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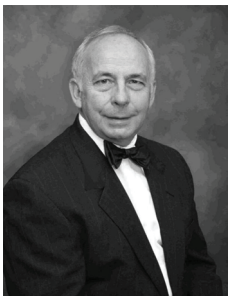

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President 2007–2008

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How you came to decide on first a career in surgery, and then, second, focusing your career in trauma surgery?

Dr. Timothy C. Fabian

Well, I went to Loyola for college and medical school. And when we were out at Maywood my first inclination was to go into internal medicine, specifically cardiology, because I have always been enthralled with cardiovascular physiology.

And I had always been told, as all students are today, that surgeons are sort of obstinate asses. Well, then I had the M3 surgery rotation and came under the influence of Dr. Freeark and several of his residents. I was highly impressed.

And I realized within a couple of weeks that internal medicine wasn't for me and surgery was. It was more exciting and to me more gratifying. You weren't just holding back chronic disease, there was a chance to cure a lot more people. So that's the reason I went into surgery.

After medical school, I entered the general surgery residency at The Ohio State University. Dr. Zollinger had a profound influence on me. He was the consummate professional. He cared nothing about money, only about his patients and the profession. I was nearing the end of my training and I had always thought that I would go back to my small hometown of Marion, Ohio, which is just north of Columbus, about 40 miles or so, and be a general surgeon

there.

Well, towards the end of the residency I started wondering if I might get bored with taking out gallbladders, repairing hernias, and performing gastrectomies after a while. At the time I was on the vascular service working with a vascular fellow, Bhagwan Satiani, who had trained at Emory and I mentioned my dilemma. He said, "Well, if you really don't know what you want to do, why don't you go down to Atlanta and be a fellow with Dr. Stone in trauma for a year or so?"

I said, "Well, gee, trauma isn't the sort of thing I was interested in." He said, "If you don't know what you want to do, there is a chance to operate a lot and you'll have a good time regardless of what you do after the year."

So I went to Grady Hospital and sort of instantly fell in love with the concept of trauma care. Again, you get a chance to cure a lot of patients, especially young people that otherwise would die. And it was the first time my eyes had been opened to doing clinical research, which I never had any interest in as a resident. And Dr. Harlan Stone was one of the most inspirational and brightest people I have ever come across.

So after coming under his influence it just sort of got me on my way to a trauma career. I stayed on the faculty with him for a year or so. And finances were tough at Grady, and he recommended, "Maybe you should look someplace else for a more stable, long-term position."

He told me there was a place over in Memphis that was building a trauma center and he recommended I go take a look. And I said, "Well, gee, Memphis, I don't know. That doesn't sound very appealing to me." He said, "Why don't you just go learn how to interview, anyway." So I did.

And I came to Memphis and there was a big hole in the ground where they were going to build a new hospital. The long and short of it was I decided to take the plunge based on his nudging.

And there was a lot of money involved! I was making $35,000 a year on the faculty at Emory and instantly got a $50,000 at the University of Tennessee, so I thought I was in "high cotton." I didn't have to moonlight on the weekends in ERs any more.

I was going to come here for four or five years, like most young academics for their first job, and then move on. Well, four or five have turned into I guess 32 now.

Luchette

What did your colleagues that you were training with and the other fellows down at Emory think about your decision to pursue a career in trauma surgery? There were a lot of specialties in their infancy at that time. You mentioned cardiology. At the time cardiology was huge at Loyola, wasn't it?

Fabian

Yes. John Tobin, as a matter of fact, was the chief of cardiology. And he was a very bright, inspirational, tough guy. And I liked him.

But I just couldn't face it—cardiology wasn't as invasive as it would become. At that

time, the interventional radiologists were doing all the catheter-based work, for instance. Perhaps if they were like interventional cardiology is today, I may have ended up going down that path. I don't know.

Luchette

But what did your fellow residents and the fellows you worked with at Grady think about pursuing a career in trauma surgery?

Fabian

Well, at that time, you know, that was 1980 and trauma was really just coming around as a recognized specialty area. Up until then, essentially all trauma care was delivered by general surgeons on call. And outside of the big public hospitals in the country like Grady, Cook County, L.A. County and the others, there weren't any trauma centers. So they didn't even think of it as a career because it was just getting organized.

