

PAST PRESIDENT GRACE S. ROZYCKI, M.D., M.B.A.

DAVID LIVINGSTON, M.D.: Grace, thank you for doing this. As you know these past-president interviews are a follow up of what Dr. Mackersie started at the 75th Annual Meeting. As well as students, there are a lot of people in residency and fellowship, and even junior faculty, who have a lot of misperceptions about the “giants” of trauma surgery. The idea in these interviews is to bring them [the “giants”] back to human stature and show that they are really cool people.

GRACE S. ROZYCKI, M.D., M.B.A.: Got it. Wonderful. I really appreciate your doing this, David. This is a labor of love for you. It means a lot to the AAST, so thank you ahead of time.

DR. LIVINGSTON: It was and is my pleasure, and it is a labor of love. Okay, the first typical question: How did you wind up in this career? In other words, how and when did you decide on surgery in general, and then, [when did you decide on] trauma?

DR. ROZYCKI: Yes, [I decided] very early on for surgery—at age 15—while in biology class dissecting the frog; I just knew it was for me. Prior to that, at age 12, I knew I wanted to become a doctor.

There were no medical personnel in our family whatsoever. [I’d] Never been in the operating room. Never had any exposure to anything in-depth of medicine, but I think I was born to do it. I just knew in my gut that this was what I wanted to do—and I have never looked back.

DR. LIVINGSTON: I’m really kind of interested. This was a calling? Everyone’s story is different. You were a preteen girl in your room and all of a sudden one day, you woke up and said, “I want to be a doctor?”

DR. ROZYCKI: Yes. I think I’d just known it for a long time. But, yes, that’s it.

DR. LIVINGSTON: Wow. So what did your parents think of this pronouncement? What did your peer group think?

DR. ROZYCKI: I pretty much kept it to myself, except for my parents. I think they knew. I studied a lot. You have to understand that I come from a very, very humble background, in a very, very small town. We only had 38 people in our high school graduating class. I went from Grade 1 all the way up to Grade 12 with pretty much the same class. This was a very small town. So I did keep it to myself, but I knew that’s what I wanted and studied very hard. And as they say, “the rest is history,” so to speak.

DR. LIVINGSTON: You obviously entered college with the idea that you wanted to go to medical school. You were clearly focused from the beginning,

DR. ROZYCKI: Right. I just knew.

DR. LIVINGSTON: Given the drive and focus, you made it through college and then successfully got into medical school, right?

DR. ROZYCKI: No, I didn't. That was the hard part. I spoke about this in part of my Western Trauma Presidential Address in 2009. We [my family] really couldn't afford for me to go any college. I had to go where I got a scholarship and that was to a local college—Misericordia. It was mainly for nursing and teaching, but it was not very good for biology. There were only six of us in the biology class. Misericordia was not my first choice, but that's where my parents could afford for me to go, so that's where I went—[with] that [scholarship] and with a lot of school loans as well. Unfortunately, it [Misericordia] did not prepare me to apply to medical school. I knew nothing about MCAT preparation, like with the Kaplan course. There was nothing along that line on campus or even locally. To make a long story short, when I finally found out about MCAT prep courses, I had to travel from northeastern Pennsylvania to Philadelphia once a week. Finally, on my fourth try, I got into medical school.

DR. LIVINGSTON: While I've heard your WTA address, I wanted you to tell it again because I think it just shows your commitment and perseverance, which are major themes in your career. I also think it is illustrative to students and trainees that to be truly successful, it takes effort and hard work. You were clearly on a mission in a lot of ways.

DR. ROZYCKI: I was definitely on a mission.

DR. LIVINGSTON: Where did you go to medical school?

DR. ROZYCKI: At Jefferson in Philadelphia. I was very, very happy about getting in there. It wasn't easy. It was my first time away from home.

We had over 200 [students] in our class, so for me, that was huge. That was a big, big thing for me to go to Philadelphia and be away from home; and medical school was not easy. You know the first two years were tough. It was [during] the clinical years where I did much, much better. The whole experience was really hard, but I was so grateful to be in medical school—I mean, just so grateful.

Every day I just say, "Thank God I'm a doctor." Yes, every day.

