

PAST PRESIDENT MICHAEL ROTONDO, M.D.

DAVID LIVINGSTON, M.D.: Thank you for doing this. Since the 75<sup>th</sup> meeting, these interviews have become part of the AAST presidential legacy. The goal of these interviews- and this is why you didn't get the questions ahead of time - is to have an "informal chat" that allows junior faculty, residents, students and even some colleagues to get a glimpse of the thoughts and personal reflections behind the leaders and legends of American trauma surgery. I don't know if you read any of the interviews Fred Luchette and I did for the 75<sup>th</sup> but the opportunity to interview Drs. Blaisdell, Trunkey, Nance and Sheldon for example were a real treat. The history and insights and humanity that came through were amazing.

DR. ROTONDO: We've been friends and colleagues a long time you know and I really appreciate the perspective of these interviews, particularly when you mention those names. Many of them were my idols that I highlighted during my presidential address. They are all in the pantheon of American Trauma Surgery.

Those were the people who inspired all of us to latch on to this mission. We just had to be a part of it. You just had to be part of the big Trauma Family.

It doesn't surprise me you were able to get them to be down-to-earth and talk openly because they were all incredibly passionate about caring for patients. They were just real amazing human beings.

DR. LIVINGSTON: Absolutely. Your own story of attending your first AAST meeting and being walked up to by Don Trunkey and simply being asked "Who are you?" just exemplifies the attitude.

DR. ROTONDO: Boy, you're so right. It was that atmosphere, the tenor and tone that they set which still exists and is happening today.

At the meeting in San Diego I met with three junior colleagues and two residents who had written me in advance of the meeting just to talk. It's always been about bringing people into the fold around the mission. That is what is extraordinarily compelling about what we do; The drive to take care of a patient population that, for decades, was neglected. It's

enough to inspire any of us to commit to do for the rest of our professional lives.

DR. LIVINGSTON: That brings up the first obvious question. How did you become interested in a career in surgery and then trauma surgery? When did you decide? Medical school? Before medical school?

DR. ROTONDO: I had done a couple of years of research related to cardiovascular physiology and by the time I got into medical school I was convinced I was very much headed for cardiology.

Even back in my undergraduate days at Georgetown I would sneak into the hospital auditorium on Saturday mornings and go to cardiology clinical correlation conference. They had all the disciplines there: cardiac surgery, cardiology, pathology. They would bring a patient on stage and present the case. You listen to heart sounds and review the whole case. I was, of course totally committed to become a cardiologist.....until my first surgery rotation.

That experience was incredible. I was inspired by the fact that, surgeons weren't just technicians. They really had relationships with their

patients. They were incredibly intelligent, problem solvers, scientists and quite honestly, I looked at them as "the best of the best". That was it. I changed career paths.

The fact that I had done a fair amount of operating in the lab was part of it, it just seemed to make sense. That shift from cardiology to surgery happened relatively late in medical school since it was one of my later third year rotations. But at that point, instead of cardiology, I thought I was headed for cardiac surgery. Even to the point of having matched with John Kirkland in Alabama for a cardiac surgery fellowship during residency. I changed my mind, after I matched, as a result of my growing relationships first with Jerry Vernick at Jefferson, who was a Vietnam era trained surgeon that I spoke about in my presidential address. Then with Bill Schwab and Don Kauder during a trauma rotation at the Cooper Hospital in Camden, New Jersey. It was Don Kauder who actually walked me around the block while I was on that rotation and said, "You know, not everybody can do this. You can do it. You should do it. You have an obligation to do it. Why

don't you think about it?" After that I went to my first AAST meeting and I was hooked.

DR. LIVINGSTON: Which AAST meeting?

DR. ROTONDO: The one in Montreal.

DR. LIVINGSTON: Another connection in that that was my first meeting, too. It was 1987.

DR. ROTONDO: Bill Schwab and Jerry Vernick conspired to get me there. They somehow found the funding so I could go. Schwab literally did not let me out of his sight the whole time. He dragged me all over introducing me to everybody. I met a whole number of past presidents of the AAST. It was amazing the number of luminaries in American Surgery that were at that meeting.

I also met Dave Spain and Glen Tinkoff and Wayne Meredith and these people have become lifelong friends and colleagues After that experience, I was totally committed thereafter.

