



J. WAYNE MEREDITH, MD
PRESIDENT 2011–2012

DR. FREDERICK A. LUCHETTE

So Wayne, my first question deals with how it was that you decided to pursue a career in surgery and what it was that made you pursue trauma surgery?

DR. J. WAYNE MEREDITH

In college, I majored in physics and I was interested in electrical engineering. That's what I was going to do. I wanted to devise medical instrumentation. So I was going to get an electrical engineering degree and an MD degree and design stuff. And so I decided that the smartest way to do that was, the most training you could get, the better off you are. So if I got a medical degree, I would know what was needed and I would understand the language and I would be able to do all the stuff, so I was going to get an EE degree and then a medical degree.

And my folks, my dad, said, "How about getting your medical degree first? Then you can moonlight and come off the payroll"—his payroll—while I went to engineering school, right? Because he had three boys that are all coming through and likely to stay in school. I did that and I discovered that, unbeknownst to me or him, I had been raised to be a doctor my whole life. Then I started doing medicine. So once I got into medical school and started doing all the rotations, it was totally obvious I'd been raised to be a surgeon my whole life. I mean there was, it was just totally obvious.

My instincts were good. I never had to think about stuff, figure things out. It was just, I was just taught to think like a surgeon from the time I was a little kid. He worked all the time,

but when we had time, we spent time together. And we spent time doing things, you know, fixing cars or working around the house. And he is a very, very great diagnostician. He is a very great problem solver.

He is very analytical. And he taught all three of his sons to solve problems in a way that turns out to be the type of decision making, the type of problem solving that is associated with master clinicians and surgeons. He said, “Well, okay, it’s pretty simple, boys. You’ve got to figure out is it getting fuel? Is it getting electricity? You’ve got to figure out is it timed? Is the timing on the cylinder off? Here is how you do some of those checks now go figure it out.”

LUCHETTE

Sounds like your Dad had a very practical and basic approach to problem solving.

MEREDITH

Yes. And that’s just how he grew up and that’s how he thought and that’s how he taught us all to think.

LUCHETTE

What was the motivation to go from just general surgery to trauma surgery?

MEREDITH

I loved the excitement of trauma and I loved the intensity. So I liked the heart surgery also because it had a lot of intensity. And I liked topics of research in trauma. I liked shock resuscitation research. And I liked patients sick enough to die—critical care—from very early. We had two great critical care professors here that were inspirational to a whole bunch of young people, myself included as a third- and fourth-year medical student. So I knew I wanted to take care of sick patients, not mostly well patients.

So I had a lot of trouble deciding. I liked CT surgery. I was really good at it, and I really liked doing it. But it wasn’t what I wanted to study. I was interested in studying extravascular lung water [EVLW] when I was in the lab. I was studying the effects of inhalation injury treated with a colloid solution versus a crystalloid solution, back in that era, right? Colloid versus crystalloid was a big deal. So I was studying that and the guys that were doing the best at that were Frank Lewis and this guy named Tranbaugh at UCSF. So I wanted to go, I was thinking I would study that, I would do heart surgery and study EVLW.

And so I had set up a time to go work with them during—I can’t remember if it was during my third and fourth year or fourth and fifth year of residency—go spend a year in their lab. In addition, I had already spent a year at a lab here doing stuff, but to learn those techniques on that and to learn from the masters. I had that pretty much arranged, and then things changed here at home so that one of our residents ahead of me was not going to be able to be a chief that year. He had to wait a year, and that made it a gap and I had to fill that gap, so I couldn’t go. And so my year away fell through and I just finished my residency. Then things lined up to where I could finish that and I could finish my CT residency, so I did that.

In the meantime, I kept hungering for it and so I was set to go back out there but Trunkey had moved. So I had to decide do I want to go with Trunkey to study trauma at a new place or do I want to go to UCSF and do a trauma fellowship there. And I decided to go with Trunkey. And that was big. That made all the difference. He brainwashed me or inspired me or enlightened me or all of the above, and I wanted to do trauma. Some of it had to do with trauma systems, which I had not really appreciated. Some of it had to do with developing a system of care and developing a trauma service and all those pieces which did not exist where I had trained, really.

And they needed it, I came back after working with Trunkey to start that here. And all that just, I could see it and I loved it. And he sent me all over the state of Oregon working on the Oregon Trauma System, which was being developed then. I'd call him all the time, "Okay, here is what they said. What should I say?" He'd say, "Well, here is what you say about that." Right? And those were real important concepts, straight from the horse's mouth, you know?

LUCHETTE

It sounds like to say your father and Don Trunkey were influential mentors is probably an understatement. Any other key people as your career unfolded that really were influential mentors?

