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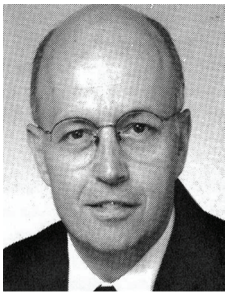

Anthony A. Meyer, MD, PhD
President 1996-1997

Dr. David H. Livingston

How did you get into trauma? When did you decide to go into that?

Dr. Anthony A. Meyer

It was interesting because my PhD work was in tumor immunology and by my the third year I had already written to a couple of places about oncology fellowships. I was early and they said it's too soon to accept applications. I was in my fourth year when I rotated at San Francisco General on the trauma service, which I enjoyed a great deal. I was working with the different faculty and probably the ultimate thing was talking to Don Trunkey about career opportunities and options and things to do. Having spent three extra years in research I wasn't really keen on two more years of oncology fellowship, although I think at that time several of them were only one year.

I decided I would probably pursue surgery and maybe something in trauma and look for clinical opportunities doing anything, maybe just general surgery. At the end of my fourth year, M.D. Anderson called me and said they had my application and had a spot for me if I wanted it, but by then I decided not to take it. I was waiting to find out if I actually had a job and, in late April of my chief year, I found out I had one at San Francisco General.

Livingston

So mentors, Dr. Trunkey, obviously.

Meyer

Well, Don Trunkey but other people. Paul Ebert, although he was a cardiac surgeon, he was one of my mentors. Dr. Blaisdell though I only worked with him for a year.

George Sheldon, Larry Way and Bob Lim were also mentors to me. Another person who was a mentor was Jim Carrico. I met him when I was a chief resident presenting my first surgical paper at the AAST at The Homestead in 1981.

Livingston

Your first presentation was at the AAST?

Meyer

I had presented some in my basic research at the federation meetings, but my first surgical one was as chief resident at the AAST.

Livingston

When you finally decided to do trauma, how was that viewed?

Meyer

I guess I never thought much about it. At that time there were a few oncology fellowships and most people did general surgery with a different focus in some specialties. There wasn't the degree of sub-specialization there is now. People just thought that was the reasonable thing to do. I didn't want to do vascular. Although I thought a little bit about cardiac, I decided it was time to be done with training. Nobody asked me or said, "You should go do a fellowship."

Livingston

San Francisco was your first position?

Meyer

Yes. Paul Ebert was the chair. I asked if he knew about any jobs or openings and he said, "Well, I can ask around." Then he said, "If you were going to stay here where would you want to be: at the VA, at the university, or at the county?" I said, "Probably at the county—at San Francisco General." He never mentioned more about it. The only job interview I had was in Cincinnati. After the interview I wasn't clear what my role would be, so a couple of days later, I sent a letter back to Joe Fischer saying, "Thanks for interviewing me but I don't really see a job there."

He sent a letter to me that crossed in the mail that said, "Thanks for coming to interview but we don't have a job for you." In retrospect it was a fortuitous thing. It wasn't until our Nafziger Society dinner, not at graduation but in late April, when I saw Dr. Ebert and he asked me if I was ready to start at San Francisco General. I was surprised because nobody had said anything. I had no formal offer, no contract, nothing. So I said I didn't have any contract and Dr. Ebert tells me we don't have them. If you want one, write one. That's when I knew I had a job.

Livingston

Although I can't imagine finishing as a chief and not knowing what you are going to be doing two months from now.

Meyer

It was a little stressful. It was a little stressful for my wife, too. I had been up at the bar getting a glass of wine for my wife and myself and that's where I ran into Dr. Ebert. I came back to my wife and said, "Here is your wine and I got a job."

Livingston

What do you think is some of best career advice you got?

Meyer

I think most people encouraged me to do what I wanted to do. I thought about doing several things, including congenital heart surgery. I thought about other things. But Don Trunkey encouraged me to look at trauma seriously and that it was a real career opportunity. I would say if you picked one piece of advice that was probably the best.

Somebody really encouraged me to pursue endocrine surgery. It was interesting, but nothing that really excited me. So that was it for that.

Livingston

Any bad career advice you've gotten over the…

Meyer

I would say the endocrine was the worst career advice. No, I think by and large most people – very few people offer advice offhand.

Livingston

What contributions are you most proud of and how do you think it influenced trauma and critical care?

Meyer

I think one of the first things I did when I was a brand-new attending out at San Francisco General. CT was just being regularly used on trauma patients and we started doing non-operative management on selected liver injuries. I wrote about that in '84. When I actually presented it first to the faculty, I got a lot of push-back. In fact one of the attendings said he didn't think it was a good idea but I said, "One of those was your patient."

It was using imaging to be much more selective in appropriate operative management. I'm sure a lot of people started doing it or thought about that at the same time, but that was one of the early papers on it. I remember I presented at the Western Trauma Association. There wasn't a huge amount of enthusiasm for the concept.

Livingston

Well, it went from almost heretical to standard of care in less than two decades probably.

Meyer

I think Gene Moore sort of challenged the idea, but that's how things change. I wrote on operative management of acute pancreatitis guided by fine-needle aspiration. That's been made a little less relevant now because of the better quality imaging.

Another area was pushing critical care as having a major role in surgical management, because when I first started doing that there were only a few people who identified themselves as intensivists. Especially as a surgeon having a major role as part of surgical management. The first surgeons who really pushed that were Joe Civetta and Frank Cerra.

Livingston

Anything you thought was a good idea, you adopted it, and in light of new data you said, "Oh, that wasn't really the idea we thought it was?"

Meyer

Well, I had spent a lot of my research efforts on trying to develop cultured skin for burn wounds. It's actually still being worked on, but there are a lot of problems that haven't been solved on it yet so it's still a potential, not an actual. People use it but there are significant problems with it because it's still grown with fibroblasts as feeder layers that get incorporated which lead to late graft loss. It's not been the big plus that I had hoped for.