DR. LIVINGSTON: This whole story really exemplifies the “small-town girl in the big city” for the first time. During those years, Philly was not particularly a nice or kind place.

DR. ROZYCKI: Absolutely. It was a big deal.

DR. LIVINGSTON: Coming from a high school of [only] 38 and then a small college—it is the rare person whose medical school class is the largest one they have encountered. There is a made-for-TV movie in here.

Jefferson is one of the older medical schools and has a very long and august history. Right?

DR. ROZYCKI: It does. In fact, I don’t know if you know this or not, but it was the last medical school in the country to admit women. It admitted its first woman in 1961.

DR. LIVINGSTON: I did not know that.

DR. ROZYCKI: Yes. I knew I wanted to be a surgeon, but I was so grateful to just enjoy every rotation—whether it was pediatrics or obstetrics or psychiatry or whatever. I just felt so privileged to be in medical school. It was all about becoming a good doctor, so I just savored every rotation.

DR. LIVINGSTON: Right. So you had this idea you wanted to be a surgeon from the beginning—since dissecting that frog. Did anything or anyone dissuade you or give you pause [while you were] on the road during the third year?

DR. ROZYCKI: Not a thing. Nope.

DR. LIVINGSTON: Okay, so you are determined to go into surgery. Did you have any mentors that helped [or did you receive] any good advice?

DR. ROZYCKI: You know, I don’t remember anything or anyone particular. I think I was just so focused. Nothing strikes me about advice for becoming a surgeon. I mean, [I heard] just the usual “work hard” type thing and “move forward,” but nothing beyond that.

DR. LIVINGSTON: You finally get to be a surgical resident. When did you decide to do trauma?

DR. ROZYCKI: Let me back up a minute. Although general surgery was my first love, toward the end of medical school I got sidetracked with a passion for neurosurgery. I absolutely loved it. So I actually ended up matching at Medical College of Virginia (now VCU), in Richmond, for neurosurgery and was a neurosurgical resident for two years. But I really wanted to get back to general surgery.

DR. LIVINGSTON: What happened? Did you get disillusioned with neurosurgery or was it something specific?

DR. ROZYCKI: It was too focused for me. I really enjoyed trauma a lot more so that's how I got back into the general surgery.

DR. LIVINGSTON: I don't think that this is common knowledge.

DR. ROZYCKI: Yes. I will tell you who was on faculty: there was Kimball Maull. He had just accepted the chairmanship at University of Tennessee in Knoxville. Honestly, I didn't have a job. They didn't have a place for me to come back into general surgery. So Dr. Maull really his open heart and decided to take a chance on me. I remember the words I told him. I said, "I really will work very hard for you," and he took me to that program in Knoxville.

I was somewhat of a pioneer there too because they were only finishing one resident a year at the program, and it was a very small program. I think they have grown to four or five residents per year now, but it was a very small program back then. I was the first woman to finish from there. I usually don't count things like that, but it was a very small program. Because of that [the program's small size], I got to do a wide breadth of cases: whatever came through the pike, I had my pick. As you can imagine, when you get to be a chief resident you are doing aneurysms and carotids and Whipples and everything.

DR. LIVINGSTON: Yes, whatever you want to do on the schedule. It's your choice.

DR. ROZYCKI: Exactly. My choice. And that worked very much in my favor. I remember by the time I finished, I finished with like 1,400 cases. Most of us in those days, David—yourself probably included—finished up with a lot more than they are finishing with now because of the way we practiced. We did so many DPLs which led to a laparotomy and all that sort of stuff. Somewhere in that experience was a lot of exposure to trauma because Kimball Maull was getting the trauma center up and going there. There was nothing [for trauma] there before.

He really influenced me. I really enjoyed it [trauma surgery] a lot. It seemed to suit my personality. In order to satisfy the Level I requirement, you had to have either a PGY4 or PGY5 in-house every night. Being that there was only one resident at each of those levels, I did two-out-of-three in-house calls. In fact, they set up a trailer for me in the back area [to stay in]. I still have a picture of that trailer. I'm serious. Nobody believes me about this.

DR. LIVINGSTON: I do. Clearly, [this was] long before the 80-hour workweek. We just literally lived on those services. The true roots of being a “resident.” It also goes along with your drive and perseverance for excellence.