DR. LIVINGSTON: When you talk about your mentors, I know you spoke about Dr. Vernick during your presidential address and your relationship with Bill Schwab is well known. Anyone else?

DR. ROTONDO: Primarily Bill Schwab and Don Kauder. It won't surprise you that Dave Richardson early-on became a mentor, as well. I remember approaching him, rather naively, at the AAST meeting in either 1991 or 1992 to collaborate on some of the early open abdomen work with the Gortex people simply because somebody recommended I talk to him. I, of course, knew who he was and just approached him out of the blue. As you can imagine, he was very gracious and open about that. Typical of Dave Richardson, the type of person who always takes a personal interest, at every meeting thereafter he would ask, "Michael, me boy, how you doing?" He never failed to take the time to offer wise counsel and that is true even to this day.

DR. LIVINGSTON: Yes. He is simply amazing and I count myself lucky being one of his fellows.

DR. ROTONDO: I totally agree. He is just amazing. In fact every decision that I made thereafter that was significant - the move to Eastern Carolina, the move back to Rochester - somehow he was

always there. So he clearly has been a major guiding force in my career and professional life.

The move to North Carolina brought me to Wayne Meredith. As I mentioned, I had known Wayne for a long time going all the way back to Montreal in '87. But he became a major guiding force, as well, and as you know, a son of Richardson in his own way.

Dave Richardson, I missed him sorely because he wasn't at the meeting in September (AAST 2018). I would have loved that he were there so I could have celebrated with him and thanked him for his continued mentorship and support. I did write him a long note before the meeting. So those two in particular, were mentors, though we both know that in our specialty, that if you ask, anybody is willing to give you the guidance and help that you need whenever you need it.

I know that when I went to East Carolina the number of people across the country who sent me potential faculty members were too numerous to count. It was as if I had a whole army of mentors and supporters who really wanted that program and the department in Eastern North Carolina to succeed.

John Morris sent me candidates, Dave Feliciano sent people, Tom Scalea sent people, Ron Maier sent people. The list goes on and on.

DR. LIVINGSTON: I think you really and accurately describe the real community of trauma critical care surgeons that exists across the country and even the world. That sentiment comes across in many of the interviews and you articulate it well.

All three of the trauma organizations, Western Trauma, EAST and the AAST, in their own way, all have their own degree of support, camaraderie and community.

DR. ROTONDO: There is one other person I should really mention, Gerry Shafton. The first time I went to the American College of Surgeons meeting I was a chief resident. We were all expected/allowed to go. It was in 1988 and Gerry Shafton gave the Scudder Oration, the title of it was *Abdominal Trauma Management in America*. If that's not the title exactly, it's pretty close. I got to meet him at that meeting and then within three years he invited me to Brookdale to be a visiting professor and talk about damage control. This



was one of the first times, if not the first time, I was invited to be visiting professor anywhere, to speak about anything. Gerry was very generous that way. I think he knew we were experimenting with damage control at Penn and he invited me up to give a talk. Since that time, literally, I have attended almost every Scudder Oration sitting by his side. Dr. Shafton mentored many leaders of this organization, he is truly one of a kind.

Early on in my career, he was always available for advice particularly regarding clinical cases and the things we were trying at Penn. Damage control was an unconventional approach which many, including us at times, thought was crazy. But we were doing it and getting some really great saves. Gerry was always supportive and in his vast experience he knew it was the right direction. David, you were doing the same in Newark - in many ways, we were learning the same things together at two different institutions.

DR. LIVINGSTON: Yes.

DR. ROTONDO: But sometimes you needed somebody to talk to who was older and more experienced someone to "confess your sins" to for violating surgical

dogma. At the time, people like Shafton, Trunkey, Feliciano, Richardson were supportive. What they would say in response is, "No, you did exactly the right thing even though it's not in the textbooks."

DR. LIVINGSTON: Yes. Gerry was a great guy and a real pioneer. My own Gerry Shafton story is that he was the visiting professor and judge for the Region IV COT paper competition when I presented my work as a fellow.

DR. ROTONDO: Isn't that amazing?

DR. LIVINGSTON: I would like to follow up on your choice of trauma as a career. I think you articulated it some of the reasons quite well but can you expand a bit. I mean when we entered the field, we thought it was the up-and-coming specialty, especially in some places. But clearly not everywhere.

