

PAST PRESIDENT WILLIAM G. CIOFFI, M.D.

DAVID LIVINGSTON, M.D.: Dr. Cioffi, thanks for making the time to do this. I don't know how many of the past-president interviews you have read, but the concept that Bob [Mackersie] wanted was to memorialize the oral history of the organization through the past presidents. More importantly, the idea is to make the interviews sound like conversations so that medical students, residents, fellows, and even junior faculty get a glimpse of people who they may only know through reputation. Let's face it, being the president of the AAST is a great honor and a really big deal. To many of the next generation, the presidents are a bit unreal. Sort of like when you were a little kid and you saw your first grade teacher in the supermarket and think, "She buys food, too?"

WILLIAM G. CIOFFI, M.D.: Yes, exactly.

DR. LIVINGSTON: So, the typical first question: how did you fall into surgery and, specifically, trauma? How did that all come about? Who or what influenced you to move you that way?

DR. CIOFFI: Sure. That's pretty easy for me. I went into medical school thinking I was going to be a cardiologist and that concept persisted up until my clerkships.

I did OB-GYN, pediatrics, then psychiatry, followed by surgery and medicine. At the University of Vermont Medical School, you have to declare senior majors in October of your clerkship [3rd] year. Since we start clerkships in January, this was the beginning of the last quarter. I had just finished my surgery rotation and was in my first month of medicine.

After my very first day in my surgery clerkship, I was certain I wouldn't be a surgeon. The chief resident totally took my head off and handed it back to me: he told everybody to come back three hours later so that we could make rounds when "Dr. Cioffi" or "Mr. Cioffi" knew anything about his patient. This was a patient who had had a Whipple followed by a completion pancreatectomy, was a brittle diabetic, had been in the hospital for six weeks with multiple complications, and a lot of things going on with him that were way above a third-year student [student's ability] to figure out in a short time.

That incident aside, the rest of the month was great. The three people who made it great for me, or made it real for me, were Richard Gamelli who was an attending,

Jim Hebert who was [first] a resident and then an attending at Vermont, and John Davis, who was the Chair at the time. There were a host of other people on the surgical faculty, but it was really those three people who I looked at and said, “Boy, I like what they do. What they do is pretty cool.”

All of them, despite having different specialties and interests, did trauma as well. Obviously John Davis’s role within the trauma world is well known—and [was] established from his time in Korea—being the editor of our journal [the *Journal of Trauma and Acute Care Surgery* from 1975–1994] and past president of the AAST [1975]. He was both a vascular surgeon and a trauma surgeon. I just looked at him as someone I could only hope to be like. Dr. Gamelli was successfully funded by the NIH and interested in research while at the same time being a really outstanding clinical surgeon. I don’t think most people know that about Richard, but the guy was really somebody who could operate. It was impressive for me to see someone who could really operate, take care of sick patients, and have an NIH grant.

I had those role models, but I still was intent on being a cardiologist until [I began/was in] my cardiology rotation in October, at which time, I had the most miserable month of my clerkship year. The school said, “You’ve got to decide on a major. Today.” So I said, “All right, I’m going to be a surgeon,” which was news to everybody in my family, including myself. But it was based on my experiences with Davis, Gamelli, Hebert, and the [other] residents in the program. We were a small program—only three residents a year—but during John Davis’s tenure as Chair, it was a very successful academic program.

That’s how I got interested in surgery. There was no plan. It was repeated exposure to role models and mentors. When I was a surgical senior major student, I applied for my surgical residency and wanted to stay at Vermont. I went to Dr. Davis and said, “I really want to stay here for residency.”

He said, “You know, we have this thing called a ‘match’ and I can’t tell you that [that you can stay at Vermont].”

I said, “Well, I’m thinking of buying a house.”

He said, “I’d buy a house.” So I bought a house, and I did my residency there [Vermont].

DR. LIVINGSTON: Well, that's one way to say what you can't legally say: "You can buy a house" or "Real estate is a good investment."

