

**PAST PRESIDENT THOMAS SCALEA, M.D.**

DR. LIVINGSTON: When did you decide to go into surgery—into general and trauma surgery, specifically?

DR. SCALEA: All right, I will tell you the truth.

DR. LIVINGSTON: That's the idea of these interviews: separate the truth from the mythology or revisionist history.

DR. SCALEA: I never intended to go to medical school. I intended to go to graduate school in experimental psychology. I had a deal worked out with a professor to go into his lab and be his graduate student.

I took the MCATS and applied to medical school on a dare. One of my friends who wanted to go to medical school said, "I bet I can get in and you can't." It was a challenge and so I did it. I took the MCATS completely hungover and actually did pretty well. When all was said and done, I got into one medical school and they turned me down at the graduate school [I wanted/intended to go to]. When I called the professor who promised me a lab job he said, "Oh, yes, things changed. I guess I could have, should have, called you."

I was working in a factory at the time. So, it was either go to medical school or continue to work in the factory. "Hmmm . . ." Medical school seemed like a good idea.

DR. LIVINGSTON: Did your friend get in to medical school too?

DR. SCALEA: He did.

DR. LIVINGSTON: It would have been even more ironic if he did not.

DR. SCALEA: I went to medical school and I generally didn't like much at all. I did like medicine [though], and I loved the MICU, which I did as a fourth-year medical student. I hated surgery, mostly because the two surgical rotations I did were in thoracic surgery where the attending thoracic surgeon hated medical students and gyn-oncology, which I thought was the world's most depressing rotation.

After I did the MICU I decided I must want to be an internist, but I had already applied to the last two rotating internships that existed in the country.

DR. LIVINGSTON: Is that because you didn't know what you wanted to do?

DR. SCALEA: Sort of, but it was more that I did not like anything until I did this MICU rotation in the fourth year. I met this guy, A.A. Fowler, who is still practicing, who did a lot of the early work

at ARDS. He is still at Medical College of Virginia and I just saw him again for the first time in thirty years. When I first met him I said to myself, “I want to be like him. I want his job.” But by that time, I only had time to apply to a couple of medical residencies and get the interviews done. I applied at MCV and I applied at the University of Rochester because that’s where I had grown up. I ranked them, but I got matched with this rotating internship at a community hospital in Syracuse. I went there intending to use it as a bridge to medicine, a medical residency, and then maybe to critical care. However, they tried to make me into a primary care doctor and I absolutely hated that.

Half-way through the year, I said, incorrectly, “Well, if this is internal medicine, I hate it.” In hindsight, and with experience, what I should have just done was recognize that I could do internal medicine and use it as a bridge to critical care. But I said to myself, “I must hate medicine, too,” so I picked surgery because it was all that was left to do. I didn’t want to do pediatrics, I didn’t want to do OB, and I didn’t want to do psych. I said, “I guess I’m going to do surgery because it’s the last thing that’s left.” I did a couple of months of surgery as an intern. It was “okay.” So I applied.

DR. LIVINGSTON: You were running out of choices there. Not much left to choose from.

DR. SCALEA: I was totally running out of choices. It’s completely the God’s honest truth, David.

DR. LIVINGSTON: This is a great story that is definitely worth telling.

DR. SCALEA: I applied to a couple of places and I got a job at Upstate right in the same town. I started as a PGY-2. The first thing I did was transplant, right in the first month, in July. I completely fell in love with transplant. Completely fell in love, mostly because I met this guy, and I said to myself, “I want to be like him.”

DR. LIVINGSTON: Who was it?

DR. SCALEA: A guy named Richard Burleson. I loved taking care of sick people. That part had not left me so I spent a lot of time in the ICU, and as you know, the transplant patients were really sick back then.

DR. LIVINGSTON: That was just doing kidneys, right, Tom?

DR. SCALEA: Just doing kidneys.

DR. LIVINGSTON: But they bombed their immune systems . . .

DR. SCALEA: Oh, yes. Those people would get as sick as a dog.

DR. LIVINGSTON: Yes, it was a lot different than today.

DR. SCALEA: That's right. I mean now it is almost an outpatient procedure. Back then, the patients were sick.

DR. LIVINGSTON: I think our trainees don't quite recognize that these people had no white cells and there was no way to restore them.

DR. SCALEA: Dr. Burluson was great and I was going to be his fellow. A little foreshadowing—there is a theme here. When I was a fourth-year resident, he went away to Boston for two weeks. It turned out that at age forty-two, he had locally advanced lung cancer and had a big chest wall resection. He died when I was a chief resident.