DR. ROTONDO: Well, we may have thought it was but there were a lot of people who didn't think that way. I decided not to pursue cardiac surgery, because I realized somewhere along the line - that just it wasn't 1961 anymore. If it were 1961, cardiac surgery would have been exactly the thing to do in my

mind. It was binary at that time; the patient was going to live or die - there was almost no in between - in the early 60's coronary artery bypass grafting put everything on the line. There was a lot of physiology that still had yet to be worked out - the science was wide open. The technical aspects of the operation were not really clear or well-articulated. Myocardial protection was definitely not perfected. There was just so much that had to be studied and worked out. By the time I had been accepted into my fellowship, most of the work was done the mortality rate for triple vessel bypass was under 1.3 percent. Not much more room for improvement.

I also knew I wanted to teach and to be an academic. I didn't really see a lot of upward mobility for either within academic cardiac surgery. It would take you ten years to do establish yourself and become anything.

I really thought that pursuing a career in trauma might, and maybe this was Bill Schwab and Don Kauder talking, be the place to make a real

difference. That was the place to make a real contribution to patient care.

I remember dreaming about it - with some kind of hubris or ignorance - and saying that's what I think I'm going to do. And I'm going to do it with these guys who don't have much of a trauma center, in a place (Penn) where they're not welcomed. But damn it, I'm going to do it. It was craziness when I look back at it.

DR. LIVINGSTON: Especially where you were. I did an away acting internship at Penn on the Chief Resident Service" in September of 1980. That service also "covered" trauma. No dedicated service back then. It was my impression, that none of the faculty there thought anything positive about trauma. It is all the more amazing what Bill and Don and yourself and many others managed to carve trauma out as a real specialty doing groundbreaking things, in a place where you clearly weren't really wanted or respected.

DR. ROTONDO: Back then I will tell you, David, we really liked being the mavericks. It helped fuel us. We cultivated and held an angry edge all the

time. It made it easier to stay up at night to prove everybody wrong. It made it easier to write a paper all weekend because we were going to present it at a meeting and have it published. We would not be denied.

DR. LIVINGSTON: It is funny you talk about cardiac surgery because, back then in the mid-80's all they and their departments wanted them to do is operate and make money. There were also very few, "academic cardiac surgeons".

DR. ROTONDO: Right. Cardiac Surgery had become primarily a technical specialty but, I had been operating in the lab on complicated animal preparations for two years before I went to medical school. So I always considered myself as a pretty good technical surgeon. In my residency program, I was considered advance by many. Amazingly, one of the first cases I ever did was Whipple in September of my internship year. One of the staff surgeons took me through it though frankly I had no clue what I was doing other than the technical steps that he laid out.

DR. LIVINGSTON: Cool.

DR. ROTONDO: So while many at the time, lived with the perception that you only go into trauma surgery if you can't operate, I was confident. I thought I should pursue it because I can operate *better* than most. I think that's one of the reasons why Wayne Meredith pursued and completed both a Cardiac Surgery Fellowship and a Trauma Fellowship. .

At that meeting in Montreal I was still waffling a little a bit as to what I was going to do. I meet Meredith and he's there with Dr. Trunkey as Trunkey's fellow. He had already finished his CT fellowship. I said I'm not sure if I should do one or the other. Should stay with the cardiac fellowship I have or shift gears. He said, "Well, you just got to do both. Do both." You can hear him say that, right? I didn't take his advice - few, if any, can match Wayne Meredith.

DR. LIVINGSTON: Yes.

DR. ROTONDO: It was a matter of thinking that whatever you decided to do, you *could* do. A misplaced sense of invincibility. I know much better now but.

DR. LIVINGSTON: I also think it may have been the beginning or if not the quite the beginning, you saw it on the horizon. The super specialization of surgery. The trauma surgeons of that era did vascular; they did thoracic; they did soft tissue; they did hand. They did damned near everything!

DR. ROTONDO: Right. That's right.

DR. LIVINGSTON: When we were trained there were surgeon who did general, colorectal, oncology and even did vascular and thoracic. The divide wasn't quite as acute as it would be maybe a decade later, but you could see it coming in a way.

DR. ROTONDO: Yes. At that time there was a movement in colorectal surgery to restrict your practice to only colon and rectal surgery. That was really controversial back then.

DR. LIVINGSTON: Same with vascular.

