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DR. FREDERICK A. LUCHETTE

Tell us how it was that you decided on a career in surgery and then your career decision to focus on trauma surgery.

DR. DAVID B. HOYT

I became interested in surgery because while in medical school, surgeons seemed to have the most fun and had the greatest sense of pride in what they did. Trauma surgery attracted me because you had to think on your feet, you had to respond, you could operate on every body cavity, and you could occasionally truly be participating in a life-saving event. I think my interest in research then derived from that.

LUCHETTE

When was it that you decided on a trauma career?

HOYT

I would say it was probably when I was a PGY-3 or PGY-4 resident. I was asked to be one of the first people to participate in this new innovative course called ATLS. We were actually offering the second or third course in the country. It was during that course and the people that I was exposed to that really helped me make a decision that I had picked the right field.

LUCHETTE

And there was a lot of new specialization going on in surgery at that time. Vascular surgery and cardiac surgery were really beginning to flourish. So how did your peers respond to your decision to go into trauma surgery?

HOYT

Well, I looked long and hard at many specialties, including cardiac. Vascular was just developing as a specialty with specific training but in particular cardiac surgery had a lot of appeal because of its technical side and the quick decision making skills of having to think on your feet with critically-ill patients.

But I had a mentor that really suggested that you pick a field where your interest in research could also be complemented by your clinical interests. At the time, gastrointestinal surgery, oncology, and trauma and critical care were sort of the three areas that were really frontiers to be challenged. And so the one that fit with my clinical interests happened to be trauma and critical care. At that time, there was nothing really understood about the inflammatory response. The concept of multiple organ failure was about two years old. Our whole approach to critically ill patients in the ICU and in the operating room was really new territory. So it really looked like an opportunity to contribute.

LUCHETTE

Who were the particular mentors that helped guide you in your decision making and what influence did they have on your career?

HOYT

Well, I was in a department where the leadership changed and it was sort of a tumultuous time. I had some external advisors that were really advisors because of what they were doing at a national level were attractive.

In particular, my chairman who I worked with for about three years, Marshall Orloff, was very helpful in helping me sort through what was attractive and tailoring that to an academic career. He was very much committed to developing academic surgeons. So the process of consideration was mentored with him, although I would say most of my sort of appeal or icons in the field came from outside my own institution, people like Trunkey, Carrico, and Charlie Lucas.

LUCHETTE

Tell us about the view that Dr. Orloff had of trauma surgery compared to the other new surgical specialties?

HOYT

I would say that trauma was considered something that young people did that was associated with being up at night with call and not surgery that necessarily challenged your technical

skills as much as the other specialties. Orloff saw the research opportunity and developed one of the first trauma training and systems grants in the country. It was really I think our generation that transformed that perception and opportunity. A lot of it was by being exposed to people that were committed to it, that had just come back from Vietnam, so people like Dick Virgillio or Jim Carrico and people like that who went back into academic institutions and really established the credibility of clinical science and the basic science I think helped it, but it was really the generation that was my age that sort of made trauma a special field.

There were no fellowships at that time so you sort of self-declared and then through your academic interests and by focusing your clinical career you declared yourself a trauma surgeon. Most of us did not declare ourselves exclusively a trauma surgeon by any means. But as organized trauma systems developed which, again, started about that time, the identity of the trauma surgeon started to take shape.

LUCHETTE

Tell us about a few of the contributions you are most proud of and how do you feel they've influenced the field of trauma care?

HOYT

I think of the two major contributions that I'm most proud of, one would be in our early work that helped define how to measure performance of a trauma system through the development of quality indicators and databases. We were talking about things that people are talking about throughout the country today, but we were talking about them 25 years ago. And I think the trauma system, the model of accountability, the conversation one has with the public in terms of exposing yourself to verification and ongoing performance measurements, we were really sort of leading in a lot of ways in that area of research.

In basic research I would say the ability to manipulate the inflammatory response, which is still a big question mark, but the opportunity to better understand that and then help develop strategies, particularly with substances like resuscitation fluid, and then the ability to ultimately test those in clinical trials, I am very proud of that as well.

LUCHETTE

Is there anything in your career that you championed and today you look back on and say that was probably not the right thing to be out there waving the banner on?

HOYT

Well, I think there are several things. But you know that's both a true-true and also why it's so important to do clinical trials. Twenty years ago, we thought that intubating patients in the field using rapid sequence intubation would be really important and published a lot of materials suggesting the potential importance of that for patient care. Then we trained people and did the appropriate trial and were not able to show improvement, in fact showed that it actually put some patients at risk. And that taught me how important it is to do a clinical trial.

