildare, and even Hawkeye Pierce. Dr Hauser argued that physicians have been forced to change as people. Medicine was once a bastion for humanism, and surgery was a bastion for charismatic individualism and creativity.

Like anyone mulling change, there is a nostalgia for the way things were, overlooking to some degree, what was bad. But do you look back on your training and entry into medical practice with horror, or with affection? The enormous humanism of those experiences has been replaced by bland corporate conformity and a profound lack of personality. It is now work, a job, no more than that. Our demeanor and personality are now narrowly defined in the name of "professional behavior," codified under the mantra of "compliance performance," and as Carl says, enforced by the corporate cudgel of "H.R."

So maybe that is the reason for the phrase, "I am not comfortable with this." Perhaps it is a combination of I don't want to do it; I don't need to do it; and it is not my job. Gagné and Deci[14] would say we have lost our intrinsic motivation and well-being. Or maybe it is simply the truth, that we are no longer competent and trained and able to take of many simple health problems. If that is the case, are we, as a profession, comfortable with that?

Training reality

Is this phrase simply a way of saying, "I don't know how to take care of that problem. I was not trained to take care of that problem. I don't have the confidence I need to take care of that problem." Evidence that this might be the case can be found in the plethora of publications that decry the incomplete preparation of general surgery residents, and the onslaught of fellowship training in narrowly focused fields.[17,18]

Some have called this a crisis of autonomy. Autonomy, from Greek autos, meaning "self" and nomos meaning "law." Essentially, self-governing. Or one of the pillars of motivation and well-being. The drive to be the origin of one's behavior and to exercise free will in choosing one's goals. As this applies to surgeons, this translates into the ability to provide quality care, in and out of the operating room, without hand-holding oversight. So how "autonomous" are new graduates?

One recent paper, shown here from Procedural Learning and Safety Collaboration, measured the readiness of chief residents to function independently, with "supervision only."[19] They had a large sample pool, a well validated measuring tool, and focused on what we would general classify as straightforward and common procedures, namely cholecystectomy, inguinal hernia repair, appendectomy, ventral hernia repair, and partial colectomy. Remarkably, only 33.3% of chief residents were judged to be capable of independent performance of these procedures. Can this be true? Are only one-third of chief residents ready for practice?

This is supported by our own College's move to develop a transition to practice program, in large part to prepare general surgery residents to function autonomously.[18] It is also true that most fellowship program directors do not find graduating general surgery residents prepared to function autonomously, as illustrated in a paper from the American Surgical Association.[20] Program Directors of the Fellowship Council were queried. Twenty-one percent believed that new fellows were unprepared for the operating room, 38% demonstrated a lack of patient ownership, 30% could not autonomously perform a laparoscopic cholecystectomy, and 66% were deemed unable to operate unsupervised for 30 minutes during a major procedure. The major qualitative data revealed deficits in the domains of operative autonomy, progressive responsibility, longitudinal follow-up, and scholarly focus after GS training.

So, it is no wonder that 80% of graduating general surgery residents go on to do a fellowship. In this classic report, Heather Yeo, the American Board of Surgery, and Dick Bell, virtually every categorical resident responded (it was part of the in-service exam).[21] Many residents were indeed concerned about their own ability to operate autonomously, with more than 60% feeling they needed more training to safely and effectively

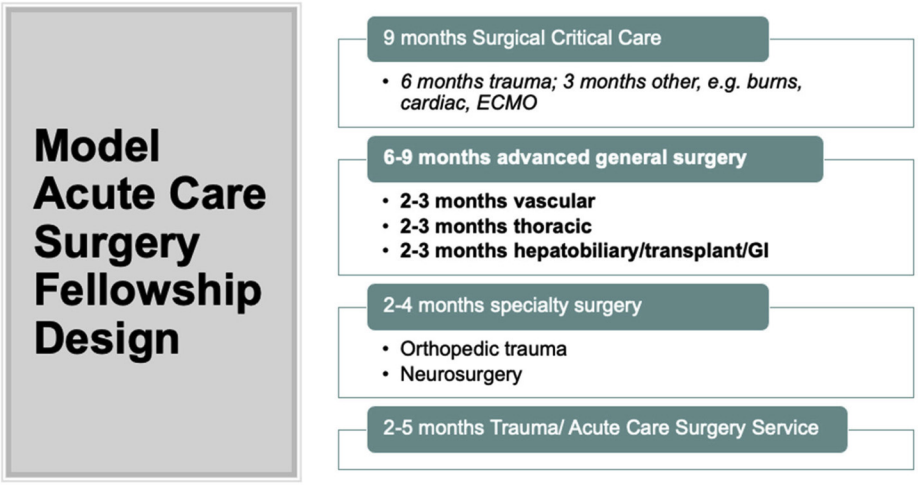

Figure 8. Model training paradigm for acute care surgery. ECMO, extracorporeal membrane oxygenation.

practice autonomously; a strong majority believed they must be trained in specialty surgery to be successful, to be competitive, and to have the lifestyle they want.