DR. ROTONDO: Correct. And there were still people who were doing general surgery and thoracic. It was all soon to change. You could sort of see it coming.

DR. LIVINGSTON: With all of the mentors you had, what do you think the best career advice you got?

DR. ROTONDO: I think the best career advice I ever got came during the time that Bill Schwab was trying to recruit me into trauma.

I met with Dr. Schwab to talk about "my future in surgery" after I had completed a rotation with him at Cooper Hospital and he had moved to Penn.

I have to set this scene. Bill is sitting in a postage stamp-sized office. If it's 100 square feet it's a lot. He's wearing Penn scrubs and with a tear in the pocket and a t-shirt with a hole in the collar. It's the middle of winter and the window air conditioner is blowing full blast. It is still about 110 degrees in his office because the old radiator system was pumping out so much heat that you could barely breath.

So, I sit down in this tiny, steamy office next to him at his desk. He is sitting behind the desk and I'm sitting to the side of the desk. He pulls out a piece of paper and he draws a graph with an



X and Y axis. He said, "If all you do is operate this is your value." He bisects the axis and draws a straight line at 45 degrees. He went on to say that for every case you do you have specific tangible value related to and limited to only those case volumes.

He then said, "But if you go into academics and you teach and you do research," as he drew an exponential curve, "then you have intangible value." In essence you will be invaluable to your organization.

He shared with me that if you put leadership competencies on top of it, then you really have something. He told me this when I was a fourth-year resident. It was clearly the most insightful explanation of a career path I've ever heard.

DR. LIVINGSTON: I never heard that story. But it is really good and was really true then, although that may be unfortunately changing in our current environment.

Okay, let's shift gears now. We touched on research. I know what you are associated with several contributions but what are you most proud of?

DR. ROTONDO: Well, I'm just going to answer with what comes into my head first.

I don't take individual credit for any of this, but the work that we did on rapid sequence induction and control of the airway in the late '80s/early '90s during resuscitation was in many ways an important contribution. That would be one.

The damage control work would be another. I have my own version of that story; that it was really a national collaborative effort, no matter how you look at it. Back in those days you and I talked about cases all the time; I talked with Tom Scalea about cases. We talked with David Feliciano about cases. We were all seeing terribly injured unstable patients with penetrating injuries. We were all in it together trying to sort out the best approach.

I happened to be in the right place at the right time and given the opportunity at the AAST, to present that work was a gift. But it really was the culmination of a lot of people's work.

The third one was the work that we did in East Carolina and the cost of the saved life through

trauma system development and all the system development work associated with that. That would be enough.

DR. LIVINGSTON: That's more than enough, Mike. I think you have a lot to be proud of and those are three really big highlights.

Anything that you championed or wrote about or embraced and then maybe thought in retrospect, why did I do that? Of that it wasn't quite the advance you hoped it would be?

DR. ROTONDO: We did a lot of work on videotape review in the trauma admitting area and the role of the command surgeon. From a research perspective, it never really took off. I think it was too hard maintain the review burden, there were too many legal hurdles. For those who could accomplish it, it turned out to be an effective way to teach resuscitation. But most programs couldn't or just wouldn't embrace it. Then after HIPPA came in, it just really fell apart.

DR. ROTONDO: I do have disappointments related to my time on the COT. I have a

COT-related story that I'm just compelled to talk about in a similar vain.

DR. LIVINGSTON: Sure.

DR. ROTONDO: The entire experience of writing the 2014 Orange Book (ACS Optimal Resource Document) was extremely arduous and frustrating. The standards hadn't been modified for about 6 or 7 years. It took an inordinate amount of time to produce the rewrite and we approached it the same way that it had been previously written.

It is a very respectable document but if I had it to do over again I'd be doing it completely differently. While I'd like to think the entire ACS COT learned a lot from that process and that the evolution of the Optimal resource Guide informed the quality standards work that Dave Hoyt led for the American College of Surgeons, it was a challenging process during which you are never sure that you are identifying the proper standards of care. There simply isn't enough evidence and you end up making a judgement call on insufficient information.

If you err on the side of being too rigorous you have eliminated the ability of 100 centers to meet the standard because it is too rigid and you thereby eliminate the verification and possible the existence of the trauma center. However, if you eliminate that standard or err in on the side of leniency, you could lose thousands of lives because you have set the bar too low. Having to live with lack of evidence and the unknown consequences of those decisions is very, very difficult. That initiative caused me the most consternation, sleepless nights, worry. The constant nagging concern and the feeling that we never really nailed it - very disquieting - and the jury is still out. That's just the truth.

