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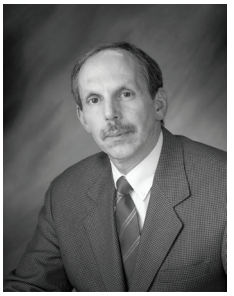

Andrew B. Peitzman, MD
President 2009–2010

Dr. Frederick A. Luchette

How and when did you decide to choose a career in surgery? And a follow up question would then be your decision to specialize in trauma surgery?

Dr. Andrew B. Peitzman

Obviously, a couple of different questions there. So I was one of those students who, for better or worse, loved almost every rotation I was on in medical school and was going to go into that field.

But even back then, whatever field it was, it was always the complex patients. It was high-risk pregnancy with neonatology so, you know, whatever my gene makeup is, from the get-go it was pretty clear I wanted to take care of sick people.

But surgery was really, largely a role model and it's just funny how these things happen. And I liked medicine a lot. That was my first clinical rotation. I loved the medicine service and the residents were great but the attending was just so condescending it just really impacted me. However , on the surgical service, the fellow who was—that was back when we had a super chief service—was just a humble, incredibly talented, good guy. And he left a big impact and is still practicing as a community surgeon. He actually is one of my community surgeons so it's sort of ironic that it worked out that way. But I tell him over and over he is one of the main reasons I went into surgery.

Trauma was a little bit more subtle. I liked a lot of other specialties when I was a sur-

gical resident. I liked cardiac a lot. But you know, trauma wasn't really a field back then. You know you've got to remember we're going back to the early '70s when it was really nascent and there weren't separate services. I mean we were general surgeons and we did everything.

And there was one case that really just sort of piqued my interest. I was an intern and the medics brought in a twenty-some-year-old girl who had jumped 100 feet off a bridge. And back in those days, there weren't trauma centers in the state of Pennsylvania. There weren't trauma services in the hospital. After patients arrived to the hospital, we resuscitated them literally in the radiology room which, as most radiology rooms are now, was dingy and dark. There was no equipment there. So it was me and a third-year resident trying to take care of this poor girl with essentially no equipment. And it just struck me that there had to be a better way to do what we were doing.

I think what ultimately made me decide on trauma as a field in surgery is the diversity. You never know what you are going to get into when you come in every day. But, at the same time, it's not a patient with a terminal disease. You can take a 19-year-old kid who is absolutely dying in front of your eyes and have them walk out of the hospital and lead a normal life. That degree of gratification is pretty hard to come by in other areas, so I think that's a long answer to your question.

Luchette

So you decided very early in your general surgery residency to commit your career to trauma surgery?

Peitzman

I did. And it's interesting how these things happen. So we did our research after our third clinical year of residency. And people were dabbling in research at Pitt and really one of the guys was sort of studying hemorrhagic shock. Unbeknownst to me, our chairman knew of my interest and actually picked up the phone and called Tom Shires in New York. I didn't know any of this until Tom Shires and I spoke actually about six months before he died and he told me the story that Dr. Bahnson had called him and said, "We have this guy you need to take in your laboratory." And he arranged that opportunity for me to go and spend a couple of years doing shock research with Tom Shires. But I did decide pretty early-on, and was given opportunities from the people around me to do the things I wanted to do.

Luchette

So it's fair to say that Bahnson and Shires were probably two pivotal mentors for you?

Peitzman

Absolutely. It's just interesting how these things happen. So Bahnson was one of the people who really brought cardiac surgery and vascular surgery to where it is today. He was that whole generation of brand-new heart surgeons.

And, in fact, when he was a third-year resident at John Hopkins, Blalock was teaching

everybody how to do the BT shunts and Bahnson was a third-year resident who traveled with him and actually did the operations.

I mean, he was always technically just extraordinary so that was his expectation as the chairman—that you were a surgeon who could do everything. And he demanded clinical, surgical and operative excellence. It was pretty clear what Dr. Bahnson expected of you. Whether you were a resident or a junior faculty member, you were expected to be an outstanding operative surgeon.

So that was his model, and then obviously the time I spent with Dr. Shires learning how to do research. And then the other two people that really had a huge impact on my career were Mark Ravitch and Dick Simmons. As you know, the Ravitch Chair is a endowed professorship that I hold, so it's kind of cool that I worked with him when I was a resident. He did everything in surgery and had 1,400 publications. There was nothing you could do or read about that he hadn't written a paper on. Whether you're talking about imperforate anus in a kid or cardiac tamponade, he had written about it. So he was the third mentor. And the fourth person was Dick Simmons because he really brought a completely different academic model to the University of Pittsburgh.