Livingston

In your career what do you think has been the big advances in trauma care that has really changed the way we do things?

Meyer

Looking back I can certainly remember as a second-year resident when we first did CT scans for abdominal trauma, for blunt trauma. It took 20+ minutes for us to scan an abdomen. By the time we were done and the patient was hypotensive, you already knew what the problem was. But imaging has made enormous improvements not just in abdominal but in head trauma and many other things. So I think it has been one of the big advances that impacts trauma care.

I think refinement of resuscitation. We have gone through different schools of thought, different approaches. At one point you'd give them too little fluid, later you'd give them too much, and then even more extreme fluid. Now I think people are getting back to a physiologic approach and so I think resuscitation has improved.

Another advance was damage control. We've done that for a long time but having actually studying it was a new thing. I think that that has helped.

Lastly and most recently has been transfusion and avoidance of coagulopathy. Those have all made real positive strides. That's in terms of the medical care. Things like routine air

bags and better car design and have made a major impact in prevention and outcome.

I guess the very last thing that I probably should say that is trauma centers. If you look at the data from the national studies, being injured in the county with a trauma center gives you a 25% to 30% improved survival. There are very few things in medicine that gives you 25% to 30% improved survival. It's remarkable.

Livingston

What about changes practice patterns that you have seen?

Meyer

We've all seen a reduction in penetrating trauma. The move to non-operative or selective non-operative management have been a couple of big things.

Livingston

What parts of the career have you enjoyed the most and found most rewarding?

Meyer

I think training residents is what I enjoy most. Taking care of individual patients and helping teams make progress in getting better at what we do. But all that is tied in to training residents. Whatever field they pursue, helping residents develop into capable surgeons who commit to taking excellent care of their patients is incredibly rewarding. Getting them to be interested enough to participate in trauma care and whatever else they do is also important.

Livingston

What has been the most challenging or distressing times in your career?

Meyer

Recently? Finances. You know, being a chair of a department that's the thing you have to worry about most, the most trying. You have to have to make things keep working because if you can do that, you can recruit and retain and build. Without it you are scraping along and likely will fail in the long haul.

I guess I never really had that much trouble with deans or even with hospital directors. If you make a reasonable case for what you want, you can usually get a reasonable response and an expected commitment. I don't go and yell and scream and pound on the desk just to prove that I can get somebody to do what I want. You may get it one time, but they soon stop listening to you if that's how you always approach a problem. At the same time the challenge of trying to get things done can be trying.

The other thing, it used to be more difficult having people that were willing to cover trauma and emergent general surgery. That has seemed to change in the past five to ten years. We've never had that much of a problem at UNC, but it is an issue in a lot of places.

Livingston

What career advice do you give your young trainees or young surgeons who are interested in a career in academic trauma, critical care, acute care surgery?

Meyer

Tell them to do what they like to do, but make a difference in whatever you do. If you're just doing this to fill a job, then don't do it. Do it because you feel you can make a difference at what you do, and then make a difference in your own life and that of your family members by also being part of them at the same time.

Livingston

Where do you see the big next challenges are for trauma and acute care surgery?

Meyer

I still think, like everything else, it is going to be health care cost control. We have pretty good evidence of the financial/societal benefit of trauma care and organized trauma care systems. But with the mounting pressures to reduce what we spend on health care because it's unsustainable it could be one of the things that takes a big hit.

Livingston

What do you think the next big advances are going to be in trauma and acute care surgery?

Meyer

It is hard to predict them. I think that there is going to be more regionalization, including acute care surgery, because they're tied together and because the trauma systems have shown it to be not only clinically effective at improved outcomes but also cost-effective.

So I think that there may be more of that. Rather than every hospital having their little ER and taking care of patients, I think if there is universal coverage for health care the indigent care referral structure won't go away but I think that the resources required to provide high-quality, comprehensive, urgent and emergent care are going to require more regionalization.

Livingston

Anything you would change in your career?

Meyer

I guess probably I would try to worry less about whether or not I would be able to accomplish anything. In retrospect I probably shouldn't have worried or been worried. But it's how I am. I tend to worry about things.

Livingston

Anything outside the hospital you would change?

Meyer

I guess I'd probably try to spend more time with my wife and children. The kids grow up pretty fast—you blink and they are gone. At times I thought I didn't spend enough time with them. Once they hit 14, they're pretty happy to not have you spend any time with them. But it's amazing how much what you did with them they do remember. So even if it may not seem as much as you wanted, in retrospect, they remember it.

Livingston

What are your next plans—career, personal?

Meyer

I've re-upped for another five years of being chair in 2012, so I plan to finish that. After that I'll probably stop being chair then and enjoy somebody else having the opportunity.

If I can still operate and enjoy it and take care of patients, I will do that. If they want me to do some administrative things relating to the health care system and I want to do it, I will do that. I'll probably try to stay involved in resident teaching regardless.

Livingston

Anything else you'd like to comment on? Any words for the 75th anniversary of the AAST?

Meyer

I think that we get all wrapped up in the concern about funding and costs and all that. But people are always going to be getting injured and they are always going to be getting sick. So trauma, acute care and critical care surgery are going to always be important. If we stay focused on doing that and making a difference there, then I think we don't have to worry so much or not get too overly concerned about the other extraneous factors.

I also think the AAST will play an essential role in improving the care of the injured patient, both in delivery of care, and research to improve care. I was at the 2012 meeting and was incredibly impressed with the commitment of the younger surgeons and their innovative ideas. Many organizations are having problems these days, but I think the AAST is an incredible organization that keeps getting better because of the commitment of its members.