Given that you grew up in a small town in northeastern PA, [if I were you] I wouldn’t tell a lot of people you have a picture of yourself in a trailer because they’ll think that that is where you grew up.

DR. ROZYCKI: Exactly. I mean it was amazing. I never complained. I was just so thrilled to be in a surgical residency. They were great people.

DR. LIVINGSTON: So you did all the things that we won’t let our residents do now: you did too much call; you did too many cases.

DR. ROZYCKI: Yes. It was such a different world back then, but we ended up with a lot of experience.

DR. LIVINGSTON: Kimball [Maull] was a big name early in the trauma game, so clearly, he must have been very supportive of your career choice.

DR. ROZYCKI: Yes, very much so. As you know, at that point in time, there was a little sheet of paper with some typed names of trauma fellowship programs. In 1988, there were just a handful of programs in the country. I looked at the list and I saw Washington, D.C. I said, “That’s where I want to go.” I have no idea what made me say it. So he got on the phone with Howard Champion and said, “I’ve got an aggressive resident here. I think she would be great.” I went and interviewed and it was great. I could not have asked for a better fellowship. In those days it was a lot of penetrating trauma—the crack-cocaine wars were on.

DR. LIVINGSTON: Sure. It was epidemic around the country.

DR. ROZYCKI: It was every-other night along with every-other weekend. Actually the joke [among us] when I was finishing from Knoxville was “Well, what are you going to do in all your spare time? You’re only on every-other now?”

DR. LIVINGSTON: Yes, right, because you were on two-out-of-three as a chief in Knoxville, living in your trailer.

DR. ROZYCKI: I know. Exactly.

DR. LIVINGSTON: Can you imagine telling a resident today they would be on two-out-of-three nights? Even every-other night? They’d look at you like . . .

DR. ROZYCKI: You’re insane.

DR. LIVINGSTON: Yes, [like] you're insane.

DR. ROZYCKI: Exactly. But I enjoyed every minute of it. I really did. Was I tired? Yes, I was tired, exhausted. But you got to do the best of the best.

DR. LIVINGSTON: Let's switch gears a little bit. You're looking back [now], and of all the things you've done, what one or two scientific contributions are you most proud of? And how did it shape trauma care?

DR. ROZYCKI: Well, I'd have to say, honestly, the ultrasound.

DR. LIVINGSTON: Yes. For you the question is an easy gimme.

DR. ROZYCKI: It is easy but it is a funny story the way it came about. Howard Champion had all these connections over in Europe. That's where he was from. He came back one day from a trip abroad and said, "You ought to see what the Germans are doing. They're doing this ultrasound stuff for trauma." I said, "I'll be glad to look at it, but I think it's going to be worthless. It's not going to be accurate enough."

He hired an ultrasound technician to train us in ultrasound at night. That person was standing there as we were working up patients in the trauma bay. This was also done on the sly because the radiologists back then controlled diagnostic imaging, but [they] weren't in-house at eleven o'clock at night and we were. We did observational studies and it worked. Not for specific injury, but it worked for "blood or no blood"—it had a focused role. That first observation led from one study to another [and then] to some multicenter studies. I'd say that was about my biggest contribution in terms of trauma care. I wouldn't say I did it all. There were many, many contributions from others, but I think I can say that I kind of got it started.

DR. LIVINGSTON: No, I think that you are being too modest here. You are pretty synonymous with ultrasound for trauma for good reason, Grace. I mean, really. Hearing that story, I'm more fascinated by the nuances of all this.

So Howard [Champion] comes to you, in his own inimitable way, and tells you about how great this ultrasound thing is and you go, "Nah." That has to be up there in the world's greatest "mis-predictions." When did you become a believer? When did you "drink the Kool-Aid?"

DR. ROZYCKI: I owe a lot to Gage Ocshner on that. We were doing these early studies and the ultrasound machines in those days were monstrosities with poor resolution and and mechanical probes that kind of vibrated in your hands and if you dropped one, you were out, oh my gosh, thousands of dollars. The one thing that struck me about the exam was that it was rapid.

You could ask a question and get an answer. It may not be the most accurate, but, boy, it was rapid and you could do it right there at the bedside. I think that's when we began to really look at how much, you know, influence this could have—at least as a screening tool, initially.