DR. LIVINGSTON: Oh, my word.

DR. SCALEA: I still have a picture of him in my office. That's how close I was to him. I now really needed a job. I decided I was going to go into community practice. The Syracuse residency was big on the community guys training us. There was one group I really wanted to join. I waited for them to ask. I waited. I waited. I waited. I waited. Nothing. You know, David, back then there were, like, maybe two or three trauma/critical care fellowships.

DR. LIVINGSTON: Yes.

DR. SCALEA: One of the trauma fellowships was in Houston—Ron Fisher's.

DR. LIVINGSTON: Didn't Parkland have one?

DR. SCALEA: If they did, I didn't know about it. So I called Dr. Fisher and he said, "I would love to have you come down." Then he called back and said, "No job." The hospital pulled the funding. It was now the fifteenth of May and I would be unemployed in six weeks. Then this guy named Norm Ackerman, who was in NYC at Metropolitan Hospital at 93rd Street and 1st Avenue, called me up. He had been in Syracuse and was now chief of surgery at Metropolitan. He called and said, "I hear you are unemployed." I thanked him for reminding me. He said, "Well, you know, we've got this fellowship. You used to always like taking care of sick people and we've got this fellowship." I didn't even know it existed. He said, "One of the people we had just dropped out. Are you interested in the job?" So again I said to myself, "Let's see, unemployment or fellowship? Fellowship seems pretty good."

DR. LIVINGSTON: There was always going back to the factory . . . . So what year was this?

DR. SCALEA: Yes, there was that option. It was 1983. I finished in 1984 as one of the very, very early critical care fellows. But the story doesn't end there. Over the years, I've stayed in touch with a bunch of the community surgeons in Syracuse. Somewhere between five and ten years ago, I was

back up there giving grand rounds and one of the surgeons from the group said, “You know, we always wanted you to join our group.” I said, “Well, why didn’t you ask me?” He said, “No, you were supposed to come to us and ask for a job. We were waiting for you to come.” Had that happened, I likely would have been a community surgeon in Syracuse, New York.

DR. LIVINGSTON: Well trauma would have lost a great surgeon and role model. The story does remind me of when you’re in high school and waiting for the phone to ring for that date on a Saturday. “No, you were supposed to call me.” “No, you were supposed to call me.”

DR. SCALEA: That’s how it all happened. I finished the fellowship at Metropolitan and, again, I was looking for a job. I had fallen in love with New York City. I really wanted to stay in New York. So I looked for a job in Manhattan but they were all really terrible, just junk. Dr. Del Guercio came [to me] and said, “I want you to go down to Brooklyn and look at this job at Kings County.” I said, “Oh, come on, Dr. Del Guercio, I don’t want to go to Brooklyn.” Of course, I’d never been to Brooklyn, but I knew I didn’t want to go there. I said, “Manhattan is where the cool people are. That’s where I want to be.” I still remember this clearly, like it was yesterday—God rest his soul. You know, Dr. Del Guercio just died a couple of years ago—Dr. Guercio just shook his head.

He looked at me and he said, “Let me ask you a couple of questions.”

“Yes, sir.”

“Do you own a car?”

“Yes, sir, I do.”

He said, “Do you have a set of maps?” (This is well before the days of computers and GPS.)

“Yes, sir, I do.”

He said, “Do you think you could find Brooklyn on those maps?”

I said, “Yes, sir, I think I probably could find Brooklyn.”

“Then why are you still standing here?”

So I went down, walked into Kings County Hospital, took one breath, and I said, “This is where I want to be.” And on my way to “the County,” I had driven through Brooklyn Heights, and I said, “Oh, my God, what a cool place. I mean, what a fabulous place to live.” So I moved to Brooklyn Heights and went to work at the County.

DR. LIVINGSTON: For the people who don't know you well, like students and trainees, when you say you fell in love with New York, it is interesting because you just seem like the archetypical New Yorker. Like you were born and bred somewhere in the boroughs, not in upstate New York.

DR. SCALEA: Yes.

DR. LIVINGSTON: Of course, now you can't get people to leave Brooklyn to come to Manhattan.

DR. SCALEA: That is correct. I could not afford my apartment today. I bought it for about \$370K back in the '80s and I sold it for \$550K about thirteen years later, and I said, "Boy, I made a killing on that." Two years after I sold it, it was appraised at a couple of million. Another example of timing in the wrong direction.