And that's also I guess sort of what appealed to me. I've always liked the idea of programmatic development and getting involved in new ventures. But very few people were really interested in trauma surgery as a career. I realized it was a gamble because it wasn't clear that it was ever going to work. At that time, your city/county hospitals were referred to as "knife and gun clubs" primarily caring for the indigents. But insured patients almost everywhere in the country went to the nearest hospital. And so there was very little money in it for either the hospitals or the physicians.

It quickly became apparent to me that the people that were getting the best trauma care were the poor people in the country and the people that had money were getting the poorest care because of the lack of a system. And I know that was true. I thought it was somewhat ironic and perhaps humorous, in a dark way.

Luchette

So which of your scientific contributions are you most proud of and how did they influence the field of trauma surgery?

Fabian

I think one of the other more important areas was development of the modern current management of blunt aortic injuries. You know, going from the issues of diagnosis, getting away from aortography and demonstrating that CT scanning was as good or, in fact, turned out to be better than aortography. I think that was important.

I know we were the first to champion the concept of anti-hypertensives to decrease risk and rate of rupture. And I think gradually this caught on all across the country. And I think it has made a huge impact on reducing mortality so patients survive long enough to have definitive therapy. It also allowed delaying surgical repair of the aorta in patients with multiple injuries, such as brain and pulmonary injuries until they are more stable and could tolerate, at the time, thoracotomy. Of course, today repair is nearly uniformly accomplished with endo-

vascular grafting.

So I think that's an important area that we've been able to contribute a lot. While some of the work originally met with some skepticism, I think most of the things we've written about management of aortic transection have turned out to be pretty much on target.

Luchette

Well, if memory serves me correctly you were actually the lead investigator on one of the first major AAST multi-institutional trials, right?

Fabian

Yes. Actually, that was the very first prospective trial of aortic injury. Well, it wasn't a trial, it was an observational study. Nonetheless, it was in the late '90s and I was chairman of the AAST Multi-Institutional Trial Committee. It was recognized that this was an important injury that we didn't, hadn't learned a lot about since Parmley described it almost a half-a-century before.

So I think the multi-institutional trial captured people's attention and made us look more closely at outcomes. For instance, consideration of "clamp and sew" versus bypass, a very controversial issue at the time. The multi-institutional trial was one of the final nails in the coffin on the "clamp and sew" because it clearly demonstrated that the results were inferior with a higher rate of paraplegia.

And I think it kick-started the AAST multi-institutional trials that have become much more important over time. We have learned how to form clinical trials groups which can conduct solid research. So regardless of the importance of that particular trial I think it did show that we could organize ourselves for clinical studies. Even though there wasn't any money involved for sponsorship, I think it was helpful in getting us moving in the right direction.

Luchette

If there was one thing that you championed throughout your career and as you look back now you say, "Oops, that was probably the wrong thing to do"—is there anything that falls into that category?

Fabian

Well, let me think. I don't know that I did anything wrong, but one thing that hasn't worked out as well as I would have hoped at this point in time, although it may still evolve over the next decade or so, was getting trauma surgeons more involved in modern vascular techniques, specifically endovascular approaches.

I did a sabbatical about 12–13 years ago as this new technology was just getting started in the country and hoped to bring part of that to trauma care as well as developing a sophisticated vascular division at our department. But the mistake that I made was overestimating the number of cases that endovascular techniques was appropriate for—and so there wasn't enough volume in the overwhelming majority of trauma centers so that five or six trauma

surgeons could attain endovascular proficiency and maintenance of their skills.

The skill set requires more volume than that seen with just trauma patients. And I sort of suspected the problem when I started, but it was a bigger problem than I realized. However, saying that, it is apparent to me now that there is a small cadre of young people in this country over the last couple of years that recognize the same ideas that I saw when I took the endovascular sabbatical. However, they are coming to a better solution to solve the training and practice conundrum.

They are beginning to do back-to-back vascular and trauma fellowships. And I think that is the way to go. I believe their practices will be primarily elective vascular surgery where they will maintain their catheter/guide-wire skills, but also leading the endovascular initiatives in the trauma population. Gradually, the core trauma faculty will learn routine endovascular techniques with the vascular specialist on-board for complex reconstruction. So I'm hoping that over the course of the next decade, there will be a reasonable enough number of people that in 20 years it will become the standard of care for trauma surgeons to be performing all of the endovascular stents for injuries to the aorta, renal vessels, and extremity arteries. Hopefully, core trauma faculties will eventually perform nearly all embolization procedures in sophisticated hybrid operating rooms.