On faculty here, my jacket said that I'm a general surgeon; it doesn't say that I am a trauma surgeon. I have always viewed myself as a general surgeon who has a passion and academic interest in trauma, but I am a general surgeon and have always been a general surgeon. And that was Bahnson's model, so we did everything. I did elective vascular for my first five years in practice. I did all of that because that was the model at the time.

And when Dick Simmons arrived, he asked, "Why is the vascular surgeon doing hernias and gallbladders?" So he really made everybody take a much more deliberate academic focus which was obviously the right way to do it. So he really changed the whole paradigm here and it was obviously for the better. But those are the four people that really influenced me the most, who were and are my mentors.

Luchette

Do you still have a relationship with Dr. Simmons?

Peitzman

Yes, absolutely. He is still here and is very active. You know, I am the vice chairman of the department. He is the patient safety director for the hospital so we have a scheduled meeting once a month and talk business for five minutes and then life for an hour after that. So he is a dear friend and still has a huge influence. He is one of those people who is scary smart and has tremendous insight into things. He is still somebody I talk to every day.

Luchette

You know, a couple of minutes ago, you mentioned a pivotal point for your decision to go into general surgery was a community surgeon that is now working with you.

Peitzman

Yes, so he trained at Pitt. You know, we had the old Hopkins model where one of the chief residents was chosen to be a super chief. And he was a super chief at Pitt when I was a third-year medical student. And so he, when he finished training at Pitt—his dad had been chief of surgery at one of the community hospitals—that's where he went. And now he is chief of surgery at that community hospital as well. But he trained at Pitt.

Luchette

Do you think he would mind if you shared his name with the readership?

Peitzman

No, not at all. It's Dick Bondi . Every time I tell him he is the reason I went into surgery he sort of pooh-poohs it, but it's a true statement.

Luchette

But you decided to go off into trauma surgery. How did Bahnson, Shires, and Simmons view that?

Peitzman

Well, it's funny. When I began, I literally had written down ten things I wanted to accomplish in my first five years. And number one on the list was to develop a Level I trauma center. That was number one on my list. This was in 1983–84 when I finished my residency. And Bahnson's job description for new faculty was a brief discussion. In the OR lounge he asked me, "What are you doing next year?" "I'm looking for work." He said, "Do you want to start a trauma center?" I said, "Sure." And that was my job offer. It was literally no more than that. But that was really how it worked. He just hired the people that he wanted. And I've been blessed to have people who let their faculty do what they need to do. You know, nobody has been a micromanager. But when you need them, they are there, so I have been really lucky.

And with my current chair, Tim Billiar, it's the same thing. You know, he just lets his guys and girls do their thing and doesn't micromanage what we do. And part of the reason, one of the major reasons I've been at Pitt so long, is I have been able to do whatever I want and gotten the resources I needed and it's just a really unique environment for faculty to grow and develop.

When I joined the department, there were 12 or 15 faculty members. It was a pretty small department. There are now over 200 faculty members so the change has been just incredible. What Dr. Bahnson had was a very strong clinical program and what Dr. Simmons did was make it the research juggernaut that it is right now. Dr. Starzl was also critical to what happened here because he came three years before we were trying to start the trauma center. And the resources that he needed to do transplant were basically the same resources we needed to have a trauma program: OR availability, ICU beds, and blood banking.

I give this talk about our trauma center and I have a picture of a minesweeper— and Dr.

Starzl was our minesweeper. He kicked down so many doors that would have been a fight for me, but he had already done the hard work and opened them for me. So that made our lives much, much easier. And, obviously the expertise that the transplant surgeons bring with liver surgery and just having them around to learn from was a great asset. But he was indirectly and unintentionally a huge help to the trauma program.

Luchette

What is your next accomplishment at this time in your career with your trauma program?

Peitzman

So, the answer is easy but implementing it is hard. The University of Pittsburgh Medical Center is sort of a freakish system because we have 23 hospitals in our system and basically cover the entire western third of Pennsylvania. There are two Level I trauma centers in our system, a pediatric Level I trauma center, a Level II trauma center 200 miles away, plus we have close working relationships with some of the other state-designated trauma centers. So we have the opportunity to build a trauma system that covers a huge area. And, you know, we're in the process of doing that. We have conference calls with hashing out protocols and making sure everybody has the same protocols. We admit 12,000 trauma patients a year amongst our trauma centers, so it's a huge opportunity to really do something special and have, truly, a regional system for a large area.