MEREDITH

My chairman Dick Meyers in general surgery and my chairman Bob Cordell in CT surgery have been heroes to me. And then, when I first came back here, Dick Dean, who was the chair of surgery, recruited me to come back here to head up the trauma program and has been probably the most constant, longest-standing academic professional mentor I've had.

LUCHETTE

How did your peers and your non-trauma peers and mentors view your decision to pursue trauma surgery rather than cardiothoracic surgery?

MEREDITH

They just thought I was out of my mind. They couldn't understand it at all. They still loved me but they didn't understand me.

LUCHETTE

Do they acknowledge you made the right decision now, you know, 20-some years later, 30 years later?

MEREDITH

I'm not sure of that. I'm not sure. Dr. Cordell has since died. And I'm not sure he or my other peers with whom I was a cardiac resident at the time, I'm not sure even they understand that it was right. I mean they think I've been successful at it, but they don't—they think I'd have been

that successful or more doing the other.

LUCETTE

And how did the leadership at your institution view your decision to push trauma more so than cardiothoracic surgery?

MEREDITH

They knew I had the interest because I had studied it a lot in the lab and I had shown an interest in it throughout my residency. And they knew they needed to build their trauma program. And then right at that time we changed chairs so we had the new chair. Dick Dean came in. And he knew he needed a trauma program and he knew he didn't know how to build one but needed a good one.

It seemed like a perfectly logical decision to me but at the time. But looking back on it now, I think that was a crazy decision on his part to bring this guy fresh out of a fellowship to start a trauma center. Right? I mean, I can't believe he did it.

LUCETTE

Tell us about particular studies that you are most proud of and how you feel it influenced the field of trauma care?

MEREDITH

That's tough. These scientific papers are a little bit like love letters, you know? They make real sense at the time, but if you dig one up from 20 years ago... Probably for me, the main paper of my career to me was the extravascular lung water paper I described to you earlier (*Am Surg*. 1983 Dec;49(12):637-41). Because it was just a hard project to do. It required doing it all myself. It was just a whole lot of things personally that made it a really important paper.

LUCETTE

So how did that work influence the care of injured patients?

MEREDITH

I don't think it did. I think it was very influential to me, but I don't think it was a big deal to the scientific community. I think of the papers that I wrote that foreshadowed or helped lead in changes was the paper called, "Non-operative Management of the Liver, the Exception or the Rule" (*J Trauma*. 1994;36(4):529-34), where we looked at our experience and stated for the first time in the literature that not only is it okay to manage liver injuries non-operatively, but that that's the main way we do it, you know, the main way we should do it. That was a AAST presentation. And that probably, if you look at—I don't think I'm famous for that or known for that at all—but I think that was the most prescient, substantive piece that I've played a part in.

LUCETTE

Are there any things over the years that you were out championing and then you look back now and you say, “Whoa, probably a bad idea to champion that in retrospect.”

MEREDITH

I did think laparoscopic cholecystectomy was going to be a flop. That turned out to be pretty wrong.

LUCHETTE

Looking back over your career, as the immediate past president, what are the two or three greatest advances in trauma care that have occurred during your career?

MEREDITH

Imaging, so CT ultrasound, and the whole piece around focusing our operative and resuscitation efforts on developing homeostasis and not fixing holes. So that led to the entire open abdomen piece. That led to the entire damage control piece. That led to the entire philosophy that you work on establishing homeostasis not just fixing everything you can find. That was a huge thing to become popularized. And it is not—it really wasn’t first brought up during my career, but it certainly became popularized during the course of my career.

So it wasn’t invented during the time that I’ve been a trauma surgeon but it’s become the norm. It’s become a philosophy that’s bigger than the technique even, really. If you think about it, it influences how we treat head injury, how we treat fractures, how we treat all bullet holes—chest injuries, right? It’s a philosophy that our goal in the initial time is of achieving homeostasis, it’s not fixing injuries. That’s huge. Then that leads to a lot of different things—open abdomen, open chest, damage control, resuscitation techniques, all that stuff. But that’s big.

LUCHETTE

What changes in practice patterns have occurred during your career?

MEREDITH

You know, it was such an operative field when I started. It was just operations as fast as you could do them all night, every night. And that is trauma. Part of that has dramatically changed. That’s big.

Bringing emergency general surgery back and compiling acute care surgery, I think, is a very big thing in terms of training and philosophy and a group of people that are going to train the next generation of surgeons, very big. Those are probably the biggest things. You know, a lot of resuscitation techniques are different, think about it, since then. We’ve talked about imaging.

LUCHETTE

You wear many different hats. At the end of the day, though, what is the most rewarding and gratifying aspect of your career? What brings you the most joy?

MEREDITH

To me, the friends I make, the people I have helped. No question about it.

LUCETTE

What aspects have you found to be the most challenging or difficult and distressing? What things keep you up at night?

