32

H. Gill Cryer, MD, PhD
President 2003–2004

Dr. David H. Livingston

When did you decide to go down the trauma and critical care pathway?

Dr. H. Gill Cryer

For me it actually developed during medical school. I had a really interesting situation in that I went to medical school at the University of Nevada. When I started it was a two-year school and then you would go to places like Tufts or Washington to finish the clinical years. My year transformed into a traditional four-year school and they hired department chairs for all the clinical departments.

Between my second and third year I got a job doing history and physicals at the VA over the summer and it turned out to be on the surgery ward. About a week after I got there I got this phone call from the dean's office telling me that "The new chair of surgery is coming and wants to make rounds with you at five p.m."

I said, "Well OK, but that's about when I'm leaving." She said, "I suggest you be there." So I'm waiting in the ICU and about 5:30 and then Bob Fulton and Don Fry walk in. I look up and Bob is in cowboy boots and Don is in his traditional black suit, Blues Brothers-type thing and they want to make rounds on all the patients. Of course there was a patient in the ICU with multiple organ failure and here are the professors that wrote the initial papers on it explaining this to a brand-new, not even third-year, medical student. I was blown away. So what happened is I became their resident because *there were no residents*. There were *no*

interns. There was just me and the department chair of surgery for the whole summer and then he arranged it so I had surgery first for another 12 weeks. He also arranged for me to have an externship on the trauma service in Louisville and I just knew right then that I wanted to be a surgeon. Terry Hicks, the chief resident, tucks me under his wing on the trauma team and I just knew that this was for me.

The other interesting thing about it was that Bob Fulton's time in Nevada was quite short—only a year or so, maybe a year-and-a-half—but as you said it almost seemed like he showed up there just to point me in the right direction and then he was gone. I know that I will always be grateful.

LIVINGSTON

So when you decided to do surgery, how was trauma looked at?

CRYER

Well, the University of Nevada was founded to be a rural-type school, putting doctors into rural America. So going into surgery and to be an academic trauma surgeon was not exactly what they had in mind.

On the other hand, once I got to the University of Louisville, as you know, it was a huge part of their culture and it wasn't just trauma. The trauma service at the University of Louisville was really an acute care surgery service before that name was ever even thought about. You'd be doing ruptured abdominal aortic aneurysms and then a gunshot wound to the heart would come in. We did everything. With mentors like Hiram Polk, David Richardson, Lew Flint, Don Fry, Frank Miller, Kirby Bland, Mark Malangoni, Neal Garrison, Rich Mullins, Sue Briggs, it was an incredible training environment and I think that it was very favorably looked on by the people around me that I would become a trauma surgeon.

LIVINGSTON

So what's the best career or life advice you have ever gotten?

CRYER

I can't tell you one single person or event that gave me really good advice but over the years, I have had many people help guide me. It is a general attitude of "when you come to a fork in the road you take it" kind of thing. It will work out. It probably doesn't matter which fork you take, if you just have the right attitude about what you're going to do with the opportunities that come your way. Work hard, learn from everything, keep the patient's interest foremost in mind and keep going. Life tends to work itself out despite the ups and downs.

LIVINGSTON

Now any "less good" advice you received in your career?

Cryer

I thought about this because you had that written down somewhere. The worst advice I ever got was "buy tech stocks" in the '90s. That set me back a bit but nothing that couldn't be overcome.

I think I learned to be careful of people who think they know what is good for you. There are a lot of them. The people who say "Gill, you know what you really need to be doing is—" that sort of thing. I've learned to totally ignore that and to go with my own gut. On the other hand, there are some people you ought not to say no to. Particularly individuals who you work for, your department chairman, division chief, and of course your spouse. If you don't want to jeopardize your career or your home life, when they ask you to do something, I think it's really important to give it a go rather than say no.

Livingston

With all the contributions you've made in the lab and in the clinical arena, what are you most proud of? How do you think it influenced trauma/acute care surgery?

Cryer

As I said earlier, from the very beginning with my exposure to Bob Fulton, the whole idea of multiple organ failure that was occurring in surgical patients when I started was really interesting and has pretty much remained my focus throughout my career. I think that it is extremely rare for any one person to makes some dramatic discovery that really changes the course of clinical history, and I certainly have not. Instead clinical innovation happens in increments by a lot of people discovering a lot of little things. Resuscitation from hemorrhagic shock and multiple organ failure, ARDS and management of pelvic fractures are the areas that I have really felt grateful to have contributed to in some small way.