DR. LIVINGSTON: Unfortunately since we can't ask him, did Gage believe in it from the beginning?

DR. ROZYCKI: Yes, he did. He was very enthusiastic and really, if I go back, it was Gage that kept me going with it. He was as enthusiastic as anyone if not more so. We had to do a follow-up ultrasound on these patients even though, initially, we were comparing it to CT scan or DPL. We did a follow-up ultrasound on these patients and I will tell you that that was really hard. You'd be up all night. You were wheeling this monstrosity down the hall, going in the patients' rooms and there were two patients in each room. It's not like you had a heck of a lot of room in there. You were trying to get a repeat ultrasound for the study. These studies required a lot of "elbow grease" and commitment. Thankfully, Gage was just as committed as I was. I was always very grateful for that.

DR. LIVINGSTON: Again, I think perseverance and commitment is clearly a theme in your life and career. It is no surprise that commitment comes through in a lot of the past presidents' interviews. So besides ultrasound, which has been a major advance in trauma, what other major advances in trauma care have occurred during your career?

DR. ROZYCKI: The evolution of CT: the resolution getting better and the ability to see contrast to identify blushes or active bleeding, for example. I think that's a big one. We've gone heavily from invasive to non-invasive treatments. The ability to watch solid organ injury. And non-operative management.

I think the other thing is the overall way we're learning. We were among the first trainees to ever take ATLS courses. That was an evolution in itself. It used to go on for two-and-a-half days or something. Nowadays I'm seeing a lot of different things, whether it's simulation or cadaver courses. So that element of the practice is done in a safer environment so-to-speak.

I guess the trade off is that those residents are not really getting the full dose of the "sweat" factor that we got. You remember what it was like. Many times you'd be there in the middle of the night and you had to make a decision. You were the most senior person [on call] and [you] were making the decisions to do something or not to do something; those decisions had consequences. I think I see that as a major change in practice.

DR. LIVINGSTON: Any other particular practice pattern changes that you've observed? I mean, medicine seems to be constantly changing so what changes in practice patterns do you see for good and for bad?

DR. ROZYCKI: I think the shiftwork. There is almost no call left anymore. It's a specific, dedicated 12 hours or 16 hours or something. The patients aren't followed. In our day, you operated on somebody and you assumed that patient's care until they left your practice or the residency practice. I think it's a lot more fragmented and, hence, I'm not sure that the residents are getting the full dose of patient care from beginning to the end. As I said in my presidential address, when we trained it was like watching a movie over and over and over and over again until the lines were memorized and we could anticipate the next scene. I think the residents are learning today, but they're going in and out of the theater without seeing the movie from beginning to end. [So] It takes them about five times as long to get to the end product. You can only learn so much in simulation or courses or so forth. I think that the delivery of somewhat fragmented care is not necessarily going to result in the best judgment.

I guess the upside is that they have to be less tired than we were. Whatever they're doing with that time off, whether they are reading or doing research, there is at least opportunity for them to do other things and have a more balanced lifestyle. I never felt compromised in any way because of anything I missed. I never had that as a regret or anything like that, but I can envision that some do. They wish they had it both ways, so to speak. They would do surgery but they didn't want to be there all the time. So those are other changes.

DR. LIVINGSTON: I think that's life; trade-offs. It also goes back to commitment.

DR. ROZYCKI: Yes.

DR. LIVINGSTON: You've found a lot of what you do rewarding. What is the thing that has been most rewarding in your career?

DR. ROZYCKI: Honestly I would say it's the patients. I really enjoy the patients now more than ever—anything from the stories they tell to the empathy. I really enjoy the patients. I also still enjoy being a doctor. It doesn't necessarily mean I have to be a surgeon all the time. My family calls me for advice on everything. What do I know about, you know, pediatrics or obstetrics or any of that? You know? Only a little bit, but I can at least find an answer and my commonsense comes through. I really enjoy being able to help others like that. I find that very, very rewarding.

It's hard to imagine that someday I won't have that. Because right now I can go into a clinic or the office and give the patients my opinion and advice. You say, "Here is what I want you to do." And they do it. You think about giving that up some day, and it's not that easy.