MEREDITH

You know, right now I am really worried about the challenges in training surgeons in general, but in particular training surgeons to be full surgeons.

My heroes when I was growing up, your heroes when you were growing up, these were people who were not just great trauma surgeons but were great surgeons. David Richardson. Don Trunkey. These were people who were great surgeons, and they were great trauma surgeons *because* they were great surgeons, who could stop bleeding and think quickly and enjoyed, embraced that moment of chaos and that moment of having to make a decision without all the facts, right? Which many surgeons hate that feeling, but a few love it.

But we are not creating those people much any more. We're having a harder and harder time creating surgeons who are ready to go "out of the box," finish your residency, start practice, who are able to cover the breadth of general surgery in the community than we were 20 years ago. That worries me. We will need to figure out ways to make that happen because the public will need people who have that skill set, the skills of managing surgical diseases, and especially the diseases for which there is not enough time to get a referral, you know, go to the internet, get a family practitioner to refer you. There are a lot of diseases where you do not have that time. We've got to be training folks to do that. And the need is not going to go away. So I'm worried about that, probably more than anything.

LUCETTE

Do you have any thoughts about how to solve that problem?

MEREDITH

Well, I think a couple of the layers, one is acute care surgery fellowships. I think acute care surgeons working in the training programs in this country will help so that the trainees who are coming through general surgery residencies will see emergency surgery, including trauma, as an exciting, viable, wonderful part of a general surgery career, not just the hard parts that are just inconvenient and hate it.

I think many residents graduating think disdainfully of emergency surgery because they're taught to see it that way by their mentors who are required against their will to take emergency surgery call. I think if they were trained to do emergency surgery by the people

who loved doing it, just like they're trained to do breast surgery by the people who love to do breast surgery and transplants by the people who love to do transplants and colon surgery by the people who love to do colon surgery, they will love to do it. Right? So it will be viewed as a good part of general surgery by more general surgeons, even though they may not spend their career in trauma surgery. So I think that's an important part of it.

And then we're investigating with folks looking at finding a way to train the general surgeon post-general surgery residency, that would be sort of a fellowship to prepare you to be a general surgeon. And we might need to do that. We can't fix the five. Right? If you could fix the five, then that will solve it. There is great reason to think you can't fix the five because we've pulled so much time out of that training and put so many restrictions on how you can do that training it is hard to imagine that you can do it with less. Right?

LUCHETTE

So in your department, are there any old-fashioned general surgeons still practicing?

MEREDITH

So I talked about this in one of my presidential addresses, that surgery residents are much less likely to see those role models than they used to be, if you think about it, much less likely.

And so we need to find those opportunities. And more and more in the general surgery residency programs and academic medical centers, those people are retiring and finishing and not doing that, and the places that trainees see it are if they go out into community practices where they get to go work with some people. Even in the community practices it is getting harder and harder because those surgeons are retiring, too. So we're going to have to find that again. But you know most places I go now, they have almost no one left who is doing what I grew up thinking was the breadth of general surgery in an academic medical center.

LUCHETTE

What career advice would you give to the young academic trauma acute care surgeons coming along?

MEREDITH

There are lots of pieces of advice to give young academic people. The first is, "It's the journey, not the destination." So many people think it's so important to have your career planned out correctly.

If you talk to people, my peers and the people above me, my seniors in this world and you get to talking to them—I bet you are discovering through these phone calls—that very few people have said, "Oh, yes, I'm exactly where I mapped it out to be from the time I was 21 years old. And I have just clicked every little click along the way and the reason I'm successful is that I didn't step off of that path." That's an extremely unusual story in my book from the people that I have met who are successful.

Most of the people that I have met that are successful have demonstrated intellect and

passion for what they're doing. They've spent their lives working in areas that they care about and that are important to them and that they are making a contribution to something that's important to them. And the point is the contribution, not what it does for your career, not for any of those things. The point to them is they are passionate about it and they enjoy making a contribution to a field. And those are the people that wind up successful.

It all comes from trying to make a contribution. And so I think focus on the contribution you can make and not what you want to do to build your career is the first thing. And enjoy it, right? That's the first step.

The second step is the piece of advice I give young people often is focus. Early-on you feel like when opportunities come along they're the last opportunity you will ever be offered again, if you don't take it you will never have another chance to do anything that will be fun or make a contribution. And that's not true. So take on things that you can succeed in, take on things you can do, but don't take on everything that you see. And I've made that mistake through multiple points in my career where I've found myself just so, so extended that I was running so fast I hardly had time to stop and think about it. And that's from an insecurity that you will never be asked to do anything ever again. Right? And that's really not true. If you do well in the things you are asked to do, you will get asked to do more.

LUCHETTE

And so what kind of advice can you give the young folks about their lives outside the hospital?

