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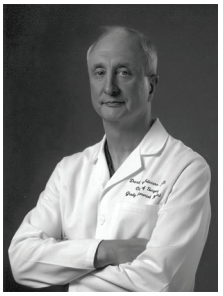

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President 2006–2007

Dr. Frederick A. Luchette

How it was that you decided on a career in surgery and then how you came to focus on trauma surgery?

Dr. David V. Feliciano

My dad was a community general surgeon. He had me working in the hospital as a high school student doing urinalysis on Saturday mornings and had me start as an operating room technician after my freshman year of college in the summer. So I had a strong father influence.

The trauma came because after I got an early discharge from the Navy, I went to work as an emergency room doctor at Saint John's Hospital in Oxnard, California.

I was the only emergency room doctor on the day shifts. There was a certain amount of trauma in the community, so I became very interested in it just based on that early exposure. As an intern at the Mayo Clinic, I hadn't seen that much trauma. But I did see a fair amount in California.

Luchette

But when you trained, emergency medicine was in its infancy?

Feliciano

Emergency medicine started right around 1970–71, if you look at when they had their first

meetings, and the hospital that I worked in was going to have an emergency room group. But, as you say, there weren't any emergency medicine physicians around. I was the first hire for the doctor who was going to take over the emergency room, and he thought it was great because I had some surgical experience.

Luchette

Now, regarding your childhood, is it almost fair to say the choice of surgery was partially genetic?

Feliciano

Yes. My dad was the oldest son of a large Italian family, all of whom lived in one small community about 15 miles from New York City, and he was a very dominating force in the family.

I was quietly programmed or groomed to go into medicine, certainly, and then surgery later. It was always in the back of my mind certainly after high school and all the way through pre-med that surgery would probably be what I would go into, though I had fleeting thoughts of other specialties.

I knew I was going into science in high school. And by the time I got to college I was pretty sure I wanted to be a physician. After my rotations in medical school, I realized surgery was probably the only thing that was going to fit my personality. I just did not have the personality to take care of chronic and incurable diseases that make up the rest of medicine.

Luchette

So obviously it sounds like your dad was an important mentor and advisor early-on.

Feliciano

Yes, I was spoiled. You know, I had a very level-headed father who was a good operating surgeon. He was so well-respected in the small community and served on the board of health and the board of education doctor. He was at every high school football game. I mean my dad was just a major figure in the community and beloved in the hospital. He eventually became chief of surgery and chief of staff. So you cannot have a better role model than I had.

Luchette

Who were some other important mentors?

Feliciano

I think the biggest ones were during my residency at the Mayo Clinic, especially Jon van Heerden and Oliver Beahrs. I took a leave of absence from the Mayo Clinic then, when to go to Detroit and fell under the spell of Drs. Charles Lucas and Anna Ledgerwood at Detroit Receiving Hospital.

They just had an incredible influence on me because they were demanding, they had broad practices in general and trauma surgery, and they were excellent teachers. So, for the

past 38 years, they have been two of the best friends and best boosters for a career that you could ever have. They have been so loyal and supportive. There is no way I can ever express enough gratitude for what they did for me.

Another mentor during my residency was Peter Mucha who set up the original emergency room surgical service, the acute care surgery service, at the Mayo Clinic back in '76 and '77. I was one of Peter's first chief residents. He became one of my dearest friends and mentors of all time. As you know, Peter died prematurely a couple of years ago, and some days I'm still reeling from his death.

And, finally, Ken Mattox and George Jordan in Houston. I spent eleven years with two giants in American surgery. I just learned so much from them, not just trauma and surgery, but a lot about running departments, public hospitals, managing residents, and recruiting. I owe both of them an incalculable debt for the way they groomed and taught me. So I have had great mentors.

Luchette

During your training at Mayo Clinic, there were several leaders in American surgery at that time. How did they view your decision go to down the road of trauma surgery?

Feliciano

They were very dubious. I mean I had been groomed as a general surgeon by some of the real giants in American surgery like Ollie Beahrs, and Bill Remine and Don McIlrath and in endocrine surgery by Jon van Heerden and Tony Edis. Several of them spoke to me before I left for Houston and reminded me that they had not traditionally trained people for that kind of an academic trauma practice.