I think the other thing that is clearly in the future is acute care surgery. And I think you know what we have done for trauma, building trauma systems over the past 20 years and doing the research to really change how trauma is delivered, that's what we have to do for acute care surgery for the next 20 years. So there has been that little bit of a shift in practices where the ship is going to try to do for acute care surgery what we've done for trauma.

That being said, without changing how dedicated we are to trauma, we just need to add resources so we can duplicate that dedication with a separate service for acute surgery, a registry, PI program, and research. So that's the future of what we're trying to do here. All the things we are talking about are "bread and butter" surgery but it's—nobody has really made a science out of it—a specialty, so that's what we have the opportunity to do which is incredibly exciting. A brand-new area where you can do almost whatever you want with it. And, you know, that's where we are. We're right on the doorstep of doing that.

Luchette

Is there one single scientific contribution that you are most proud of?

Peitzman

I've done okay for myself. I don't view myself as a highly prolific researcher. I think I've done all right. I think our program has done really well. And I think that's really the key and what Dr. Simmons taught us is that if you have 14 or 18 or 20 faculty in your group not everybody can be a triple-threat. It's just not an achievable goal. But that pie that comprises your section

of trauma/acute care surgery has to hit all the marks. One of your faculty needs to win the golden apple for teaching every couple of years. You need to have a great clinical program. And you need to do the research and get the NIH grants. So I think the long answer to your question has really been a programmatic approach to what we do and a team game. And I think that has been critical to our success.

I once had a faculty member come in—this is years ago—who was doing a great job, had been with us for about four months. And he sat down and just said, "I don't belong here. I feel like a fish out of water." I said, "Whoa. What are you talking about? You're doing a great job." And he said, "I will never get an NIH grant." And I said, "Well, what do you like to do?" He said, "Teach and take care of patients." And I said, "Well, that's your job and you do it well."

So it's funny, if you don't clearly tell people what their jobs are and make sure that you put square pegs in square holes and round pegs in round holes, then people will get frustrated. So, again, this is sort of a long answer, but I think it is critical to make sure you play to everybody's talent and do it as a team game. And you have people that are going to get NIH grants and those that aren't and just play to everybody's strengths and then everybody is happy.

Luchette

What brought you to focus on the management of splenic injuries and study it?

Peitzman

Well, so first of all when we began our trauma program 25 years ago—and I told you about our list of goals—there were two major goals. One was to build a great clinical trauma program. And the second was to do the research that would change how trauma care was delivered. Those were our two goals out of the box. And, obviously, grandiose goals, but that's what we were trying to do.

So the multi-institutional trials group at EAST—and this is truly how it happened—Tim Fabian was the president and basically said, "Peitzman, you are chair of the MITC Committee, go do some research." And I mean that's how it went down. And so I don't know how we specifically came to the spleen but that study and then Samir Fakhry's studies on small bowel injury actually, came out of that simple command from Tim Fabian.

I just think it was a common injury and nobody knew the answer. I think—actually one of the things that sort of prompted it was just how all over-the-board the research was at that time. And the two confounding issues at the time were everybody was talking about non-operative management of spleens and livers as a single entity, which we now know the natural history is not the same. Most of the papers had kids and adults lumped into the same paper, and we obviously know now that kids behave differently and that skews how the spleen behaves.

So I think those two observations are probably what prompted me to go after the spleen because the hypothesis generation was pretty easy. You know, you take kids out of the equation and you just look at adults and you say, "Okay, what are the things that predict who needs an operation and who doesn't?" And the other thing was the high-grade splenic injuries

are relatively uncommon. And then you have single institutional papers that say you can treat all splenic injuries non-operatively and they've got four Grade V's and another paper is six Grade V's. So there was a need to do that study based on the literature we had at the time.

And it's just funny. So the two recent studies that have looked at the National Trauma Data Bank, you know, showed that we're trying to treat 40% to 50% of Grade V injuries non-operatively and our failure rate is over 50%. So even now we haven't learned what is already out there, which is kind of interesting.

Luchette

Tell me about maybe one or two things that you originally embraced and thought were great, but in retrospect you think were probably not the best things to champion.

Peitzman

You know I don't have an easy answer for you. Really there is nothing that came to mind, so I don't have a good answer, even though I've sort of thought about it last night and this morning.

Luchette

What do you consider the two to three greatest advances in trauma care that have occurred during your career?

Peitzman

Well, this is an easy one to answer. I think the laparoscope and endovascular techniques have revolutionized everything we do in general surgery and in trauma care. So I think if we try to make that a more narrow question I would put damage control in that list as well. It has really revolutionized how we take care of sick patients. But it's hard to deny that the change toward minimally-invasive technology and surgeons skilled in these techniques have had the most profound impact in how things have changed.