MEREDITH

Well, I wind up giving advice about this a lot. The first thing I think is part of the reward and the joy of being a surgeon is being a surgeon. In other words, we get to enjoy our work more than most people, and so we get to enjoy our profession. So some of our work, time at work, in my mind, counts as our fun time. So when I walk out of the hospital, I've already had some of my fun time.

Another piece of advice is that having balance in your life doesn't mean that you pick three areas in your life and you spend precisely a third of your time in each of those areas. Having balance in your life means you are able to put the emphasis in an area when it needs it in an amount that it needs it. There are times when your job, your patients, your professional associations need a lot of your time and attention, and there are times when your family, your friends, your partners, your church needs a lot of your attention. Achieving balance is about giving them all they need when they need it, not about the same amount all the time. And the secret to doing that is to show your family every day how important they are to you by genuinely paying real—real, actual—attention to them not just spending time with them. All right?

LUCHETTE

Now that ACS is a recognized specialty, what do you think the challenges and opportunities are for the future of trauma and acute care surgery?

MEREDITH

Well, the biggest challenges for us are going to be challenges of substantive products. The pressures on medicine, on health care for the next decade is going to be how to deliver the care of higher quality at lower cost. And frankly, there is a huge risk that it's actually lower-cost, lower-cost, lower-cost at a quality that the public will accept, not actually higher quality.

And that could lead to some perverse decisions in terms of how we staff all of our emergency care in our country. And we need to be thoughtful of that and watchful of that and make sure that we are providing the best that there can be for patients that need emergency care of all types.

LUCHETTE

As you look back on your career, is there any one thing that you would change?

MEREDITH

You know, I would not change a damn thing. I would just do it more. I really would. I would not change a thing in my career. It's way more than I deserve. It's way more than I expected.

LUCHETTE

Is there anything what would you change in your life outside the hospital?

MEREDITH

You know I would have to say very little there. I have great relationships with the people that I love. They're all strong and none of them, you know, my kids have grown up well. They have very high integrity, very good work ethic, still love me and their mom. I tell you, I'm not sure I would change it much because it would be easy for it to come out differently.

If you took the time machine back, it could easily come out differently. And I think of the possible futures there are a lot more worse, possible futures that are much better than the path I've actually had the chance to experience.

LUCHETTE

What are your plans for the next 10–20 years clinically, academically, and personally as you enter this new phase of your career?

MEREDITH

So what you're saying is now that you're a past president and we're planning on putting you out to pasture, what are you going to do in the pasture? I want to keep doing what I've been doing. You know when my son was 16 years old and I was looking at should I become a chair and I was being recruited to do this job, I wasn't sure that I wanted to do that job.

My life's vision had always been to be a trauma surgeon and a trauma director, not the chair of a department. Gail and I were talking about it and my son came in. He was 16 years old. He has always given me really good advice. But he said, "Dad, which of these jobs that

you're looking at can you make the most contribution in?"

And I sorted through that. And then I finally came to the conclusion that it was probably the chair job. He said, "Well, then you ought to do that job because your whole life is about making a contribution." And that's where the pleasure comes from. That's where the joy comes from. And so, "That's pretty damned cool," I thought. It kind of chokes me up to realize that he was that observant, smart. And he's, that's just how he is. You know. So that's what I'll do next. That's what I'll keep doing. Because it is the journey, it is not the destination.

LUCHETTE

Lazar Greenfield writes about retirement and transitioning and, I know it's premature, but have you ever even thought about that phase of your life?

MEREDITH

Barely. I just turned 60. And I'm really just beginning to admit to myself that I will need to retire someday. And I'm really just now sorting out what to do with that. I won't need to do it for quite a while, probably 10 years. I've saved well and all those things so I don't have a lot of financial decision-making to make about that, which is a blessing.

I think I will, as time goes on, find ways to do more and more clinical care. What made me do this in the first place. The patients. Absolutely right. And it was hugs. Right? That was a family saying, "Thank you, Dr. Meredith, you saved my baby." Yes. That's what got me going.

LUCHETTE

But I do want to give you the opportunity to make additional comments for the readership about anything that we haven't covered in our discussion on the 75th anniversary of the AAST.

MEREDITH

Probably not, but you know, look through the changing times, look through the people who have made contribution to this organization. It's been a dramatic contribution to our world if you think about it. The way that injured patients get treated today compared to the way injured patients got treated when this organization began is unrecognizable in terms of systems, in terms of the science behind what we do.

They're unrecognizable, probably more than many, many other fields in medicine. It's a big deal. And an awful lot of that has been the AAST. So it's been a great 75 years. It's a great organization. To the young people that are listening, get involved in the AAST. Send your papers here. Get your work published here. Get noticed. Go to the meetings. Work hard. Work for the contribution you can make, not for the recognition you can steal. And you will find out that the AAST needs a lot more people like you and lots more time from people like you.