I think the other thing that has been very rewarding is [the ability] to influence others. Whether it be inspiring them or mentoring them or something. I have always enjoyed that. My belief is everybody has something to bring to the table. It doesn't have to be brilliant. It doesn't have to be something new. It could be just something really tiny. I'm actually on the ICU service this week because I'm filling in for somebody. I didn't plan on it, so I only have a little bit of time to do the teaching that I want to do. So I told the resident, "We're going to do bite-sized teaching," and so we do a couple of questions or we discussed an article today on thoracotomy. We're doing bite-sized.

You don't have to give an hour lecture, just bring something to the table. Sometimes it can be done in a very subtle way. I really enjoy [teaching] just the approach to the patients, the professionalism. I hope that they [the residents] pick up something because that's the way you want the profession to live on: in a very high regard and professional mode because I still believe it's a calling.

DR. LIVINGSTON: Well, every student or resident of yours I've ever met has related that to me. You have left that legacy, Grace. There is no doubt in my mind about that. I think your Western Trauma Presidential Address on mentorship clearly demonstrated that love and commitment.

DR. ROZYCKI: Thank you, David. Thanks so much for mentioning that.

DR. LIVINGSTON: What has been the most difficult part of your career? What is challenging? Or what still keeps you up at night? Either with patient care or the headaches of leadership or research or whatever?

DR. ROZYCKI: I think it's challenging to keep up with everything that's going on. I'm, you know, getting ready for my recertification exam again. I'm agonizing over it.

DR. LIVINGSTON: I'm taking it a week from Friday.

DR. ROZYCKI: Oh, God. Well, you'd better just tell me it's easy or something. Can I go there and round in the ICU? Of course I can. But my knowledge base is basic commonsense; critical care commonsense. I wouldn't say that I'm up-to-date on every article or whatever, so that's challenging.

I look at transitioning my career to taking care of patients in a different way. Part of my role here as chief of surgery is to look at the patient experience in all of the surgical divisions in our department from clinic to discharge. I believe that's important work to do because I know I can help patients in another way.

Some of those things are not that easy. It's frustrating to have to go through so many layers, for example, just to get another nurse practitioner—gathering the data together to justify it. Those things are challenging. I don't know if I would say that they're negatives, but I think it's important that, as years go by, there is a transition of your emphasis or a transition of your career to realize that there are many different ways to take care of patients.

Also the research component. I still have ideas: I just try to work with medical students or junior faculty to get them executed. It's hard. They are not exactly staying post-call to do research. They're going home. I remember that's how I got my research done. It was being [there] post-call and figuring out what can I do, or I came in on weekends. I would say that's another component of it: to have an idea and then to move it through the system is still hard. It's challenging.

DR. LIVINGSTON: I totally get that sentiment. I used to read my bone marrow plates when I was on-call or post-call [and sometimes] falling asleep into the microscope.

Let's change topics. I know that you've thought and spoken about this: What do you think the future of trauma and ACS is? Challenges? Opportunities?

DR. ROZYCKI: I actually think it's a good time for trauma and ACS because it is one of the last areas where we can operate on almost any part of the body. Pediatric surgeons used to say that, but I'm not even sure they do that much anymore.

You can do almost anything as you gain in experience. I think the downside is it's not as operative as it used to be; hence, that's why we have emergency general surgery. I think that's, you know, an exciting piece of it. I think we just have to figure out how to translate a lot of the wisdom so that these trainees [can/will] treat these patients [directly] all the way through [the system].

Sometimes, when the issues are easy, it's okay to do the shift work; the patients are going to be fine. But other times, these patients develop complex issues—as you know from the work you and David [Feliciano] did on the operate through the skin graft abstract. Those patients need complex operations and one physician making the decisions. I think that's where there is a bit of a challenge and nobody else wants to do it. It's not like the minimally invasive surgeons are standing

in line to care for these patients. They've got their own niche. I think that's a direction and an opportunity for ACS.

I also think we have need to work with our colleagues in other fields. We've established some relationships with the Purdue engineers here in Indiana. There are projects where I want to see something progress. For example, we have a lot of patients with rib fractures and who have chest tubes, and they're just sitting around trying to wait for the lung to come up. I would love to see [the creation of] some device, that we can partner with the engineers to make, to get the lung up in a non-invasive way. There is lots of excitement about the potential for thinking "outside the box" and making progress like we never have before.