DR. CIOFFI: Yes, and you know what? That house, out of all the houses I've owned in my life, was the only house I made money on.

DR. LIVINGSTON: Given your mentors and role models: Jim Hebert, Dick Gamelli, and John Davis, it's totally understandable how you got into the world [field] of academic trauma.

I'm going to take a different tact for a little bit with the next question. Reflecting now in your role as Chair and advisor to many, do you think your experience with mentors and role models is the same [as it was for you] with [your] students today or not?

DR. CIOFFI: I absolutely believe it is. I'm going to base my answer on both a little bit of historical data, and then, what I think [is true] today.

In '99 when I was president of the SUS [] I did a survey of residents to try to figure out what drove them into their careers, what kind of careers they wanted, and what they didn't want. About a third of the chief residents responded as well as 20 percent of the junior residents. The most important thing, they said, was that their decision on career choice was based on role models and mentors. So, that was true for me in 1979. It also appeared to be true [for students] 20 years later [1999], when I did that survey.

Now [after] almost [another] 20 years [2017], I'm absolutely sure [it's still true] as I sit down with my residents. They are driven toward careers by exposure to a person or people who they want to emulate. I have no doubt in my mind that that's true. We always have at least one [resident] a year that goes into trauma and one [resident] a year that goes into vascular. Those faculty [members] are big influences. I would say for Brown medical students in general, those same factors drive the students into surgery, especially in a school which specifically says their intent is not to train surgeons, per se, but to train "academic primary care people."

DR. LIVINGSTON: Yes, I agree that mentorship and exposure is vitally important. I wonder if some of the changes in medicine: the increased need for billing, and all other non-direct patient care stuff ,which potentially interferes with our interaction

with the students and residents, is going to alter that. I think it is exposure and mentorship that makes the medical career system work. I know that's a little philosophical but . . .

DR. CIOFFI: Well, it is philosophical, but it is what I talk to my faculty about. Thankfully, I don't have to talk to them about it much. They feel the same way. There are all these things that irritate us about work—whether it's an ERH, or something the health system did, or meaningful use, or some new state narcotic prescribing rule that we have to adhere to. You can go down a laundry list of things—none of them make us very happy as practitioners or clinicians. But we can't let our negative feelings about these peripheral issues roll over into our interactions with our patients or our students because, if it does, then you need to rethink your career.

In the early 2000s I think the ACS did a survey about “would you want your kid to go into medicine and surgery.” It was discouraging, the number of older surgeons who said, “I would not want my kid to do this.” I think that that has totally reversed in 2016–2017. For instance, I have interviewed a lot of students for internship this year who have relatives and parents who are surgeons. A lot of them [in the past] have had physician relatives, but this year, I was amazed at how many [students had relatives who] were surgeons and the very positive push they got from their parents about going into surgery—despite all the issues with the EHR and meaningful use and all the things that make our lives [as surgeons] miserable. We need to be the role models that inspired us. We've got to maintain the enthusiasm for what we do clinically. I think trauma surgeons—okay, I have a bias here—seem to do that better than most.

DR. LIVINGSTON: I do think one of the best parts of the job is mentoring students and mentoring residents.

DR. CIOFFI: Well, David, you know how I feel about you and that you do a great job with that [mentoring].

DR. LIVINGSTON: Thank you. It means a lot coming from you, but it is also one of the reasons I try to keep sending you students.

DR. CIOFFI: There comes some time in your career—whether it's at 20 years, 30 years, or 40 years—no matter how much you enjoy operating and doing another cases, although fun, it's not as much fun as mentoring a student or a resident. [It's fun] Getting them excited about their career or helping them take a patient through the worst

experience of their life. If it [the mentoring] happens to be in trauma, great; but it is not the operation [teaching essential technical skills], per se, but the whole experience [of mentoring a person] that is so rewarding.