In my laboratory years, studying the microcirculation in shock and sepsis led me to a totally different way of looking at almost everything. Just by looking you can see a tremendous amount of heterogeneity in what is going on. There is so much going on that it's just ludicrous to think that there is going to be a single mechanism that causes it or a single bullet that is going to fix it.

Livingston

Anything you championed or thought was a great idea that finally decided, "I wish I could take that one back" or maybe, "I wish we had known a little more than we did"?

Cryer

Yes, this one for me is indisputable. It was the whole idea of super normal resuscitation. When I was a resident, we resuscitated patients with 3:1 lactated Ringer's to every unit of blood. I don't ever remember giving anybody fresh frozen plasma. We had all these edematous, swollen patients and all of my mentors said, "Edema is good." That was sort of the prevailing opinion—actually it wasn't opinion, it was gospel. Then this whole idea came along that we

would put a Swan-Ganz catheter in everyone and if we pushed their resuscitation to super normal levels of oxygen delivery they did better. This made us give even more and more fluids trying to make that happen. The number of people we drowned, caused abdominal compartment syndrome, and ARDS—almost all iatrogenic—was huge. It's incredible that it took us over a decade to figure out that that was wrong.

I was out there writing papers saying how good this was, going to conferences, being visiting professor and giving talks about it. It just turned out to be dead wrong. The whole episode reminds me of something Will Rogers once said, "It's not what you don't know that will get you in trouble, it's what you do know that just ain't so."

Livingston

As your career spans mine, I am interested to know what you think are the big practice pattern changes that have occurred?

Cryer

I think that is something that's really interesting because we are in the middle of a great change now and we need to be the leaders in making it change in the right way. The whole idea of acute care surgery and trauma surgeons delivering excellent care while teaching others to do it really depends on being able to create an environment where the young people coming up can excel and yet still not get driven into the ground. The level of commitment and the kind of work that you and I have done in the past, the 36-hours on and 12-off thing for your whole life, just isn't a good work model. It's not good for the patient. It's not good for the residents. It's not good for the faculty, either. So I think as that has evolved we are being forced to figure out how best to deliver that high quality care.

Livingston

What do you think are the two or three biggest advances in trauma care that have occurred in your career?

Cryer

It's remarkable how many there have been. But for me the biggest one is the development of CT angiography. It really changed everything. It allowed us to be able to see what is in the "black box" and know exactly what we have to take care of, which led to different paradigms in managing patients.

I mean, in the old days when I was a resident we operated on everybody that had a red cell on their diagnostic peritoneal lavage. We did so many unnecessary operations that now hardly ever occur that that just has to be huge.

Another one that was pretty dramatic was the understanding of the abdominal compartment syndrome. We always kind of knew it was there but we never really quite got it until we started doing decompressive laparotomies and open abdomens and damage control resuscitation and damage control operations. That was another whole paradigm shift that went

counter to the idea that we're the big hero that goes in and fixes everything in the middle of the night and don't-quit-until-you're-done kind of thing. So I think those are huge for me. Others include interventional radiology, improved enteral nutrition, vascular stents—the list just goes on. There are so many. I mean it's just on and on and on. If you think about all the things that have changed over my career, it's almost a different career now than it was.

Livingston

What is the aspect of your career that you found most, you know, rewarding, gives you the most joy in going to work?

Cryer

Yes, this one is pretty easy. It's taking care of the patients and teaching the residents. Doing a job well. It sounds like cornball stuff, but it's really about the patient. That's what I'm good at and that's why I'm here.

Training residents. We have a great opportunity to be able to pass something on. We are really fortunate in that not very many people in their careers really have the opportunity to train their successors like we do. We are lucky to have a really pretty remarkable job.

Livingston

What part of your career has been the most challenging for you?

Cryer

Well, I think it's the same thing, right? It's the patient that doesn't get well or the patient I can't get well or the resident that doesn't seem to, quite get it—trying to figure out how to be successful more often. I think that is the frustrating part. What I really hate is when I'm in the middle of an operation and it all of a sudden dawns on me while I am working my butt off, that even as everything seems to be going okay, I'm not going to get this patient well, that it's not going to work out. You can just sense that the life energy or whatever just has gone out of the patient. No matter how hard you try in the OR or ICU you just know that it's just not going to end well. That one is a tough one.