DR. LIVINGSTON: Those are great opportunities.

You mentor a lot of students, residents, and fellows. Clearly this is a big part of your life. What career advice do you give them? How do you "life coach" for both their academic and their non-academic careers?

DR. ROZYCKI: I think it really centers around being a good doctor. The better doctors we are, the better surgeons we will be—whatever the chosen field. I focus a lot on that: the care of the patient and the professionalism.

I believe as they grow into whatever area they want to do, it's a good idea for them to focus. It's one of the best pieces of advice I was ever given by Steve Shackford. Focus. In other words, don't try to do everything. Don't try to do three or four things halfway. Just focus on something and commit to it. It will pay dividends in the long run. If they're going down the route of academics, for example, and they really want to do research and publish. [I'll tell them] Don't just dabble or dive into it. Think about it. Learn how to do it right. Develop a solid hypothesis and that's good.

If they want to be an excellent technical surgeon, they have to think about practicing all sorts of knots and suturing and so forth. Think about the 10,000 hours at a minimum, that they say the Olympians do, to become experts. I think that it's a combination of dedication and focus.

DR. LIVINGSTON: I really liked the way you use the word "doctor" in the real doctoring sense: the global sense of not just being an internist, not just being a surgeon, but being that person who is caring for another human being. The professionalism and the patient care and just the whole gestalt of being a physician is really, I think, what you're talking about. From all of your students and trainees I have met, I think that is what you impart in a great way.

DR. ROZYCKI: Well, it's very special. I mean what other profession in the whole world allows you to touch another patient or to really examine somebody. When you think about it, I mean, these people are so vulnerable, in pain and emotionally distraught, and their families, too. They really need to look toward the doctor who says, "It's going to be okay. You're going to make it," or "The first 48 hours are the worst, but you'll get better from there on in." We sometimes forget the talent or the inner strength that we have to convey to the patient. I think and truly believe that's something very special.

DR. LIVINGSTON: Totally great and well said, Grace. Just a little bit to finish up. You sort of touched on it a little bit before about changing your role and the many ways to care for patients— either on a personal one-on-one or on a more global institutional level. So, as you move on to chapter 5 or 6, or whatever chapter of your career we are in at this point, what's next for Dr. Rozycki?

DR. ROZYCKI: I wish I could answer that. I'm probably not too unlike a lot of other surgeons out there. It's been a very, very big part of my life. I'm also very grateful for it. It's not as though I find it burdensome. I do know that I need to transition a little more. Probably give up some of the clinical eventually and do maybe a little more administrative. But exactly when and where and how and all of that I just haven't figured out yet. I'm reading books, actually, a couple of books. One is *The New Retirementality* and the other is *Trending Toward Significance*. I think that's the one. I'm just trying to gather information at this point in time.

I'm 65 and sometimes I feel it. It's time to begin to inch toward that because no one does "cold turkey." [There must be] Some kind of transition. That's why I'm trying to just gather information now and just figure out how to best transition to whatever that will be.

DR. LIVINGSTON: So if you had your choice and you could waive the "magic wand," describe the dream job. You're still doing research, you're still seeing patients, and you have a lot of administrative responsibilities. What do you want to give up? What do you want to keep?

DR. ROZYCKI: I don't have an answer for that. I think physically, I don't do night call anymore so that's, I think, a good thing. My stamina is clearly not what it used to be when I was 25. So for me to be able to do what I need to do on a daily basis, I don't want to be up all night. Exactly what to do and how to get there I'm not really sure, David. I don't know.

DR. LIVINGSTON: Yes, I understand. These are all of the questions we of a certain age are all asking ourselves. It is interesting how we are all approaching it. I ask myself, every day, the same questions. Anything else you want to add, Grace, that we didn't touch on?

DR. ROZYCKI: Well, I just wanted to say thank you so much for taking the time to do this. This has been insightful for me. Sometimes it's nice to be able to reflect on all of this and have somebody ask you a question that allows you to come straight from the heart when you answer it. There is nothing fake about it at all. It's just nice to sometimes reflect on all of the things that are very important in your career and life. The things that you've lived for and that you consider to be representative of who you are. So thank you, again.