Luchette

So you see that becoming a more significant part of the practice of trauma care?

Fabian

Yes, I think for sure it's going to happen. But, somewhat like acute care surgery, we've got to get a critical mass of people out there doing it. I know of at least three people right now, so there are probably two or three times that number around the country that are starting to go down this path. But it's going to take at least a decade for us to get there. And it will be very career fulfilling for the people that are doing it, as well as improving patient outcomes. So I think it will be a win-win for everybody.

Luchette

As you look back over your career, what do you think are the two or three greatest advances in trauma care that have occurred in the last three decades?

Fabian

CT scanning has revolutionized trauma care. We're able to both diagnose injuries more accurately and not have a high false-negative rate or false-positive rate for laparotomies. Another really important advance that may seem mundane and doesn't get much attention, but I believe has had a very important impact on patient care, is pulse oximetry. You instantaneously see what is going on with oxygenation. I think it's made a significant difference in patient outcomes over time. Many lives have been saved, and many brain injuries ameliorated.

But, clearly, the major leader has been CT technology. It's really changed the whole

game. It's allowed for non-operative management. You know, if it wasn't for CT scanning we'd still be operating on nearly all liver injuries. But today we're only operating on 5 percent of them. It makes a big difference in patient outcomes.

Luchette

What kind of changes have you observed in the practice patterns of trauma care that have been positive and negative?

Fabian

Oh, I really don't think there has been that much negative. I think for many years people young people finishing their training were less interested in trauma care because of the fact that, "Those are the guys that are up all night taking care of poor people that don't pay," and all of that typical whiney stuff that we heard over the years.

I think that is changing today, probably part to do with generational attitudes and quality of life issues that now I think it's sort of becoming a plus to be able to work your shift and walk away. A lot of people don't like to hear that, but I have no doubt that that will be attractive for a lot more people and be a positive aspect about trauma surgery and care.

Another big shift that has occurred, which is clearly for the better in my opinion, is the number of women that are in trauma care. Over the last ten years, at least half of our fellows have been women, which is a lot more than is represented in surgery departments over the same period of time. And I think it's healthier for the practice. Acute care surgery is also a major change. It will be curious to me to see how rapidly this evolves.

Going back to the lifestyle, you know, most hospitals in the country today are having a hell of a time getting enough general surgeons to cover their emergency rooms. As a consequence, regardless of us organizing acute care surgery, this is going to happen one way or the other—and actually something a little bit depressing to me is a couple of days ago I had heard the term "surgicalist," which made me want to puke when I heard the word.

But, nonetheless, I thought, maybe this is just something I don't understand. I thought it was a made-up word. Well, damn, I went to the internet and looked up "surgicalist." There are all sorts of places around the country that are advertising for these people which are surgeons that are covering ERs and in-house consults. I don't really like the way that this process is going, but I think because of manpower issues and career choices that we're probably going to go down that road to a more significant degree than I would have hoped.

I hoped that acute care surgery would make it a more formalized process and maybe, ultimately, we will win this. But I'm afraid that the manpower requirements for the hospitals that are looking for the damned surgicalists are going to overtake us if we don't get out in front of it.

I worked with two of our hospitals here in town to provide acute care surgery programs because of these reasons—they can't get surgeons to cover the ED. Well, I worked for a year-and-a-half with both of them. And they ultimately turned out just recently to start advertising for basically this surgicalist thing. And I told them, "You aren't going to get the same quality of

care. And, it's going to be at least as expensive as the formal acute care surgery *program*." But they just want somebody that is employed by them and they can tell them what to do. They don't get it. And everybody talks about quality of care, but I think so many of these administrative types talk about it because of it being tied to future reimbursement. While they talk about it, they wouldn't know quality if it bit them in the ass. So I guess when we get to the downsides of what I'm seeing, that is it, the surgicalist.

Luchette

What are the facets of your job that you find are the most rewarding and bring you the most personal joy?