Luchette

What do you think is the single most important change in practice that occurred during your career?

Peitzman

Well, I think that would be the super-specialization of medicine. You know, we sort of intimated that as we've talked. I have mentioned several times that, first and foremost, I consider myself to be a general surgeon and will always be a general surgeon. As I see the residents coming through and my junior faculty, what they have become comfortable doing has decreased just because of the specialization. It's a necessary change but I think that specialization has obviously impacted the entire face of surgery, not only in the U.S. but internationally. When we started practicing surgery, we did not have vascular surgeons. We did not have endocrine

surgeons. So I think the super-specialization has really been the thing that has changed most dramatically.

Luchette

And how has that impacted practice patterns or the practice of surgery?

Peitzman

I think the most simple example is vascular trauma, where there is a huge range in the experience a general surgery resident experiences during their training. If they've been exposed to vascular trauma, the likelihood is that the high proportion was managed with endovascular techniques. And you have trauma surgeons and vascular surgeons who are performing either zero or five vascular injuries in their training, so you have vascular surgeons who don't know anything about trauma and know little about general surgery.

So with the vascular injuries, there is a new generation of trauma surgeons who are not comfortable with vascular surgery and then vascular surgeons who know little about management of traumatic injuries. So that's the one area that to me most glaringly demonstrates how the specialization of surgical care has impacted what we do.

Luchette

As you look back over your career, what have you found to be the most rewarding part of your job, what brings you the most joy?

Peitzman

Well, there is no doubt my partners are like my second family. And I just think that is incredible when you come to work and basically are coming to be with your friends. I think there aren't many professions where that is true, and there are a lot of medical centers where that is not a true statement. So I think my junior partners and seeing them grow up and mature and become skilled surgeons has been incredibly gratifying. I think with everything that has happened in medicine, the two things I still like best are taking care of patients and teaching, so that has not changed even over the past 30 years.

Luchette

What have you found to be the most challenging or difficult aspects of the practice of trauma care and acute care surgery?

Peitzman

Well, I'm going to give you a narrow answer just because it's the one thing that I haven't been able to figure out. So it's in a situation where you have a clinical scenario where you identify the problem and come up with a perfect Plan A and you implement Plan A, and it doesn't work and you need a Plan B right this second. It's amazingly difficult to teach people how to recognize promptly Plan A is not working and you need a Plan B and you need it right this

second. Whether you are talking about failed attempts at intubating somebody or whatever, it's the one specific issue that I think some people have the gene that they can do it and some people actually don't have the gene to do that, to change a plan on their feet instantly.

And so that's my narrow answer to the question but I think that's the one issue that keeps coming up over the years that I've been doing this. You had a great Plan A but, boy, it took a long time to figure out that's not where the bleeding site was and you had to go somewhere else.

Luchette

You've seen just about everything that comes along clinically and professionally. Is there anything that keeps you up at night any more?

Peitzman

I think just what is on the horizon for all of us with the health care reforms and that nebulous "black box" and not knowing where we are going and what the future is going to be and what is going to control what we do. So I think that – yes, that keeps me up at night. And you know, I work at a great place and it's a great health care system, but I just think what we do and the good things we do, some of that may be at risk with what is going to happen over the next couple of years.

Luchette

What would be some advice you give the young surgeons interested in a career in either trauma or acute care surgery?

Peitzman

I tell both my students and faculty to do what you're going to have a passion for the rest of your life. Pick a niche that's a little bit different than everybody else's. Again, I think that's part of our success, that we don't have people competing for the same ring and everybody has a little bit different academic focus.

Also, to obviously realize that their lives at home are more important, if not equally important, to what we do in the hospital every day. So maintaining that balance and being with your kids and, having outside interests—whether it's going to the gym every day or woodworking. You have to have balance and it's really the same thing as I've tried to teach my kids. You need to work hard but you need to play at least as hard. That would be my advice.

Luchette

You've had a hugely successful career. I know you're a proud family man. And you're also a passionate Penguins fan. But how do you do that? I mean is it time management skills? Is it something gives in exchange for the other? How do you do that?

Peitzman

So, I'm not sure I'm the guy to talk about time management. I usually sleep five hours a night, which helps a little bit, that I don't need eight hours of sleep. There is no doubt early in my career that I spent more time away from home than I, in retrospect, probably would have or should have. I do think it's critical that we have within each of our hospitals, our sections, a critical mass so people can protect the families at home.