I think we went through the same thing with hypertonic saline. We had a lot of very significant basic science data from many labs around the country and some preliminary clinical trials suggested that it would really be a panacea for inflammation. And when we did the clinical trial it did not improve mortality and in fact, again, there even seemed to potentially be a safety concern.

So those are the two ideas where at the time, based on animal data and basic science data, there seemed to be a lot of excitement. But in retrospect they were wrong.

LUCHETTE

What you think are the two or three greatest advances in trauma care and science during your career?

HOYT

I think in terms of practice patterns the development of systems of care and the team approach to a critically-injured patient as a prototype for how you should take care of a cancer patient or somebody with complex GI disease or any other problem. We don't have those models yet developed but what we've learned from trauma care and how that can reduce mortality by having an organized system and a team approach is probably one of the most significant contributions that has reduced mortality.

I think another is probably the impact of imaging and its ability to evolve non-operative management of many injuries. I mean that sounds a little strange for a trauma surgeon to be saying that, but when I think of a lot of the things we did 25 years ago that we don't even think about doing today and the results, it's really amazing to see the impact that CT scanning and technology has had on the evolution of care.

In terms of specific care, I think you can look at it in terms of a specific drug or technique like better ventilatory management or the use of a different resuscitation regimen emphasizing less volume. Or you can look at it as the application of process measures, the use of bundles of care, the use of, again, clinical processes that make care consistent. I think both of those have contributed significantly to improving ICU care. So those would be four examples to me that have really evolved over the last 25–30 years.

LUCHETTE

You've done so much in research as well as teaching and administration. What aspects do you find to be the most rewarding and that bring you the most joy at the end of the day?

HOYT

Being associated with a field that was evolving, that developed an identity along the way, that really did seem to make a difference and that you could, at the end of the day, feel that you had really done something to improve patient care. You could feel that on a daily basis working as a trauma surgeon. And with your colleagues and nursing colleagues, that was probably the most satisfying part of my entire career. I would put in there my partners as well, just because

you really can't do this work without great partners.

In terms of difficult issues, I think trauma has always had to push itself against the inertia of a hospital or people who don't want to participate in emergency call or the sub-specialization of fields of surgery where people increasingly got less interested in participating in caring for trauma patients or found them to be economically unattractive. All those things that we continue to worry about and fight for have made it a real frustration and put a target on our backs as trauma leaders. I think some of those things are starting to change but they really continue to be the biggest set of challenges that we have in terms of really all agreeing on what the right thing to do for patients is.

Trauma can often be very time consuming on a particular case. The commitment this requires is not something that some people want to make independent of whether it involves the on-call part. The patient clientele can often times be challenging. I think we're seeing it in people's willingness to participate in emergency room coverage and that kind of thing. But we've seen it for years in terms of not every general or specialty surgeon wants to be part of a trauma program. The conflicts and the difficulties that occur with your colleagues during this time is, in my opinion, the hardest part of being a trauma surgeon.

LUCHETTE

What advice would you give someone who wants to pursue a career in an academic setting practicing acute care surgery [ACS]?

HOYT

I think the most important thing is to be sure that you enjoy the clinical side of trauma and critical care. If you want a successful academic career then it's best to find an area of academic contribution, whether it's in outcomes research, health policy research, basic science or clinical research, that really complements that activity. And then try and become the best at that activity to complement your clinical interests. You can't take away from somebody who really enjoys what they're doing. If they're willing to work hard at it, they will succeed.

LUCHETTE

You advice or guidance for these young folks on how to have a life outside the hospital?

HOYT

Well, I think the biggest opportunity that, again, a career in trauma and critical care offers in that regard is that you have partners and can practice as a team and cover each other and each other's patients so that people can have protected time.

On the one hand, you have to perhaps devote as much or more time than any other group in surgery because of the on-call responsibilities, etc. But if you take advantage of the team it can also be very liberating for people to pursue their outside interests, their family, etc. I think there is real evidence for that in the attractiveness, in particular, to a career in trauma amongst young women. Some are picking it because they realize that they can balance a very

aggressive surgical practice with their interests in their family and other interests.

LUCHETTE

What you perceive to be the greatest challenges and opportunities for the future of acute care surgery?