Luchette

Tell us about some of your proudest work and how it influenced the field of trauma care.

Feliciano

I think my organization of abdominal vascular injuries into regions was one of the best things I did. I always had trouble explaining to residents how to expose things and what's the approach. Dividing the abdomen into five regions, which we have kept in our trauma book even though most people use only the standard three zones had been helpful to people to learn which vessels are in which area and the difference in exposing them for a hematoma versus hemorrhage. I still write that chapter in our trauma book and feel very possessive about the various vascular injuries in the abdomen and pelvis.

I think the second contribution was in hepatic trauma. There are few organs where we have so many different ways of handling the bleeding. This includes hepatorrhaphy with sutures up to resectional debridement versus more exotic things like packing or vicryl mesh wraps, balloon tamponade, etc. I think some of the papers I wrote on packing and our large series on operative hepatic trauma were helpful to young surgeons.

I think a third area I've really been interested in is peripheral vascular trauma. It's important for young surgeons to understand the fine points of operative technique and recognize that many of these injuries are managed by non-vascular surgeons. I think there is a very structured, orderly and safe way for a general surgeon to repair what is otherwise a healthy vessel in a young trauma patient.

In more recent years, I have focused on things like shunts and balloons. Historically, the introduction of PTFE grafts (which Ken Mattox introduced me to) and fasciotomies. You know, a whole part of my CV is peripheral vascular trauma. So I think those three areas are the ones that I've been most interested in, honestly.

Luchette

I'd like you to take a minute to look back over your career and tell us about a topic that you were passionate about 25–30 years ago and now, as you look back you say, "Boy, maybe I shouldn't have been so vocal about advocating for this because it was probably not the best thing for patients."

Feliciano

I think the biggest thing was the emphasis on doing angiography in all patients with penetrating extremity trauma. We had such a generic definition that anybody who had a bullet wound within an extremity got an angio. When I was at Ben Taub General Hospital in Houston, we had second-year surgical residents doing percutaneous angiograms. In 18 months, the residents performed 554 of these!

Rick Frykberg and Jim Dennis from Jacksonville later recognized that most of these, of course, were negative studies and that a physical exam was probably just as good in many ways. I honestly was embarrassed to realize that, with such a high true-negative rate it's probably not a necessary study in many patients.

So I wish I had recognized that it was probably unnecessary in a fair number of patients. Rick and Jim's work on selective angiography has stood the test of time, and it's really changed the practice. I wish I had thought of it. And I have told Rick that a thousand times.

Luchette

What do you think are the two or three most significant advances in trauma care and science?

Feliciano

Two of them are imaging. Certainly CT and surgeon-performed ultrasound have incredibly changed our practice with blunt trauma and sometimes with penetrating trauma. The third one, without question, is the concept of damage control. I think we recognized in Houston in the late '80s that we were way over-operating on patients. I have great admiration for what Mike Rotondo, Bill Schwab, and Mike McGonigal and their colleagues did with codifying the term and pushing a concept that I think many trauma surgeons were unwilling to accept in the beginning.

So CT, ultrasound, and damage control are the three things that I feel have really changed our practice in my 34 years.

Luchette

Is there a fourth? What about the concept of shunting for peripheral vascular or major vascular?

Feliciano

That's something that is done only in 8–9% of patients, so I don't think that's up there with the others where the number of patients affected is so much greater.

Luchette

How about changes in practice patterns during your career, not so much advances in the care but rather changes in practice patterns?

Feliciano

One is the team approach. Certainly, when I started my career I felt totally responsible with the residents for everything about the patient. We didn't have the help of physician extenders.

And now with fellows, nurse practitioners, physician assistants, etcetera, you can offer a higher level of care. So, I do believe in the team approach. I hated to give up some of my authority over time, but believe that patient care is better for it.

The other really big change is the 80-hour work week for residents. I don't know if it is a practice pattern change, but I view it as that. Prior to 2003, when a surgical resident was working 120 hours each week at the junior level, I had consistent support on patient care with the same team all the time. I am one of those people who feels that the shift work related to the work hours has fragmented care tremendously. Since 2003, I have felt this pressure with my own patients, both in my general surgery practice and my trauma practice, to keep an eye on them because of the many changes in the resident team.