Livingston

You have young resident comes up goes, "Dr. Cryer, I want to go into academic trauma/critical care. I want to be like you." What advice do you give them?

Cryer

I tell people to just go with your heart. If you love it, do it because there is really nothing more satisfying than doing what we do. I think they get that. They get that energy. It's interesting to me that there was a span of about 10 years or so where nobody from our program wanted to go do what I do. Then all of a sudden, in about the last five years, about a third to a half of the residents want to do that, which is really quite interesting.

Livingston

Why do you think that is? Why do you think that was?

Cryer

I think it's multifactorial. Sometimes I think it's that I've changed. Maybe I'm feeling happier about life or happier about doing what I'm doing. The residents recognize that and respond. I don't know whether that's true or not, but I wonder about that a little bit.

But also, I think all the efforts that we've made to get this whole acute care surgery thing going, to create an environment where people have some control over their lifestyle. Some people have looked at that negatively and said it's shift work but I look at it in a completely different way. It's the job of a trauma director to design a program where everybody works well together as a team and that you can rely on your colleagues when you're not there so you can get sleep at night, do things with your spouse, have children and actually participate in raising them. At the same time your service becomes respected for being able to solve the tough surgical problems 24/7 and everyone knows they can rely on your team, surgeons and internists alike. That is what has made our field a little more attractive.

That process is one of the things that makes me really proud of the AAST. The germination of an idea which happened maybe 15 years ago and just percolated through many boards of Manager and president after president until it just grew. Like a relay race, sequentially handing the baton off for a good ten years, getting further each time until acute care surgery came to fruition.

Livingston

Okay, now you get to predict what the next big things are going to be in the next decade. How are we going to take care of patients? What are the next big advances?

Cryer

You know I've learned long ago to quit trying to predict the future. First of all, I do think that life gets more complex all the time. It is busier and faster and this affects the diseases, the patients, the doctors taking care of them and the technology we use to do it. The solutions to that will be continual innovation. More computers and simulators and all this stuff to allow us to take care of all that increased complexity. That's sort of on a philosophical ground

I think minimally invasive technology will become the norm even for the bleeding multiple trauma patients and hopefully we will be much better at resuscitating patients.

Livingston

Anything you would change in regards to your professional career?

Cryer

Just like trying to predict the future, there is no point in worrying about the past. It's already done. But all in all I'm pretty happy with the way things turned out. We all make mistakes no

matter what. Luckily the ones that I've made I've been able to circumvent and come out okay. I don't want to brag, but I feel that what I'm doing is the thing I'm absolutely best at. As a result I'm happier doing that than anything else I do. I don't know what more a guy could ask for.

Livingston

Anything you'd change, life outside the hospital?

Cryer

No, I think that's another important thing that I learned along the way. You really have to treat that part of your life with just as much energy and passion as you do your career work.

For instance, you have to make time for children. You treat a child's baseball game or play just like it is an operation. If it's scheduled then you're going to go do it. You learn how to not take the troubles from work home, and that one is a little tough. I guess I could be a little better at that.

Livingston

So what is in the future? What is your next ten-year plan?

Cryer

That one, again, it's hard to improve on what I'm doing now. It's a good question because I've had multiple opportunities to go look at different positions. Maybe chief of surgery somewhere rather than just a trauma director chief and so forth. But I really have found what I'm good at doing and, in some respects, when I think of that it just seems foolish to go try to learn to do something else that I'm not as good at.

Livingston

Any other parting words on the 75th anniversary of the AAST?

Cryer

It's all about the AAST and it's just really important. It's growing and it's doing wonderful things that we've never done before. But I think it's really important that we don't lose what made us great as an organization.

I reflect back on when I was a resident, going to my first AAST meeting and presenting some research paper that we did, scared s---less, and it was remarkable to me compared to other meetings that I had been to how approachable everybody was in the AAST.

All the giants, you could walk right up to them and they'd introduce themselves and they'd talk to you and talk about your research. I remember having discussions with Bill Blaisdell, Don Trunkey, Charlie Lucas, Harlan Stone, and many more when I was just a young nobody. It was just so easy to talk with people and they cared about what you were doing and they would remember you later. It's just not like any other organization that I've been a part of.

So I think fostering that is extremely important and the whole reason behind these interviews is to perpetuate that ideal. That is really a great thing. It is part of who we are. Thank you so much for giving me the opportunity to talk about these things, I really enjoyed it and I feel quite humbled to have been included.