DR. LIVINGSTON: You got into trauma surgery basically through the critical care medicine aspect of it, which is different from a lot of others. They wanted trauma—with the bleeding on the floor and the severe injuries—first. We mostly think of trauma first with the critical care aspect just coming along for the ride. Again it follows your nontraditional pathway. It is especially interesting given your position now, as the head of one of the most internationally known trauma centers in the world.

DR. SCALEA: Yes. It is just the way life and things turn out.

DR. LIVINGSTON: You mentioned some of your mentors, such as Dr. Del Guercio. Are there any other people who helped to shape or guide your career? Mentors?

DR. SCALEA: Well, Gerry Shaftan. Gerry left the County about the time I got there, but he was still hugely influential in my life. And Sal Scalfani. Sal and I were colleagues. We were the two Italians from Brooklyn, but we were sort of mentors for each other, I guess. When I got there, the chief was only two years older than me. There was no seniority. We just figured it out as we went.

DR. LIVINGSTON: Doing these interviews and hearing the stories . . . it seems that in many departments and divisions around the country there were these little, mini "golden ages." A time when the people and places just came together for a couple of years, for whatever reason, and magic happened. Sounds like some of your time at the County was like that.

DR. SCALEA: Yes. Definitely.

DR. LIVINGSTON: What did the other people in your department think about you trauma/critical care guys at the County? Was your specialty viewed a stepchild? It wasn't cardiac or thoracic. It wasn't oncology. Or did anyone even think about it?

DR. SCALEA: When I was in Brooklyn?

DR. LIVINGSTON: Yes.

DR. SCALEA: At the County we were considered the bozos in the back of the building. The residents knew better, though, and loved it. When I got to Kings County we were busy, but three years later, the crack wars came. Then we were really, really, really busy, and the residents loved it even more. At that time there were eight chief residents in the department. Only four of them got to do trauma and they fought over it. Despite that, when you were the chief on the trauma service you were in the hospital all the time. You literally moved in and you were on call for three months. No one could conceive of an 80-hour work week. What we would usually do on Sunday afternoon, whoever was the on-call attending would send the chief resident home so they could eat a meal that wasn't from the hospital, do whatever needed to be done at home, get some clean clothes, and then they'd come back Sunday night. Because we were operating literally twenty-four hours a day, seven days a week. The residents loved it and thought it was great.

On the other hand, the rest of the faculty had zero interest in playing. As a matter of fact, when we went down a faculty person and said, "Wouldn't it be nice if somebody would take Sunday call or a Tuesday call," they informed us that while they were perfectly capable of doing trauma, they chose not to do it. So yeah, we were really sort of isolated.

Again, back then in the 80s, the residents ran the general surgery service at the County. You could rarely find an attending. We ended up doing a lot of general surgery because the residents would come and say, "I'm sure I'm fine to do this, but you're not going anywhere are you? Could you walk into the OR in about an hour?" We did. Then I started a practice over at the University Hospital across the street and did general surgery there. Over the course of fourteen years I became the busiest general surgeon on campus.

DR. LIVINGSTON: Let's switch gears a little bit. Of all the many things you have accomplished or championed in your career, what couple of things you are most proud? Scientific? Programmatic? Whatever you want to talk about.

DR. SCALEA: The single thing that I am the most proud of having done, David, is endowing a professorship in my mother's name.

DR. LIVINGSTON: Which is totally cool and amazing.

DR. SCALEA: I know you've heard me talk about my mom and how influential she has been in my life. She has no idea of how cool it is to have an endowed professorship named for her, but I do. As long as there is a University of Maryland, there will always be an Anne Scalea Professor of

Trauma. I am a giving back to the person who gave to me in a way that I recognize as valuable. That, I think, is the coolest thing I've ever done.

I think influencing the way trauma care will be delivered in the future, too. I've done that mostly by training a zillion people that have and will go out and spread the gospel. The training is more, or at least I hope it is more, than how to do a quick hepatic lobectomy. I hope that I have trained them in how to approach patients and how to approach our craft: the absolute necessity of not hiding behind a computer and really sitting down and talking to the patients.

It's interesting that you called me today, David. Deb [Stein] and Stevie Jordan threw me a big party at the Las Vegas meeting when I was the president. About a hundred of the fellows that I had trained came back. They gave me a book where each of them—not all, but many of them—wrote something. I re-read it today. The thing that they wrote that really resonated and made me feel the best were when they mentioned the lessons about going in and sitting on the bed and talking with the patient. Holding the patient's hand and listening instead of talking. Just the willingness to do the right thing when it was needed. I'm very proud that that is what they took away from me.