DR. LIVINGSTON: Absolutely. Dr. Davis, as Chair, was a vascular surgeon but he was also such a big a figure in the trauma world. I would imagine your decision to go into trauma was a natural extension of your residency and [that your decision was] pretty well accepted at Vermont. I would think that John [Davis] and Dick [Gamelli] and most everyone on the faculty were very supportive of that decision. Especially compared to other institutions at the time. We [many others of us] trained where the response [to the decision to go into trauma] was likely, “You’re going to do what?”

DR. CIOFFI: Right. What was weird about that—and I have always thought, “How did I end up in academic surgery and [in] trauma as a general surgeon?”—was [that] that’s all I knew. I was fairly naïve coming both out of medical school and residency. Being at Vermont, I just thought everybody wanted to do this [trauma] because that’s the kind of faculty that John had. It was like, “I can do trauma and I can do foregut oncology or whatever I want. I’m trained to do it.” I can do all of it, and that’s what my career has been.

I was naïve to the fact of [the attitude at] places like you described where [they’ll say to you], “You’re going to do trauma? What, are you not very good [at surgery/anything else]? Is that the problem?” I didn’t even know that world existed during my residency, or even for a good part of my early career, because I went from residency to the burn unit working for Basil [Pruitt]. Down there, I did burns, trauma, oncology, and research. I said, “Oh, isn’t that the way the world is?” Obviously, as I got older, I understood it wasn’t.

When I negotiated for my job at Brown in 1994, I told the Chair, who was a surgical oncologist, that “I do trauma and oncology. You need to make sure that’s in my contract and that I can do [all of] that when I get there.” To his credit, he did support me in that. So the reality is, I was really lucky, but I also was really naïve coming out of residency. I just thought everybody loved doing trauma because, how could you not?

DR. LIVINGSTON: Well, yes. Maybe it was naïve, but as a student and resident at Vermont, this was the world you knew. Why would you know any different? What is clear is that while good mentorship is invaluable for guidance, it is your own

commitment and determination to do it all that is the key to success. You were incredibly fortunate to bounce from Vermont to the military with Dr. Pruitt. Hard to get a better pedigree.

DR. CIOFFI: You know having John Davis and Basil Pruitt as your first two bosses isn't all bad. It's not bad at all.

DR. LIVINGSTON: Especially since they saw the world the way we like and hope the world to be.

DR. CIOFFI: That's exactly it.

DR. LIVINGSTON: Bill, of all the things in your career, what are you most proud of—from an academic or scientific/academic contribution? What do you look at and think, “That was really some of my best work” or “I'm happy I did that”?

DR. CIOFFI: Mine is a mixed answer because I've had several jobs—as a faculty member, a division chief both at the Burn Unit in San Antonio and here [at Brown University], and finally now as a Chair at Brown.

As an individual, the things that I did that had the greatest impact on trauma care happened when I was at the burn unit. We really published the first papers about lung protective strategy in surgical patients. It happened to be in inhalation injury, so it didn't “catch fire” with the world. But we started that [work] in 1986 when I got to the burn unit because I was working with Forrest Bird, the guy who developed Bird Ventilators and Baby Birds. I had met him previously at Vermont because we were using his high-frequency ventilators in the ICU there. So in 1986, I started working with him on the concept of lung protective strategy for inhalation injury. From 1986 to 1994, we did several clinical studies and a large primate study. With Basil [Pruitt] [as my boss], I had the opportunity to do so many things from a research perspective [both] in a translational and a clinical way. But if there is one thing that I did that I'm proud of, it was the studies we did that changed the way we treated [and treat] inhalation injury. While it was specific to burn patients at that time—as you know, we talk about lung protective strategy all the time now as the “standard of care”—but it wasn't truly accepted until the *New England Journal* paper came out, and even then, it took another decade before it became common practice. The burn world has been talking about it for 30 years.