Fabian

Training, teaching programs and clinical research, those are the most interesting things to me. I like to be around students, residents, fellows. It's always stimulating. You can never get mentally lazy because of it. It's very gratifying to see people progress along the years in their residency from being a clumsy intern that you wonder why the hell they went into surgery to the fifth year they turn out and you say, "Damn, they're pretty good."

And then the research aspect is really—if it wasn't for that I would probably have done something else, too. It's fun to ask simple questions and stick with it and find answers that I think are meaningful. I don't denigrate basic science, but I think we can make a lot more contributions for a lot less money spent with sophisticated clinical research. And that's an area that I think is tremendously under-appreciated.

Luchette

How many fellows have you trained over the years?

Fabian

That's a good question. It's between 35 and 40. I should know the exact number but I don't know.

Luchette

I mean that's got to be personally very gratifying?

Fabian

I don't think I've had over three fellows that have just gotten completely out of an academic career. And many of them have come along and taken leadership positions. It gets back to what do I enjoy. Well, I enjoy training surgeons and those are some of the reasons.

Luchette

What about the future of trauma care and acute care surgery keeps you up at night?

Fabian

I guess the corporatization issue that we talked about and physicians being employees of health care systems. I realize there are many health care systems, some of the larger in the country, that have done it successfully for years, but those have been based on elective practices. I'm not sure that it is going to translate quite as well to the trauma and acute care surgical approaches that are necessary. And I just worry that it's going to become less of a profession and more of a job, punching the clock and so on and so forth.

You know, whatever happens, I guess it's always going to be fun taking care of sick people. This is my solace whenever I get a little cynical about where the hell the future is. I think with good leadership we can probably keep the cart in the middle of the road, but it's going to take a lot of work. And, of course the unknowns are where health care really is heading over the next 10 or 15 years.

Luchette

What kind of advice would you give to the young people in training that are interested in pursuing an academic/trauma/acute care surgery career? How should they approach it? What are some do's and don'ts according to Tim Fabian?

Fabian

Well, I think there are a couple of things. One is get some real research ideas and not "pie in the sky" stuff. Ask some simple questions and sit down and figure out a way to get either local funding from the hospital or from professional organizations. Do something and don't just talk about it. I've seen people talk about an idea for ten years and never do a damn thing.

The second thing I would say is stay as clinically involved as you possibly can. I was criticized as a resident because I would never leave the operating room. Well, that's where most of the fun is. Get in the operating room as much as you can. You know if you are going to be any good, you've got to be clinically and technically an expert. Establish some area of surgical expertise. So I guess those are important pieces of advice from my perspective.

I would suggest that to get around some of the perils we've discussed associated with corporatization as it relates to emergency surgical care, I think where we should go is regionalization of emergency surgical services, similar to what we have done with trauma care. Except now, instead of a regional trauma center, it needs to be a regional emergency surgical hospital. And I would encourage young people to push and think along those lines.

You know, the manpower shortage in neurosurgery is a great example. They don't want to take call on two or three or four hospitals. It would make sense from a manpower concern to regionalize neurosurgical care. And the orthopedic community, now that we are having big toe doctors and little toe doctors, there are not too many really broad-based orthopaedic guys available for call. So just for manpower alone I think we ought to be regionalizing surgical services. That doesn't mean every case of acute appendicitis needs to be taken care of at a regional center but, sick critically ill patients should be cared for in a regional center.

I think that is the future. And it makes so much sense independent of the manpower is-

sues because of the economic efficiencies and quality of care efficiencies regionalization offers. I think we should really push towards that. And I think that will go a long way to fostering the practice of acute care surgery and trauma care where it should be, in leading and taking care of sick people.

You know, the surgicalist can take care of the appendicitis and drain simple abscesses and stuff like that. And ruptured aneurysms and all the care for emergency neurosurgical diseases would be appropriately centralized. It needs to be more than just trauma surgeons. It needs to be surgical specialists managing nearly all surgical emergencies. And I believe that's going to happen. It just makes too much sense. It's sort of like the vascular thing we talked about a few minutes ago. It may take another 10–15 years, but it just makes so much sense I can't imagine that healthcare won't move in this direction. I don't think there is going to be much of an argument, really. So I think it could happen a lot quicker than the nearest-hospital concept of taking care of somebody that was in a wreck with a couple of fractures.