DR. LIVINGSTON: In your career, which spans what some people would think is the heyday of trauma care, what do you think the two or three big advances have been? I understand there are a lot, just want your top two or three.

DR. ROTONDO: It's amazing how much has happened.

DR. LIVINGSTON: I didn't say the questions are easy!

DR. ROTONDO: I'll try to go by decade. In the '80s, the advent of the CT scanning, the movement to non-operative management of solid organ injury and the rise of trauma systems.

In the '90s I'm going to pick the change in management of devastating penetrating abdominal injury using damage control surgery and the rise of surgical critical care.

So far in the early 21<sup>st</sup> century it's the advent of damage control resuscitation and the combination with damage control surgery. Decade by decade - that is what comes to mind.

DR. LIVINGSTON: I think that nails a lot of the big sea change in practice decade-to-decade.

You have had the multiple roles you have had in your career. You went from a very accomplished trauma surgeon to a very accomplished chair. Now you have transitioned to a real leadership role in managing a faculty practice/clinical enterprise at Rochester. I am sorry but I can't remember your title exactly.

DR. ROTONDO: Enabler of faculty.

DR. LIVINGSTON: Yes, that's good. What do you think the major changes in the practice patterns in surgery? Not only trauma but surgery in general.

DR. ROTONDO: I don't know if people would agree with this or if this is right but I think the most dramatic thing has been the change around the concept of continuity of care. You and I trained in an era when continuity of care was you and you alone; you saw a patient and you owned a patient. The shift now is to team-based care. That old practice pattern is essentially gone.

I do think that trauma has had a lead role in promoting that change because by necessity, we have to work as a team to provide the minute to minute round the clock care that patients deserve and do it in a way that meets their every need in a detailed way. If you believe that the patient deserves to have their needs met the moment they need it - it is impossible to do it alone. You have to work as a team.

Now when you have to be reliant on team transitions, effective communication becomes paramount.

It creates a different sort of challenge to maintain that very same set of values for the patients. I think that's the biggest change in the care delivery model that now exists across all of surgery.

DR. LIVINGSTON: There is no doubt that that is a big, a big change. I think that's a great example and the era of doing it all yourself is gone. That ship, not only has it sailed, I think it's sunk.

DR. ROTONDO: Yes. I'm not pining for the days of yore and I think what has happened is the right thing. But what I found myself as a chairman, and even in my role in the COT, continually preaching about not losing our core values around the challenges of a specific environmental conditions, whatever they happen to be.

We have a set of values that I believe are immutable. The patient comes first. We try to be excellent in everything we do and we take care of each other.. These are the things that are most important.

It is totally impossible to meet the demands of today and take care of each other and yourself without a team approach. Twenty years ago,



though an EAST initiative, Tom Esposito and I wrote a paper regarding attitudes and manpower needs on a busy acute care surgery service. It had a section on "lifestyle and longevity" needs for faculty. At the time, the editors of the Journal of Trauma would not publish that portion of the manuscript. In their view, it was simply not appropriate for the Journal. It never got published. The readiness to consider the importance of self-care simply wasn't there yet.

DR. LIVINGSTON: What has been the most rewarding parts of your career? As we discussed you have had a lot of jobs, but what has given you the most joy over the years?

DR. ROTONDO: Two things come immediately to mind. One is the ability to say that I was part of something that made a difference to save lives. That's important. I was part of something that we created together as a profession which I believe saved a lot of lives.

I think that was true in the '90s with what was happening with gun violence and it was also true during the war in the utilization of damage control

approach across an entire system to move those patients across large geographic areas. I'm very proud to have been a part of that.

The other piece I'd like to think I am proud of is part nature, part nurture. I have paid it forward in that I've been able to interact with my junior colleagues in a productive way. Helping those who are coming after us to continue to grow, to continue to inspire them to do what we were inspired to do.

DR. LIVINGSTON: What's been the most challenging? You talked about the COT and the Orange Book, but what in your time as trauma surgeon or chair position, that kept you up at night?

DR. ROTONDO: I think it's about resources. It's always about resources. At Penn in the '90s, were in the box on call every-third, every-fourth, every-fifth night. It was about having enough resiliency to maintain the level of patient care necessary, maintain your family and maintain yourself.