DR. LIVINGSTON: I think that it's unfortunate that things happen like that. I know the work and it really was completely groundbreaking. It's one of those things that was either too far ahead of its time and/or didn't get the widespread press that it might have received now in the internet-connected pubmed world. Back then, it was considered just too much of a specialized/niche kind of treatment.

DR. CIOFFI: I think that's a lot of what happened. So when I read papers about lung protective strategy, it astonishes me that they just ignore the inhalation injury world. In some ways, I get it [why they ignore it]: inhalation injury is a mucosal-oriented disease rather than an alveolar-oriented disease. Nonetheless, I think any critical care doc understands that, for the most part, "ARDS is ARDS."

The other contribution [I'm most proud of] was during my first 10 years here at Brown. We published a large amount of literature on the effect of gender—I guess "sex" is the right word—on outcomes and whether there is a sex-related difference in outcomes for hemorrhage and trauma. Although I don't know if that has come to fruition the same way as other things, it did highlight that we're not all identical or homogenous, especially compared to mice that have the same genetic makeup.

The flip side of that story is that as a Chair or division chief, it [success] is not about specific things that you do personally. The most exciting part is having both residents and faculty progress—[such as] faculty getting their NIH 'K' awards—and watching the departmental research expand. I continue to be fortunate. I inherited a really good inflammation lab at Brown and we have continued to grow that enterprise. I've got research faculty like Al Ayala who has had three R01s the whole time I've known him and people like that. We've been able to maintain and expand that activity. I will say [that] inheriting a lab whose focus is on things you're [personally] interested in isn't all bad, either.

DR. LIVINGSTON: It is clear you've grown a phenomenal department and [you] should be very proud of that. Compared to those successes, is there anything that you thought was a good idea, or something you championed that didn't quite turn out the way you thought? Sort of, "Oh, I wish I didn't do that"?

DR. CIOFFI: Oh, God, I mean there are a zillion things like that. Clinically and research-wise. A number of negative ideas and experiments are part of the process. In

some ways, the sex-related outcomes are an example of that. It turns out to probably be true in animal models and maybe not so true in people.

DR. LIVINGSTON: Maybe it's just more complicated in people.

DR. CIOFFI: I agree that it is much more complicated [in people]. I think there are so many other genetic influences on [that effect] outcome following trauma and sepsis that we just don't understand [yet]. The Glue Grant was trying to get at some of that. Certainly, we understand it [] more in oncology than we do in trauma. It has to play a role. How could it not? Especially if it plays such a prominent role in oncology, how does it not do the same thing following injury?

DR. LIVINGSTON: Yes.

DR. CIOFFI: As you know I am a little bit frustrated by our inability to truly get our national clinical trials network off the ground. I'm not giving up on it and I think we will succeed. I'm just disappointed that the growth of that hasn't been as robust in its first few years as we'd like. But it's like the difference between basic science research and being a surgeon. A surgeon expects immediate outcomes and gratifications; in contrast, research and bureaucratic things don't ever have immediate outcome and gratification. It's a slog and a process.

I'm still very hopeful on that [clinical trials network] front. It's not gone exactly the way I wanted it to, but I certainly learned a lot of lessons about how to try to do things on a national stage. Some of those [truths] shouldn't have been surprises to me given my job here as Chair. "I think it could have been done better" is the best way to put it. I am certain we'll figure it out.

DR. LIVINGSTON: In your career, what do you think are the top two major advances in trauma care?.

DR. CIOFFI: One of them is really simple. When you and I trained, it didn't even exist. That is: non-operative management of many injuries, but especially, solid-organ injury. The concept is so simple. It was there the whole time in the pediatric world and we just didn't embrace it.

I remember as a resident how many trauma laps I did for a positive DPL and had a little scratch on the liver that I looked at. Or to make it a real operation, put a stitch in [it] or ran the bovie over it and said, "There it is. I just repaired the liver." We did not need

to be there. We do that with stab wounds now and people are doing it with some select types of gunshot wounds. To me, that's certainly been a game-changer for patients. I think that would be number one.