Residents change, of course, every four to six weeks, like they always did, but now we don't have continuity in the patient's care. I feel it is very hurtful to complex trauma patients to change residents in the middle of the day.

Luchette

What is the single most significant "job" that you find the most rewarding and joyful at the end of the day?

Feliciano

A good operation with a patient who then does well or a complex trauma operation where you do the right things. I still take care of patients every day.

In the end, if all the other stuff was taken away from me, I'd be happy just being a surgeon, caring for trauma patients and practicing general surgery. So, my most rewarding

experiences of all have been with patients. I can't believe that we have the privilege of doing what we do.

The second thing has been the trainees. I've trained over 245 chief residents and about 30 fellows during my time at Grady. And, I can tell you where most of my former chief residents are—not all of them, but most. I can tell you where all the fellows are. Grace [Rozycki] has really helped me recognize how important it is for us to groom our successors and do it well. And it's a great joy to train younger surgeons and then have them call me for advice to tell me how their careers are going.

Certainly the chief residents that I have trained have been incredibly loyal. At my 60th and 65th birthdays, many chief residents from Baylor and Emory flew in from all over the country just to attend my birthday party. It was overwhelming. And I'm just so proud of the way Grace [Rozycki] developed the Grady fellowship and refined it. So that's the second thing.

And the third thing that I'm really proud of is my peer group in surgery. I mean your peer group always rises as time passes. But I am part of a peer group, including yourself, that has been responsible for wonderful contributions in general surgery, vascular surgery, thoracic surgery, and trauma.

I really am proud of a lot of my friends. We went through a bunch of changes in our careers with imaging and less operative trauma and the resident work hours and all the things we've discussed earlier. It's just been so exciting for me at this point in my career to look around and see who the leaders of American surgery are. And, a lot of them come from trauma and a lot of them are in the peer group.

Luchette

What sort of issues or changes keep you up at night worrying about where health care is going?

Feliciano

One of the things that has always bothered me is that the complications that will be discussed in the surgical M&M this week are the same complications that were discussed in surgical M&Ms when I was an intern and a resident. It really points out to me that we have failed as surgical educators—not just in trauma, but also in general surgery and related services. Since we have failed to communicate when we make mistakes and how best to avoid them, our trainees do the same silly things over and over again. I go insane when I go to M&Ms because it's no different today from my time at Ben Taub in Houston. It's the same complications: people closing the skin when there is stool all over the place and people not taking precautions on wound fascial closure with patients who are on steroids, are distended, and have COPD, etc.

The other thing that has bothered me is that you know from doing a lot of operative trauma that one can predict, almost in the emergency room based on blood pressure, base deficit or lactate, who is going to survive and who isn't. The whole concept of irreversible shock has driven me nuts my whole career. We clearly can fix the injuries in bleeding patients. But, if we don't get them soon enough, they are still going to die despite massive transfusion

protocols, warming of the operating room, and a gifted surgeon. I just haven't seen that much progress in how to bring people back from being near-dead. I can open a chest in the emergency room and can tell the residents whether or not they're going to live because, if they don't generate a real pressure, they're going to die. If they don't have a cardiac rhythm, they're going to die. Their heart is still beating but this irreversible shock "thing" has always bugged me.

Luchette

Do you think the over reliance on CT scan contributes a little bit to that delay and that "irreversible shock?"

Feliciano

You know, not so much because, traditionally those are more stable patients. It's just the inevitable delays with exsanguinating patients. It's the time it takes EMS to get there. It's the time it takes to bundle them up and get them in the ambulance. It's the travel time. And we always lose, 25 or 35 minutes, even in a compact, urban environment in the prehospital phase of care. I don't know whether that can be changed. But I do know that in the hospital there is nothing new that we have done other than damage control that might have some impact on this near death group.

Every trauma center that does penetrating trauma has people exsanguinate, either during the prehospital phase or in the emergency room. And I think there are some things we could do like putting operating rooms in every emergency room for these kind of patients, which some places do.

Luchette

And what advice would you give to young trauma surgeons or academic surgeons interested in a career in trauma and acute care surgery? What life coach advice would you give them as they start out in their career?