DR. LIVINGSTON: That is a great gift, Tom. Imparting that kind of wisdom and human approach to patient care for a generation of providers is invaluable. It sounds like a tremendous accomplishment

DR. SCALEA: We did a bunch of cool research and we helped change the way things were done for patients. But as I get older, I'm most proud of how we talked to our patients.

LIVINGSTON: That's a legacy long after the presentation is delivered and the paper is written. That is a true a legacy.

Is there anything you jumped on the bandwagon for or championed that you had to either retract or, in retrospect, say, "Oh, I wish I hadn't done that."

DR. SCALEA: Yes. This whole idea of hyper-dynamic resuscitation which, of course, defined the beginning of my career. It turned out that it wasn't that good of an idea. Made a lot of sense at the time. Oh, well.

DR. LIVINGSTON: You weren't the only one.

DR. SCALEA: No, but we were right there at the beginning of the debate. I remember every time I would present something, I would see Frank Lewis get up and go the microphone and I'd think,

“I’m screwed again.” He would take me to task about my obvious inadequate understanding of physiology. Of course he was right all along.

DR. LIVINGSTON: Forgetting hyper-dynamic resuscitation, what do you think have been some of the advances in trauma/critical care during your career?

DR. SCALEA: There is no question that the whole concept of damage control, though we over-subscribed to those lessons, was a big change. I remember, David, being in the bar one year at EAST (the place where I spent most of my time at EAST)—it was me, and John Morris, and, I don’t know, [Mike] Rotondo, and maybe [Bill] Schwab. We were just sitting there late one afternoon going through all of the steps that led each of us to a greater understanding of the physiology of damage control. We were all kind of doing it in some way, but those discussions helped lead to the enormous change in the way we all did business. It stuck, and though we may do it more than we should or some think we should, it was a huge advance.

I think the other big advance—and I will take a certain amount of credit for this one—is endovascular care for trauma. The idea of curing with catheters has been hugely influential in us saving more peoples’ lives, not just doing it with open surgery.

I would say the third big advance we have made in trauma care, even though our understanding of brain injury is still primitive, is in the care of the patient with traumatic brain injury. Just the idea of intracranial pressure monitoring and targeted resuscitation to prevent secondary brain injury.

I guess you could also say the development and birth of acute care surgery was a big step. It rescued a profession that was dying in the early 2000s even though people like you and me have been acute care surgeons for, like, thirty years. We just didn’t know it.

DR. LIVINGSTON: We didn’t know what we were called.

DR. SCALEA: Yes, we didn’t have a label. But many of us—you and me and David Feliciano and Gene [Moore]—that’s what we’ve been our whole lives. Our whole lives. It has always been, “Oh, call him. He’ll take care of it.” “It’s a problem. I don’t want to deal with that. Call him. His service will take care of it.” “Too hard for me. Call him or (now) her.”

DR. LIVINGSTON: So you think the establishment of acute care surgery has been one of the major practice pattern paradigm shifts?



DR. SCALEA: Yes. Though as I said, a bunch of us have been doing it our whole careers. But if you think back, we couldn't give fellowship jobs away in 2000, nationally. Now *I* couldn't get a fellowship; if I had my CV when I was a resident, I wouldn't even interview me.

DR. LIVINGSTON: I don't know. Given your history, someone would call and you'd fall into a pretty good one.

DR. SCALEA: It's better than being unemployed.

DR. LIVINGSTON: "Let's see . . . factory vs. fellowship? Yes, thank you, I'll do your fellowship." Let's switch topics again. Which aspects of your career or practice do you find most challenging or difficult? What, if anything, keeps you up at night?

DR. SCALEA: You mean in my clinical practice?

DR. LIVINGSTON: Yes, this is sort of an open-ended question, so you can answer it any way you want to.

DR. SCALEA: I worry about the future, David, I really do. I just feel, now I know, I'm a dinosaur. I know that nobody will ever run the place the way I run it, for instance. That is okay. But what is not okay is I feel that there is this shift to "It's not my problem anymore" mentality. I don't think that that is a good way to care for patients with complicated cases.

The patient with acute appendicitis on the general surgery side or the stable person with a gunshot wound to the abdomen is not the issue. You do an appendectomy or laparotomy and fix their GI tract. They are going to do well as long as nobody comes in and shoots them a second time while they're in the hospital. Does it matter how we care for those patients? Probably not.