I think number two [second major advance] goes on the opposite side. It doesn't have anything to do with individual patients. It has to do with the development of trauma centers and trauma systems and globally improving the outcomes of our patients. We certainly were able to see the fruits of that here in Rhode Island with the Station Nightclub fire where we had the best [medical] outcome [per injuries to fire victims] from an indoor fire disaster in the history of mankind. That was because the trauma center was ready, and the trauma system was in place, to some extent, in the state. It wasn't perfect, but it did function. And the "pseudo-trauma system" regionally, at least for burns, worked in terms of the distribution of patients to the Boston teaching hospitals.

DR. LIVINGSTON: Two great examples.

You touched on this a little bit earlier, but what provides you with the most joy in the job? What do you find most rewarding?

DR. CIOFFI: Number one, I'm a surgeon and taking care of patients is everything—there is nothing better than taking care of your patients. I mean anybody that goes into medicine in general, and especially surgery, I hope, would say the same thing. There is just nothing better.

In my job as a Chair, it's helping to grow something. To bring people along that have a common vision, or a strategic plan, of what your division or department can be and how you interact with other pieces of the department, or the school, to build something a little bigger than what you started with. That encompasses a host of skillsets—from mentoring and role modeling to leadership skills, but when it works, it is amazing.

I tried to touch on the leadership part in my presidential address because I do believe that surgeons are natural leaders. [Although] I think we tend to invoke one leadership style because that's the leadership style that works in surgery. We do need to learn that the leadership style that works in the operating room, or works in a trauma resuscitation area, isn't necessarily the leadership style that you need, or even should use, in other venues. You've got to have a whole set of different styles to use at the appropriate time[s].

DR. LIVINGSTON: Yes. Someone told me once, “Surgeons are excellent builders. We’re lousy “maintainers.”

DR. CIOFFI: I like that. That’s probably because we think, “Okay, we built it, let’s move on to the next project. Let’s accomplish something else.” Surgeons like immediate gratification.

DR. LIVINGSTON: Yes. It’s like maintaining something is boring.

DR. CIOFFI: Someone else can fertilize and water it. Exactly.

DR. LIVINGSTON: Yes, and boredom is when your faculty gets into all sorts of aberrant behavior. On the flip side, what are the aspects of the job and your career that you’ve found to be the most challenging or distressing? What keeps you up at night—if anything keeps you up at night?

DR. CIOFFI: Boy, what keeps me up at night is balancing economics versus expectation. Unfortunately, as a Chair, that’s the thing that tortures you because the economics of healthcare are just getting harder and harder and harder. There are unrealistic expectations on multiple fronts on what you can do with a single dollar. But in many ways, that probably is the same for the solo practitioner. The solitary provider, whether you are a surgeon or otherwise, has the same pressures and probably the same inability to influence the outcome very much.

I think the crux of the healthcare crisis in the United States is the tempering of what we can afford versus what our expectations are—I don’t care if that’s for trauma or cancer or for primary care. We have very high expectations and yet we don’t want to pay very much.

DR. LIVINGSTON: What career advice do you give your young faculty or your trainees [who are] either going into trauma or acute care surgery or other specialties? What life-coach advice do you give them about their jobs, balance [balancing life], and life outside the hospital?

DR. CIOFFI: I think it comes down to three areas. [The] First is choosing your specialty. It’s easy to choose the specialty based on the things you like because you’re going to naturally gravitate toward things you like. But you really need to look at that specialty and figure out the parts that you don’t like and be totally honest with yourself [about them]. Because there are aspects of every specialty that are routine, mundane, and not

what we really like. You have to look critically at those negative parts—whatever they are and no matter how small they are—and answer [the question], “How does that effect me? Does it drive me to distraction so [much so that] every time that negative thing happens I’m going to want to kill somebody? Or, when it happens, I can shrug my shoulders I move on?”