So, what exactly is it that drives this push to specialty training? Is it a sense of incomplete or inadequate training? Is it a fear of operating autonomously after general surgery training? It is clear there are patient issue and demands, with our own Bulletin suggesting patients will prefer a specialist, if they have a choice.[22] Perhaps it is also driven by volume performance data, the incessant scoring of doctors and hospitals, and advertisements by big pharma and doctors themselves. But the patients are also saying doctors are less caring, less professional, less available, and act more as service providers than professionals. The idealized version of the physician of the last 100 years is certainly changing.The net result, of course, is the salami slicing of general surgery. But this is not just true of surgery, it is true of all fields of medicine. While there are many drivers of this tsunami of specialization, and the resulting reluctance to care for anyone outside of that narrow focus, I submit that there are 3 main drivers affecting us now.

First, the resident application pool is different now than it was at any time in the past 100 years, and new surgeons expect different things from a career in medicine. I am, however, hopeful of many qualities of the millennials, those now in medical school and early residency, for they have the characteristics of being civic-minded, with a strong social consciousness and environmental awareness, recognize global citizenry, and are entrepreneurial. I have great hope for them, as should you, for they are our future, they are our hope.

Secondly, while training work hours are more humanely limited, they come with unintended consequences, including loss of ownership, frequent hand offs, missed rare opportunities, and loss of autonomy. This could be fixed by simply allowing chief residents in the surgical specialties to bill for Medicare/Medicaid services; or perhaps with enforceable and valid milestones in training progress. But neither seems imminent. We have work to do in this area. But mostly the trend to specialization is, I think, because of us, the mentors and the teachers. The vast majority of surgical educators today are super—specialists. And the numbers 1 and 2 drivers of career choice for today' trainees are mentors and lifestyle.

I am not comfortable with this. For where does this leave us, the trauma and acute care surgeons of the 21st century? Halsted thought that every hospital of merit should have at least 1 surgeon who can operate on any patient, any problem, and care for the sickest of patients. Many Scudder orators, including the Detroit icon, Dr Alexander Walt, have argued that the trauma surgeon must be that complete surgeon.

In his 1978 Scudder address, Dr Walt centered on the thesis that no surgeon has a greater need of a broad and rigorous training that those who declare themselves to be trauma surgeons. He admonished that the increase in scientific knowledge is no justification for a diminution in our range of interests as we pass into practice.[23] Dr Walt wrote and spoke eloquently, and I suspect he would be aghast by the phrase, "I am not comfortable with this" from any of his colleagues. He recognized the frightening fracturing of patient care, with these words: "The injured patient, propelled past a stellar array of super-specialists without the services of a galactical surgical pilot, may be needlessly lost in eternal darkness." What if we, the trauma and acute care surgeons of now and tomorrow, started saying, "I am not comfortable with this" as we

encountered a new patient in the ED, and began asking for someone else to take on this responsibility of care? One might argue for, or imagine, many changes in medicine and surgery that might alter this seemingly inevitable outcome of salami slicing, depersonalization, and deprofessionalization of surgery. Here are a few:

- Perhaps general surgery training programs must exist in isolation, without any specialty fellowships in the same institution.
- Perhaps more rural or large town hospitals should have general surgery training programs.
- Perhaps EMTALA (Emergency Medical Treatment and Labor Act) should be changed to alter the ready transfer of any medical problem to a hospital with supposedly more resources.
- Perhaps funding of medical care should change to discourage the plethora of consults and their fee for service.

You, in the audience, will, of course, have your own ideas and dreams and fantasies on this solution. I would like to propose one other that I believe we have the most control over, the most reasonable possibility to change, and that is the enhanced training paradigm of acute care surgery (Fig. 8). As originally proposed, acute care surgery training was to be a 2-year, post-general surgery fellowship, and would incorporate surgical critical care, trauma, and emergency general surgery, and bolstered or enhanced training in the management of vascular emergencies, hepato-biliary problems, and thoracic issues.[24] We must return to this model. The convenience of have a "pretending" fellow who simply functions as an additional person to take call, with minimal or no direct education or help or expert assistance is all too common for most of the second year of this fellowship, and I think we can, and must, do better than that.

To be sure, time on key nontrauma clinical services and exposure to patients with vascular, thoracic, and hepatobiliary issues has been severely hampered by our specialty colleagues in those clinical arenas denying access to these cases, typically under the defense of having to train their "own" fellows. This must stop. We must find a way to train acute care surgery fellows so that they are comfortable with the broad array of surgical diseases that populate their consult list. We must make this happen if we are to remain the galactical pilots, or the complete surgeon, or even the one, last group of surgeons who will not say, "I am not comfortable with that."

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