Feliciano

I have mainly been in academics and divide academic careers into thirds. You know the first third is when you really spend a lot of time doing clinical work and operating and rounding and getting your skills up to par and then start doing some studies and writing. Then during the second one-third of your career you're starting to angle for leadership positions and maybe doing more sophisticated studies and moving up in the societies. Finally, the third phase of your career should be the last ten-plus years or so—this is where you really have reached the level where you can do what you want, where you can take on what you want, operate on what you want.

And I always remind people that to get to that third phase you've got to do things right in the first two phases. I hear a lot of young faculty in my travels talk about their frustrations in academic careers. My response has always been the same: "It's your career, and there are certain things that you feel are impeding you. You can either try to change things at the insti-

tution you're at or you need to leave. But it's your career. It's not so much anybody holding you back." I mean if a career is not going well and your medical school says you have to write 50 papers to become an associate professor, this is not a point that you argue. You write them. You figure out a way to get help and write them. So I think understanding how to run your career is a big deal.

Secondly, with the privileges we have to get this far in our lives, with all the people who have been involved in training us and supporting us, I like to see surgeons give something back. Whether that is serving your community, setting up a hospice, training residents, writing papers that will help the community surgeon get better, volunteering—I don't really care what it is, just give back.

Unfortunately, there are a lot of surgeons these days who have become so internalized and focused on themselves, their income and their family, that they're missing the boat. There is a whole other world that they can impact. Therefore, I think giving something back and keeping that in mind from the day you start your career. It's not, "Oh, well, I'll do it when I retire." That's nonsense.

The third thing is to take care of your family. We have been given this privilege and the family certainly pays a price, as all of ours have, with not being there all the time, not paying attention to a spouse. I would do certain things better in my younger years as I was writing a lot and spending a lot of weekend time in the hospital. In retrospect, I would take the time to make my family know how much I appreciated them. There is no particular order of those three, but family is something you've just got to balance with the career. And, it can be done.

Luchette

Giving young upcoming surgeons advice on how to live their lives outside the hospital. Any other advice on outside activities away from medicine?

Feliciano

Yes. Part of it is being really organized and disciplined. When I was staying busy in Houston, my oldest son became a pretty good soccer player. I made up my mind that I would not miss any of his games. If he had a four o'clock game at his prep school, I would leave at 3:30. And, I would just get somebody to cover me. It would be easy not to do that, but I think paying attention to your family demands that you have to be highly disciplined and structured. Also, you have to have good relations with your colleagues. You cover for them, and they cover for you. It's an art form.

I think the second thing that I would do differently is dealing with friends. All my friendships have been in medicine and, particularly, in academic surgery. Whether those people are colleagues or true friends is sometimes hard to know. But, I've never spent enough time at any place I've worked paying attention to the people around me. It would be those two things in terms of life outside the hospital: family and more attention to colleagues and friends, particularly outside of medicine and surgery.

Luchette

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

Feliciano

I think everybody has to recognize that this is going to be a specialty that is going to attract, much as trauma and critical care did historically, a limited number of people. It still is hard in the sense that you're doing emergencies on difficult patients, often at off-hours, and reimbursement is iffy sometimes. Whereas it offers a benefit beyond a career in trauma and critical care, it also has some of the same limits. I think the day that every chief resident in a surgery program is going to go into acute care surgery is never going to happen.

I do think they are going to be doing shift work. Also, a guaranteed salary will be a major inducement since lifestyle is so important to the current generation of trainees in surgery. Also, I think that with interventional radiology and stents and other new technology, we're probably going to be doing even less and less operative management in emergency general surgery. For example, there are the laparoscopic washouts for perforated diverticulitis. Whereas acute care surgery certainly brings more operations to a trauma surgeon's practice, he or she is not going to be the busiest surgeon in the hospital. Shift work and dealing with some diseases that may be better treated in ways other than surgery impose some limits.

That being said, I think it is needed in certain universities and communities. In many communities, the general surgeons will want to hang on to their emergency practices and their emergency room coverage so that they can help feed their elective practices.

Luchette

Where is acute care surgery going to be in 20 years?

Feliciano

Well, the most important thing that we're all going to have to do in acute care surgery is do what we did in trauma, i.e. not accept the way we're doing things now and study how we can do things better or in a more innovative fashion.