Because in a[ny] given specialty, even if you really enjoy 80–90 percent [of it], if the other 10–20 percent drives you to distraction and makes you crazy, you probably should not do that specialty. You will be miserable because the only thing you will think about are those things you don’t like.

DR. LIVINGSTON: I really like what you said about the parts of the job you don’t like. I’ve done a lot of these past-president interviews and I think that’s the first time I’ve really heard it [that issue] articulated in quite that way. It’s [addressing] the less glamorous parts of the job. If those [aspects] are intolerable, then no matter what, even if you like 95 percent [of what you do], it [the job/specialty] is not going to be a good fit [for you].

DR. CIOFFI: Right. No. You spend all your time making up for being pissed off about something. And nobody wants that.

I think the second thing [advice I offer] is something I get asked a lot: “How did you become a Chair?,” or “How did you become a division chief?” [It’s/They’re concerned with] All about titles and positions. I just tell them, “When you see a void, fill the void, and worry about the permission and recognition later. If you see something that needs to be done that’s not getting done, just do it. Don’t go asking permission first, necessarily; but more importantly, don’t go looking for recognition for it afterward. Do it because you want to fill the void. If you do that and accomplish something, people will recognize that in its own time. I don’t care if that’s taking care of a patient, taking care of a problem, running a division, or altering how you do something, how you care for a certain kind of patient, or how you run something within your department or hospital. Fill the void and worry about the recognition later because it’s not about the recognition.”

DR. LIVINGSTON: Yes, that’s the “take out the garbage” or “do the dishes” philosophy. When you see the pail is full, just take out the garbage. When you see the sink is full, do the dishes

DR. CIOFFI: Right, but I am not so good at either of those two things. Seriously, you ought to be doing it [what you're trying to accomplish] for the right reason[s]. If you're doing it because you want recognition or you want a title, then you're doing it for the wrong reason[s].

The life-balance part is the third thing [area of advice]. I tell our students and residents, "You're not going to have the same number of hobbies as you would have had had you gone into something different from surgery. Surgery will take up some of the time you would have for a few of those [things]. But you're still going to have the opportunity for many things. Figure out what those [important hobbies, etc.] are. Early on, it's going to be your family. Later as your children grow and move on, it may be something else."

The perception that medical students often have is [that] you can't have life-balance as a surgeon or a trauma surgeon. That [idea] can't be farther from the truth. I actually think, even though we undoubtedly miss some life events at times from being on call, we have a lot more control over our lives than a lot of other professions. And if we have to be working, we actually like what we're doing. Nobody wants to get up at two o'clock in the morning and operate. But once you are there operating on a sick patient you think, "Hey, this is fun!"

You also have to seek life balance. That's the thing that always struck me from the time I was a student and a resident at Vermont. With all my friends around the country, and the world, and in the AAST: it is being part of a big family. You are part of the WTA and go skiing with everyone every year. The guys that I play golf with from the AAST— such as Martin [Croce] and Wayne [Meredith]—we make it a point to find time to play. If I'm going into D.C. for a meeting, I'm apt to fly into Baltimore the night before and have dinner with Tom [Scalea] and Sharon [Henry] instead of flying to D.C. direct. These things really make the national and international parts of our jobs enjoyable. You need to do the same at home.

DR. LIVINGSTON: Absolutely.

DR. CIOFFI: These are the special things. I don't think that the students understand that we have fun outside our work life. Or more correctly, that [fun/special things] meshes with our work life. I feel lucky to have those connections.

DR. LIVINGSTON: What do you think are the challenges and opportunities for [the fields of] trauma, critical care, and acute care surgery going forward/in the next decade or so?

DR. CIOFFI: I think it's exactly what [what's within] our strategic planning process that Bob Mackersie outlined three or four years ago and what Raul Coimbra's got us doing again [since] this past December (2016) and going forward. It's looking at those three components [], if you will. But it is also [about] education and research. The AAST has to be at the forefront of those endeavors.