When I was trying to build the program East Carolina it was about having enough human resources. Am I ever going to recruit people to come

and help me do this? Can we actually get what we need to deliver what these patients need to reduce the mortality and morbidity rate?

In the current job it's about having enough financial resources to build systems of care that people can comfortably work in to deliver the care. Whether it's infrastructure support around the electronic health record or having enough medical office assistants to support primary care doctors and when they're trying see high volumes of patients. It's always been about having enough resources to support the mission.

DR. LIVINGSTON: What career advice do you give young surgeons now? Your trainees or young faculty about a career in trauma/critical care/acute care surgery?

DR. ROTONDO: At the very core of it after usually a lot of other discussion, I'm simply trying to convince them to always do the next right thing. Follow their instincts. What feels right to you? Do something that's right.

By the time I've gotten to that point, we've already talked about the fundamental building blocks of an academic career. Invariably, I find I am repeating and paraphrasing the advice I got from Bill Schwab that day in that broken-down office with his torn scrubs...find a way to add intangible value.

But I'm also talking to them about building their base. Making sure they're good technical surgeons and that they attend to their patients carefully. That they set a good example. Make sure that they teach, that they always look for opportunities to teach at every level that they're comfortable. Never suppress difficult questions. It's important to create an environment in which difficult questions can be asked and so they can eventually be answered.

Make the next right move. Whether it's continuing to build your practice, continuing to work in the laboratory, whatever it happens to be. But follow those instincts based on the fundamental values.

DR. LIVINGSTON: What's your life coach advice for outside the hospital?

DR. ROTONDO: This is where I always go blank, David. This is what I have learned, though I wasn't always able to live it: you've got to continue to pursue your passions outside of surgery. Looking back now that I have more discretionary time and if I had it to do over again, I would have lived it a lot earlier.

The amount of time I now spend playing music, even though a lot of times it's at 10 or 11 o'clock at night, nourishes the soul. If you don't do these things, you will find yourself bereft and very empty. What I say now is make sure there is always one activity that you can guarantee is going to fill your bucket and use it to fill your bucket.

If it's your family, spend the time. If it's hiking, spend the time doing it. If it's music, if it's art, if it's theater, if it's reading, do it. Don't do it half way. Don't do it while still being connected to work. Don't cheat yourself out of it because in the long-term you are shortening your ability to contribute to others.

DR. LIVINGSTON: That is truly great advice. What do you think is the greatest current

challenge and opportunity for the future of trauma and acute care surgery.

DR. ROTONDO: I did my best to outline what I thought they were in the presidential address. I think there are two main forces that are at play and if we are smart we are going to be able to use them to our advantage.

One is the downward economic pressure that we're feeling in health care. That's the threat. Our opportunity is that we provide a level of service that's going to be invaluable in a resource-constrained environment; because we're actually available to patients in a timely fashion. We're there to receive the patient and to manage a problem the moment it comes in. We've always been willing to do that for trauma and critical care, and now for emergency general surgery.

So the biggest threat is economic, still. What will happen to the system? Are we going to be able to maintain our values through those external threats and adapt and change? Our biggest opportunity is to make sure that we maintain a position that allows us to be the solution to the problem. If we do that, I

believe we'll always have both tangible and intangible value.

Second, we've got to establish a clearer direction for acute care surgery. There are certain areas that we have to stop quibbling over. We simply need to make a decision. During my presidential address I said it doesn't matter what they call us; we just want them to call us. So this quibbling over the name is silly.

DR. LIVINGSTON: The answer is likely going to be "not much", but would you change anything in your career?

DR. ROTONDO: I pursued my career with tremendous passion and energy because I just loved it. I was fully engaged but, there was a considerable price to pay for that. At times, it was very hard to remain fully engaged with my family because I was so sleep-deprived. It was a byproduct of long hours that we worked.

I recently digitized all of our family videos. It is interesting to watch myself in those videos. In the '90s, I was in two modes when I was with

my kids. It's sort of comical but at the same time kind of sad. I would either be totally manic, picking up toys and directing the action or, I would be just on the couch, unable to move, exhausted. In either mode, I don't think I was really effectively engaged with my kids. In retrospect, I would have liked there to have been a little bit more balance. It is clear to me that at the time, I was just exhausted.