I do think that is vitally important. But you just have to keep your priorities straight and work hard and then realize you've got good people around you. I think the other thing that is important is you really need to undergo a metamorphosis about every ten years. If you just come to work and keep doing the same thing you've done every day for 30 years, you're going to stagnate.

I think as you add things to your plate, you do need to make decisions that there is something I need to give up—I just can't do everything that is on my plate now. And those are the hard things. When you talk about time management, we all come to work every day and there are ten things that are great things that we should do, but you can only do four. And you have to pick four.

Recognizing that is how life works and knowing that you're not going to get everything done every day, those are just the realities that you have to learn. You have to learn that you're not going to solve everything every day and it will be there tomorrow and you can come back tomorrow and that's okay.

Luchette

What do you see in the future for trauma and acute care surgery during the next 10–20 years?

Peitzman

Well, as I mentioned earlier, I think it's wide open. There is obviously a need for us. There is a shortage nationally, so job security is not going to be an issue. I think we have to do the science for acute care surgery, for the emergency general surgery as we have for trauma. If I were a junior faculty member right now I'd be tremendously excited about this opportunity .

Luchette

If you had to predict where trauma and acute care surgery would be in 20 years, what would be your prediction?

Peitzman

I think it will be a recognized specialty. I'm not sure if it's going to have board certification. We could debate about that a long time. But I do think we will be a real field and be the—as we have always been—the surgeons who take care of sick patients. You know this is what we have done forever. We have just put a label on it so it's not that we're doing anything differently.

Luchette

Is there anything looking back after an illustrious career of 25–30 years now, anything you would change in your professional career?

Peitzman

No, I don't think I would. As I mentioned, I've been blessed to be at a place that has been kind to me, surrounded by great partners, and we have a blue-collar work ethic at Pitt. Nobody is impressed by themselves, nobody is pretentious, which makes it a fun place to work, and an institution that has resources to help us do what we want to do, and obviously a wife and kids who are tolerant of what we do and how we do it. But, no, I really wouldn't change anything. I've been pretty lucky that way.

Luchette

What are your future plans? You said just a minute ago that you try to retool every seven to ten years, so what is next for Andrew Peitzman?

Peitzman

Again, the science of emergency surgery, of acute care surgery, number one. And, number two, really bringing the opportunity to have a regional trauma system for the entire third of the state to maturity. Those goals are pretty clearly set in my mind. Obviously, carrying them out is going to be hard, but what I hope to accomplish is pretty clear. I'm just doing what I'm doing. I think I am being more drawn to the system-wide growth and development and less at the "mother ship" now. That has been sort of a subtle shift. With the number of trauma centers that we are running, I need to shift in where I actually physically spend my time every day.

So from the get-go, when we added each of the trauma centers to our system, it was pretty clear that the CEO of the hospital system called me up and he said, "Go work with those guys and girls." And the advantage of being at Pitt so long is I knew everybody and had an established relationship, so it just made it a lot of fun. It's been incredibly gratifying actually bringing the other hospitals into our system and standardizing protocols and expectations.

And it's funny, when I visited one of the hospitals for the first time and was meeting with the CEO he said, "What is your title?" I sat there dumbfounded and I said, "I don't have one." And I never thought about it so my retort was, "You can say I'm the czar of trauma." And that's just how it works here. I mean it's just like my job offer was so many years ago. It's just here is the opportunity and go deal with it and that's just how we work. It's a very goal-oriented place.

Luchette

Are there any other important points you'd like to comment on or any last parting words?

Peitzman

I would like to mention just the international part of the world because I've spent so much

time there and it's actually occupied a lot of my time and energy. I do think we have to not be provincial as we talk about trauma care and trauma systems. There are huge opportunities to help and learn globally. And one of those opportunities I just stumbled into, it wasn't planned.

I think my parting comments would be to remember that we are a global village and all the things that we are dealing with our friends around the world are with resources that aren't as great as ours. I think we have an obligation to learn from them and help teach them. So that actually would be something we haven't talked about that I do think is critical for all of us as we sort of look where we want to go and what we want to do.

I think what people need to remember is that there are five million deaths globally from trauma every year. The issues and needs are different in differing parts of the world but even bigger than that, or equally big, is just the need for "bread and butter" general surgery.

You know, 500,000 women die from pregnancy-related complications every year, and it's simple things like nobody is there to do a C-section, nobody is there to fix a torn rectal wall. So there are a lot of things that we can do to help. And it's trauma but it's really surgical diseases more globally. And even the World Health Organization has acknowledged that this is a problem and we need to do something about it.

So I think we need to be part of it. And it's not simply trauma. It is all of acute care surgery that we ought to be involved with.