I've got a guy upstairs that recently came in. He was almost our first EPR candidate: Sam Tisherman's "suspended animation" project. He came in with no recordable blood pressure. Had he arrested we would have enrolled him in the study. He underwent bilateral thoracotomies and a laparotomy. He was just about dead for a long time and got a hundred units of blood in the first day. That's not the person that ought to be cared for by a 12-hour shift guy—not in the ICU and not on the trauma service—but that is more or less of what we have said is okay. We have said that it's okay to take care of that person by the hour, by the day, by the week. I just think those patients deserve better than that. I know I am in the vast minority. Many of my younger partners say, "No, no, this is my problem [now], but on Sunday night it's not my problem anymore. It's your problem." I struggle with that because it will be my problem a week later. I will

do it the way I do it until I can't do it anymore. Then I think I probably have to go away because I don't want to watch the aftermath.

DR. LIVINGSTON: Well, we are somewhat dinosaurs. I think you can and you have inculcated that concept of care for these specific patients in your trainees. The messages they left you [in the book they gave you] indicate that. I'm very proud of my partners for doing and taking that on. But it's hard.

DR. SCALEA: It's a complicated; it's a complicated thing to do.

DR. LIVINGSTON: So, do you think that this is the greatest challenge facing trauma and ACS?

DR. SCALEA: Yes, and I guess the other thing . . . You asked me what keeps me up at night.

DR. LIVINGSTON: Yes.

DR. SCALEA: Getting old. I think about it all the time. Am I too old to be doing this? Am I losing my skills? Are people just humoring me? Have I lost it? You know, am I throwing fastballs still? Should I be taking calls? When do I stop? What will I do next? I worry about it. I don't have an answer yet, but I think about it a lot.

DR. LIVINGSTON: I totally get it. I don't know about you, but over the past three to four years even if it's not that busy, I can't sleep in the hospital. I used to be able to fall asleep at a moment's notice and wake right up. I can't anymore.

DR. SCALEA: No. That's right. I toss. I turn.

DR. LIVINGSTON: I find myself reading at two in the morning and finding all sorts of interesting research threads and ideas. I sit and free associate. Unfortunately, I also find I'm worthless the next day, too. You, too?

DR. SCALEA: Yes.

DR. LIVINGSTON: So is that the challenge to ACS and trauma? Fighting the shift-work mentality for those patients who really need our care? What do you think the opportunities are? Are there any?

DR. SCALEA: I think the opportunities are enormous because I think there is a whole bandwidth of clinically interesting areas that are ripe for research where we could lead the charge. The first is bad soft tissue infections. I find those cases to be the most challenging of the ones that I care for. Like any disease, you have simple problems and you will have to drain some butt puss; but bad, acute soft tissue infections are a pretty complicated disease. Sharon [Henry] has taught me an enormous amount about how to take care of them. We now have a couple of people that are writing

like crazy about the information from our database. We are understanding a lot more than we used to.

I think that we've abandoned critical care as a discipline, which I think is a mistake. I think most people sort of do critical care because they have to. But we've really looked at the organization of critical illness, at least in our state [Maryland], and are establishing a network that looks a lot like the trauma network. We built this critical care resuscitation unit and have used it to drive big volumes of patients in of all types, including acute care surgery. So I think that's a place where surgeons really have the opportunity to be leaders but it's in sort of a nontraditional way and it's not what we do all the time. It's not trauma.

I agree in principle with what Andy Peitzman has been saying for years and years, about how we need to get as good as the other subspecialists. I think we need to train better in minimally-invasive techniques and other modalities. We have been one of the leaders with surgeon-performed vascular intervention. I think there are other opportunities to really go out and own another big piece of business. Just like with REBOA, we saw an opportunity, and we went out and captured it. I don't know if we are leading the way, but we are one of the groups of people that are out in front defining these things. I think there are lots of opportunities out there, waiting.

DR. LIVINGSTON: Given all those opportunities, what is your career advice to your trainees and to your young surgeons interested in an academic career? What life-coach advice do you offer them?

DR. SCALEA: I don't know. I know that you have to do what you love doing. I think that there are lots of ways to skin this particular cat—academic surgery or trauma care. Not everybody is going to be in the lab, likely very few of us. Not everybody is going to be a 500-manuscript professor. But there are a huge number of ways to contribute and to get recognized in education and institutional service, particularly now in the era of . . . I don't want to call it "clipboard medicine," but I can't think of a better name. These areas are important to get to better patient care. Jose [Diaz], for example, just became the quality and safety officer for the hospital, the entire medical center, for all surgical disciplines. It's a big job.