Looking at our trajectory from when I attended my first AAST meeting in the early '80s until now is how the AAST has morphed from an organization that put on an Annual Meeting and published a journal, mostly related to trauma, to an organization that is involved throughout the entire spectrum of trauma, critical care, and acute care surgery in a positive way. We clearly have grown in a big way, and we've got to keep doing that.

There are a lot of things, and even other people and organizations, that compete with our mission. We just have to compete [with them] as best we can in those arenas and figure out who it is we need to partner with [in order] to move ahead. Sometimes, if we're going to get acute care surgery to be meaningful, we're going to have to partner with people who, in the past, we wouldn't typically have thought we'd partner with.

Go back a short 15 years ago: we were worried to death about acute care surgery. Now, I suspect almost every academic teaching hospital has a division of acute care surgery. As most Chairs are not trauma surgeons, the fact that these departments have those divisions is proof enough that the change has been viewed in a favorable way. Sometimes, [the creation of those departments is] for ulterior motives but, to me, that [divisions of acute care surgery in teaching hospitals] is a very big step forward. Even five years ago, I don't think we had that kind of recognition.

DR. LIVINGSTON: Yes. I think you're right. Anything you would change professionally? Anything you would change personally?

DR. CIOFFI: In terms of challenges?

DR. LIVINGSTON: In terms of like wanting something different. Decrease your [golf] handicap for example?.

DR. CIOFFI: I am in the midst of winter [golf] lessons. It's pretty defeating when your pro [instructor] says, "This winter, we're going to break your swing down entirely," it's like, "Really? You're really going to do that to me?"

No [but seriously]. I think what's been the most fun for me in my career . . . hmm . . . I have to be careful how I'm going to phrase this: I've been fortunate to have had lots of different parts to my career—being a clinical surgeon, doing research, being a division chief, and now being a Chair. The beauty of an academic career in surgery—in medicine in general, but especially surgery—is the ability to have a career over 30 to 40 years where you get to do a variety of different things. For me personally, that is important. It goes back to something you said about building but not maintaining. I've had to have new challenges or I get bored, and it's not good to get bored. Sometimes you wish you didn't have so many challenges administratively, but as we talked about [earlier], someone has got to do it.

As weird as my career has been—joining and spending eight years in the Army but getting to do it in the burn unit with Dr. Pruitt and then coming to only one [non-military] institution. I've been at only one civilian institution for 22 years, so my 30-year career has really been just in two places. Yes, there are lots of things, mostly little, I could say I'd change, but the reality is, I wouldn't change any of it.

Starting with John Davis and then getting Basil Pruitt as your boss, and having those two guys as your mentors and friends and role models and people who I could pick up the phone and talk to—Basil and I still talk a lot; obviously, John has been dead a couple of years now—I mean, what the hell would you change? It all seemed to happen so fortuitously. There was zero planning on my part. I was really very lucky.

DR. LIVINGSTON: I would imagine most people would totally agree with you. I never met Dr. Davis and only know of him through others. I do know Basil a bit and he's just been nothing but the gentleman [that] he is to me in my career. He has been great.

DR. CIOFFI: The things I liked about Dr. Davis were that: Number one, as long as what you did was for the best interest of a patient, he could forgive a lot. That was number one. Number two, he expected you to have fun. You know? Which meant you got in trouble some nights in the hospital because you were having fun.

But it was amazing to me how he could blow that off and keep you out of trouble or at least get you out of trouble. He never got upset with you about it as long as he knew that you were driven by what was in the best interest of your patients. To me that was the remarkable thing about him. He kept me and some of my coresidents and even some of the faculty out of trouble [and kept us wanting to work/strive for our careers] when I think many departmental chairs would have been happy to just to hang you out to dry.

DR. LIVINGSTON: Bill, thank you for your time to do this interview. It was great chatting [with you], and I think the stories are going to come out great.

DR. CIOFFI: No problem, and you are welcome. I'm glad we got it done.