DR. LIVINGSTON: Yes. I don't think we're the last generation that lived that way. Maybe another one or two beyond us. No one talked about work-life balance when we were working 120 hours a week as residents or even when we were starting our careers.

DR. ROTONDO: No.

DR. LIVINGSTON: As you mentioned, you couldn't get the paper on longevity published in 2005. That sea change is really only in the last 10-15 years

DR. ROTONDO: Yes. It changed because it had to.

DR. LIVINGSTON: There did not appear to be any choice.



DR. ROTONDO: I will say that in the moment...while I was in training and in the throes of building a career. I truly loved it. For me it was like being at "surgery camp". I didn't have kids until later in residency. I don't know, I got in hyper-drive mode and just stayed there.

But I think in my quiet moments now, and I'm not even sure I would have answered this question the same way five years ago, it would have been better to be a more present. I've talked a lot to my kids about it. They're 31, 27, and 25. Fortunate for me they don't seem any worse for wear. I have initiated conversations with all three of them on the subject over the years. Best we work it out now together rather than having to work it out much later on their own. You know?

DR. LIVINGSTON: Yes, I know. I truly understand that.

DR. ROTONDO: I'm sure you do.

DR. LIVINGSTON: So how do you view your time as president of AAST?

DR. ROTONDO: I loved it. It was just too short. Probably that's because I was an "out-of-

ranks" president. It seems, you have only got a year to make a difference compared to being on the board for a long time.

One thing I tried to be very careful about is to NOT be the guy who comes in the critical care unit on Monday morning and changes all the vent settings. It was important to get in the flow of the organization and maintain continuity.

DR. LIVINGSTON: I get that. The analogy is very apropos.

DR. ROTONDO: I was determined not to be that guy. The fact of the matter is Raul Coimbra and the Board had worked so hard on the Strategic Plan, I was hell bent on getting some of it done and making sure I didn't capriciously change things. I really tried to understand the issues and move them ahead and create a couple of new things that might be of value.

It's too early to tell if they are of value. One is Anne Mosenthal's Palliative Care Committee which is just getting up and going and the other is Kristen Staudenmayer's and Joe Minei's Health Economics Committee.

But the presidential year is a year where you clearly work. If you truly engage, it's not an honorific year. You actually get to do things if you're willing to do some work. I have to tell you I enjoyed it immensely. The experience is heightened dramatically, not just by the other members of the Board and the past presidents, it is heightened dramatically by Sharon Gautschy and the staff. They are just excellent. They really do propel the organization forward and enable you to actually get things done. Without them you wouldn't get anything done.

DR. LIVINGSTON: That is an excellent segue way into the next question. Where do you think the organization is going to be in 20-25 years? Let's say it is 2045.

DR. ROTONDO: You know we are going to try to look at that carefully. That's one of the things that Martin (Croce) is supporting us over the summer to see where the AAST might be in the long-term. I think if I had to try to prognosticate I'd say we're going to have a very different economic model to support the AAST. Primarily because the economics around the

journal, which has been the "cash cow", is shifting dramatically.

That model I believe is going to be based on our ability to monetize our intellectual content and the cachet that we do have in a different way.

So, the first thing that comes to mind is a different economic model. I'm not exactly sure what it will look like, but I think it's going to be related to the things that make us uniquely who we are. That includes the science that we produce and our ability to move the field forward in our own unique way.

I think our method of communication, which has already shifted dramatically, is going to shift even more. I am hoping that human beings will still get together for meetings once a year! But I think we're going to be communicating in a much more effective virtual way than we are right now.

And then I think technology, beyond communication, is going to continue to change our field dramatically. I think technology will continue to reduce injury. Short of what is happening with gun violence we'll continue to become safer in the workplace

and safer on the roads. Technology will continually change how we diagnose and treat injury.

DR. LIVINGSTON: Do you think we'll have gun violence and the gun settled in 25 years?

DR. ROTONDO: No.

DR. LIVINGSTON: Me too.

DR. ROTONDO: I don't.

DR. LIVINGSTON: That's is depressing.

DR. ROTONDO: Yes.

DR. LIVINGSTON: Anything we didn't cover that you want to mention, talk about? Parting shots?

DR. ROTONDO: Oh no, that's plenty. That's it, David. I appreciate the opportunity.