Luchette

What you think are the greatest challenges and opportunities for the future of trauma and acute care surgery?

Fabian

The greatest challenges, I suppose, are appropriate funding to develop these concepts that I'm considering, like the regionalization of emergency surgical care. I suppose I am assuming that we're going to have a cadre of young people that really like to do this and like the lifestyle.

I suppose there is a threat that if they perceive it's not as much fun as I think it is, that could be a problem. But I don't think that's going to happen. I think it's too much fun that there is not going to be a risk of people not wanting to practice as an acute care surgeon. I guess there are two challenges I see: concern for manpower and making sure there is enough money for salaries so that people don't feel punished for doing this.

Luchette

And the other part of that was the opportunities for the future of trauma and acute care surgery?

Fabian

I think there are two opportunities. First, young surgeons are able to participate in something that you can actually see societal benefit from—you can actually save lives and have the personal satisfaction that you're making contributions to help care for the reasons we took the Hippocratic oath, not the hypocritic oath. Second, I just think that if we get more and more organization in the way we're delivering trauma and emergency surgical care it's just going to be a lot of fun *that works*.

Luchette

What things would you change related to your professional career as you look back?

Fabian

Oh, I guess seeing the way academic surgery and medicine in general has developed it is clear to me that the very best jobs are division chief-level jobs. I've been a chairman now for, I guess, going on 13 years. And it has taken me more and more into administrative responsibilities and further away from the things that I really enjoy doing which is, again, teaching and operating and research. And as a chairman, you find out that about 80% of the activities, administrative activities that you participate in have almost no substantial impact but they take up a lot of time. And it's frustrating. So I guess I question whether I should have just stayed at the division chief level.

You know, in all honesty one reason that people like me do this is the threat of the unknown, that "If I don't do it, who will?" and then you're at risk there, too. But just being honest, I think I sort of wish, in many ways, that I had been able to stay a division chief.

See, things have changed a lot. I guess even 13 years ago the administrative responsibilities weren't quite as bad as today. And you had a little bit more authority to go with the responsibility. The way most academic medical centers are changing today, the hospital administrators have more and more clout. They control the dollars and who controls the dollars controls most everything else. And I see this around the country. It is not just here in Memphis. I don't know if this needs to make it into, you know, anything written on paper but I would advise young people to choose very carefully.

I offer this advice for anybody that does do something like this, a recommendation that you surround yourself with good people and then pretty much leave them alone as much as you can. Do not micromanage. I've seen too many people, smart people, make the mistake of not doing that. It makes the department run much better if you get good people and get the hell out of their way and be there to support them when they need you.

Luchette

How it is with your busy professional life that you have a life outside the hospital is beyond me, but if there was one thing you would change in your life outside the hospital, what might that be?

Fabian

Nothing, really. I can't think of anything I would do any differently. We like to travel a lot and we actually do. I don't know. I can't think of anything I would do differently.

Luchette

So what does the future hold for you, both professionally and personally?

Fabian

Oh, I'm going to work a few more years. I've got to pay for those kids' educations! So of the five kids, four of them have moved back to Memphis which I guess speaks for the quality of life that we have. Professionally I will continue to try to provide leadership here at the University of Tennessee and stay involved nationally and would like to continue involvement with the AAST. Right now I'm serving on the AAST Foundation. I'll continue that for a while and provide any help I can to the organization through research or other things. But otherwise I'm going to continue pretty much doing what I'm doing for a while.

Luchette

Any last words you want to leave or something that you feel like you would like to contribute that I haven't asked you or you haven't had the opportunity to put in words?

Fabian

I guess I would just say that of the various areas of surgery, trauma is probably one of the most gratifying. It offers the opportunity to provide care and to teach and to do research and there is always something different. You know it's a cliché that you're always learning something new every day but it's pretty much true. Many days I'll see something that I've never seen before.

So I would strongly recommend the young people to look into a career in trauma surgery for those reasons. It's a lot of fun. You can really make a difference in the lives of a lot of people, not just one at a time. I mean you run a trauma center and you can have some impacts on huge numbers of patients. You do some research, you can affect not only the patients you care for, but the patients that others care for by providing good research answers to sometimes not very overly complex problems.