HOYT

I think the ACS model is evolving. But as physicians increasingly become hospital-based, collapse into groups to cover a particular hospital, ACS services are going to just continue to grow and flourish, just like trauma systems have.

I think the biggest challenge to acute care surgery is to maintain the surgical abilities and interest in some type of elective practice to balance what acute care surgery offers. I think this is something that has been discussed since the ACS's origin. I'm not sure we have it right yet but it's very important that people have an opportunity to continue to develop clinically as a surgeon and really it's essential that they participate in some way in elective practice to do so.

LUCHETTE

What do you think acute care surgery is going to look like in 10–20 years?

HOYT

I think most hospitals will be covered by an acute care surgery team. I think if it's a large inner-city or large academic medical center in a large city where the volume of general surgery, emergency general surgery is such that everybody is so busy with that and trauma and critical care that they don't have time to do anything else other than academic responsibilities, that will be one model. If you go to a smaller community hospital in a large city, it will be a group of surgeons that probably are employed by the hospital but do a combination of emergency surgery and elective practice. And then if you go to a smaller community where there is a mix of so-called rural surgeons; I think our biggest challenge there is to figure out how to support their needs so that they are not disproportionately affected by the call burden and at the same time that their practices are not stripped of interesting cases to keep them interested in rural practice while balancing that with the expertise that is available at larger hospitals.

And I think having a system of care that involves people practicing in smaller hospitals, maybe with some call coverage from a larger hospital's group or an integration with a larger hospital's group, those models that seem to be evolving seem to be successful and will probably be what people evolve to.

LUCHETTE

As you look back over the years, is there anything you would have changed or done differently?

HOYT

You know, I think one struggles to sort of balance with the optimal mixture of your career and your personal goals and life. I started out wanting to be a freelance writer and actually went to film school for about a year before I went to medical school. That has been a recurring interest to me. As to when I am going to start writing, finally, the great American novel, the great American script, I don't know.

Another thing is how to really spend a little bit more time with your family and balance that against your kids and their needs, etcetera. That is very hard when you are running a trauma system and a trauma service. Oftentimes the choice was to do what the hospital or the patients needed. But I think there are better ways to manage that today. I think we've given ourselves permission to be a little bit more realistic about balancing those needs relative to my own generation. And I think I would change those things.

You know, it's really hard when you love what you do because you know most of us in trauma do this because we really love it. I mean there are certainly plenty of things in medicine or outside of medicine that would be a lot easier to do. But the thrill and the excitement for me was always there. Even now I still miss the excitement of being on-call and that kind of thing. I don't miss losing sleep. But once you discover that in yourself, it's very difficult to just find an optimal balance. So I don't know if I'd balance it any better if I did it again.

It's the profession, the opportunity to serve, the opportunity to be involved that has always found a way to eclipse a lot of other choices. And I'm not sure if that's bad or good, it just is what it is for me.

LUCHETTE

What plans do you have for the future clinically, academically and personally?

HOYT

I made a decision two-and-a-half years ago to come and work with the College. And that had to be a thoughtful decision because I knew that I could not maintain a practice and maintain a lot of academic involvement. Although I love those, the draw and the opportunity to contribute at a different level challenged me and I made that decision. So I don't think I will return to clinical practice or academic practice because I'm not sure that I would draw the same satisfaction from it that I have in the past now that I've done something different.

I still participate academically in some things and do some writing. But the challenge for me has been to try and take a lot of the ideas and things that I've learned as a trauma surgeon and try and help apply them to practice more broadly through the American College of Surgeons. That's a daunting task. It's got me plenty challenged. So at least for the foreseeable future that's what I'm going to be doing.

Personally, I looked at getting a master's in a film school in Southern California about three years ago. They have a night school course. And so you know, maybe I'll go do that some time.

LUCHETTE

I want to offer you one last opportunity to make any additional comments that we haven't had a chance to cover?

HOYT

I think an organization like the AAST is really the epitome of a group that is convened and meets on a regular basis to not only foster science exchange but to really foster the essence of what a trauma surgeon is. I don't think you can derive any more personal satisfaction from your career than you can through your professional relationships. The AAST and its sort of companion organization, the Committee on Trauma, are those organizations. I think they have been the forum that we've all looked forward to participating in and contributing to because it really defines who we are.

The only thing that eclipses that in my mind is really knowing that you really helped somebody get better and their families, as a result, have the satisfaction of having somebody that lives or gets better. Those two things—the professional association and the relationships with your patients—are what it is all about.