DR. LIVINGSTON: That is a very big job.

DR. SCALEA: It's an important job because if we don't do it then some knucklehead is going to come in and say "This is how we are defining 'quality,'" and it's not going to be anything we

recognize. Those sort of nontraditional tasks are becoming increasingly important and recognized as legitimate in academic circles.

DR. LIVINGSTON: Maybe in some institutions more than others.

DR. SCALEA: Yes. I think you've got to pick your institution, but, yes.

DR. LIVINGSTON: While this generation may not need much life-coaching advice about life outside the hospital, what do you think our generation has to offer the next generation about that, or not? Or maybe we should learn from them?

DR. SCALEA: They need to give that advice to me! But for us, our generation, we need to remind ourselves that it's okay for them to be the way they want to be. We may or may not have been that way [they way they are] or have wanted to be that way ourselves. This generation wants to be that way [to follow what's important to them], so those of us that are still running the shops need to create a way where this generation can be who they want to be, and be successful, without having the wheels come off the bus.

I do tell the younger people, our fellows and the young faculty in the group, that they've selected the world's best job. I just can't imagine what is better than going down and telling some mom that their kid came in next-to-dead and now they're going to be okay. What's better than that? Or leading a team through a complicated set of circumstances and coming up "smelling like roses" on the other side. I think that's wonderful. I totally understand that they don't want to be like I am and they don't want to do it the way I did it. I just hope that they understand how wonderful and important this job is, and [that they] understand what a privilege it is to get to do it—just how cool it is to do this. I hope that they treasure that idea no matter how they are going to do this work. That [feeling] should not change. As well as the recognition that we're really doing God's work here and, Lord knows, nobody else wants to. I hope that they get that part, too. They can do it in shifts. I don't . . . Okay, I do care about this. Eventually, I'll get over it. As long as they embrace acute care for really being as important as we know it is, it will be okay.

DR. LIVINGSTON: That was really well said, Tom, and I echo the sentiment. Another change of topic: prediction time—recognizing that with most future predictions, younger people just get to make fun of you, right?

DR. SCALEA: Of course.

DR. LIVINGSTON: What do you see as the big advances in trauma, critical care, acute care surgery in the next twenty years?

DR. SCALEA: I think that our next big advances are going to be physiologic and not anatomic. I don't think that we're going to find a new way to fix the liver. Maybe we'll do more, but [it will be] more endovascular stuff. I think the next big advances are going to be about the physiologic response to injury and perhaps the personalized approach to it.

DR. LIVINGSTON: Is there anything you'd change in your professional career?

DR. SCALEA: I would have come to Maryland a few years earlier, maybe. David, I've been so freaking lucky. Most people never get to live in "Camelot." Only you and I and a few others [have had that chance]. Most people don't even know what that means, but you and I do. I've gotten to do it three times in my career. Amazing. The original trauma group at the County, and then the Department of Emergency Medicine, and then [I've had] several iterations of Camelot here in Maryland. You have [had the same] in Newark. You know you've built a wonderful group with a wonderful reputation. Most people don't get to do that. Most people, for their whole career, they're kind of "Eh-eh-eh-eh." I didn't do that. I think that's incredibly good, and I am so fortunate.

DR. LIVINGSTON: Anything you'd change on your life outside the hospital?

DR. SCALEA: No, not really. My family has been enormously supportive. I've been lucky enough to be surrounded by people that let me be me. Why they stay is beyond me, but that's just been wonderful. I just feel very, very blessed.

DR. LIVINGSTON: When you finally decide you don't want to take any more calls, and when you [decide to] turn over the keys to "Camelot," what are you going to do?

DR. SCALEA: I don't know. I really don't.

DR. LIVINGSTON: Anything you want to do?

DR. SCALEA: I don't know. I really struggle with this and continue to struggle with it. I just became executive director of the Panamerican.

DR. LIVINGSTON: Yes, I saw that. Congratulations!

DR. SCALEA: Thank you. This idea of international outreach, it's intriguing. I don't know that I want to travel like that, though. Maybe. Or maybe something . . . you know, we're not that far from Washington. [Perhaps] something at the level of national policy, if I have the ability to do that. Maybe.

DR. LIVINGSTON: Well, you clearly make more sense than all of Washington put together. Any last words?

DR. SCALEA: No, I think that's about all, David. This has been great.