When I started my trauma career, there were many things being done like exploring everyone who had stab wound through the abdominal wall or doing a cervical exploration on everyone with a little poke hole through the platysma in the neck. Once we studied these clinical situations, it was recognized that there was a high negative rate and exploration that non-op management is certainly appropriate in properly selected patients.

We are going to have to do those kind of studies in acute care surgery centers to actually convince general surgeons to do things a better way. If we study some things like which patients really don't need an appendectomy and which patients are going to benefit from a tube cholecystostomy, that would be the right way to convince the field academically.

Get these controversial areas studied properly, so it becomes a true specialty of its own. Then it will impact the way general surgeons who are not part of an acute care group practice

in the future.

Luchette

Is there anything you would change in your professional career?

Feliciano

Yes, without question: I would have left my last academic job before the new chairman started to dabble at Grady. We will leave it at that.

Luchette

Is there anything else you would have changed as you look back related to your life outside the hospital? To take care of yourself better, maybe?

Feliciano

Yes. I think if you enjoy this, like a lot of us do, you tend to not develop the other side of you. And, as I get closer and closer to retirement I mean people ask me, you know, "What hobbies do you have?" And I always, embarrassingly, have to say, "Well, I don't." Because I've really been spending all this time working at the hospital and then you come home and squeeze in family time. One day you wake up and all of a sudden it's 34 or 35 years later. Certainly the younger generation are much better about playing sports, enjoy traveling or have a true hobby. I regret not figuring out what other things would have made me happy.

When I was just starting my residency, immediately after serving in the U.S. Navy, I was a powerboat racer. I realized as I got into my residency that there weren't going to be too many weekends where I could be driving over to Wisconsin or Iowa to drive my boat. And I stopped. It's one of the single greatest regrets of my life because I could have, again, with a little organization and some cross-coverage with colleagues, kept doing it even now.

And I held on to my boat and all my equipment for years until my sister who was storing it for me finally made me sell it. But there was a hobby I absolutely loved. And, I gave it up. I have real regrets about that. I still, even as I get older, think about doing it. My son just gave me a gift on the history of boat racing, and I love it. Anyway, that's a regret.

Luchette

So what are your plans both clinically and academically and personally for the next ten years?

Feliciano

I'm going to work somewhere between two and five more years and hope to continue writing and mentoring people. And what I am also going to do in that time is try and find the other area outside of the career that might really excite me.

I've talked to enough friends and colleagues in recent years who have retired, and I've certainly spoken to Lazar Greenfield about this with his surveys of surgeons in the American Surgical Association and the American College of Surgeons. In essence, your health will

deteriorate rapidly after retirement if you don't have a focus that gets you out of bed in the morning, forces you to intellectualize a little bit, and that brings you some satisfaction. I've been really working at a high-intensity level for a long time. And I'm looking for another challenge after I stop operating.

I have teaching skills. Unfortunately, it is the least valued attribute that you can have in an academic surgical department. If you make money, they love you. If you do a hundred Whipples a year, they love you. If you bring in money-running courses they love you. If you get an NIH grant, they love you. If you have 35 teaching awards like I do, nobody cares. I am looking for something medically-related, but, if not, then something else that will really stimulate me and keep me intellectually active and happy. I am not going to sit there and play golf.

Luchette

Any last parting comments you want to leave for the readership?

Feliciano

Yes, I think one of the nicest parts about being involved with the trauma field is the people in trauma are some of the best I've met in my life, in or out of medicine. I really admire the incredible commitment that my peer group and the people who have preceded us and followed us have to the whole patient. I really appreciate the sacrifices everybody in this field makes personally and, sometimes, family, as we mentioned.

I have great admiration for the science that has come out of trauma during my three-and-a-half decades. Many of my peer group have done really brilliant studies that have absolutely impacted patient care, not just in trauma, but elsewhere. So, I think my contact with people in the trauma field has just been extraordinarily rewarding. And I'm sure people in breast surgery and laparoscopic surgery feel the same way. And, that's fine. But I feel I am part of a really special group of surgeons with this extraordinary energy level and commitment level, as I said. And, it's been wonderful to have colleagues like that.

There are a lot of people in trauma I really look forward to seeing at meetings. Though I am not a social person, there are some meetings I go to like the AAST and Western Trauma where I feel so comfortable. It's interesting to talk to everybody and see what they're doing and what they are planning for the end of their careers and how they are grooming young people.