

WTA Presidential Address: The Man in the Glass

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I want to thank you, my colleagues and friends in the Western Trauma Association, for having given me the opportunity to be the President of my most favorite organization. I came to my first meeting in 1988. Dr. Austin Mehrhof, a plastic surgeon at The Medical College of Virginia, suggested that I come to a Western Trauma meeting here, in Steamboat Springs, because I loved to ski and was deeply interested in trauma and critical care. Since then, I haven't missed a meeting and look forward to the next one the minute I'm on the plane, flying home. The Western Trauma became a wonderful opportunity to bond with my children and to meet colleagues and their families in a beautiful setting. So it's super to be back in Steamboat Springs, where my journey with the Western Trauma began.

The title of my talk, "The Man in the Glass," should not be construed as sexist. It refers to all of us as a species, not male or female. As the first person of the Western Trauma Association who has retired before assuming the Presidency, I would like to take this opportunity to look back on my career with my thoughts for members of our society, surgical residents and medical students interested in surgery. At this stage in one's life, we need to look back at those individuals who provided critical advice or support at the various forks in the road, our mentors. Tom Nealon was my adviser when I was a medical student at Jefferson and was helpful in many ways as I moved toward a career in surgery, with a slight miss-step as a medical intern. I was a resident at the Hospital of the University of Pennsylvania, or H.U.P., and owe much to Leonard Miller, a surgical basic scientist there, and Billy Fitts, the first editor of the *Journal of Trauma*. Basil Pruitt saved me from a stint at a 20-bed Air Force hospital when he was able to get me back into the Army at the end of my chief resident year, which gave us two wonderful years defending you in Germany. He was subsequently very supportive with the Army Department of Defense extra-mural research contracts when I returned to academic medicine after a stint in private practice when I joined the faculty in 1978 at the Medical College of Virginia, which was under the leadership of Lazar Greenfield. Dr. Greenfield was a solid, honest Chairman who was very supportive of his faculty and whose word



Fig. 1

could be relied upon. Integrity, that must be the watchword for a physician and a department administrator. When I was a resident at H.U.P., Dr. Jonathan Rhoads was the Chairman of the Department. Dr. Rhoads was a gentle, but firm giant and the surgeons on the faculty were true gentlemen. There was a strong ethic of collegiality, respect for the rights of patients and their families and interest in promoting research for the enhancement of patient care. The economic restrictions and incentives were not in the forefront of medical care or research. There was never a question of faculty integrity—and that was true of my resident colleagues as well. It was not a utopia, but it was certainly a pleasant environment in which to learn both the skills and ethics of surgery. It was an exciting time, when total parenteral nutrition was developed and applied at H.U.P. with Drs. Dudrick, Wilmore and

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Rhoads. We received patients from all over the East with horrendous fistulas, malnutrition and gut failure. Acute respiratory failure from sepsis, aspiration or severe lung contusion responded to treatment for the first time using positive end-expiratory pressure during the two years I spent as a "Shock and Trauma Fellow." This was the time when the idea that a patient could be in shock and still have a very high cardiac output came as a shock to some of my senior physiologic colleagues in medicine. Dudrick and Copeland take justifiable credit for getting me to switch from an internal medicine residency to surgery, after they were "stealing" most of my patients, as they needed operations.

O, those were the good old days. Departments were awash in money and could liberally support resident and faculty research projects. The Deans weren't pushing for more and more clinical productivity because of the decrease in physician and hospital reimbursements. Since then, insurance companies have squeezed hospital lengths of stays, physician and hospital income, refused to pay if the patient did not have prior authorization for their visit, and have become obstructive to patient entry into the health care system. Over the course of my career, economic demands have increased to the detriment of resident and student education and clinically productive research. The residents see mentors become more and more driven to increase clinical productivity, money for the department and the Dean, as well as themselves. Department Chairmen need an M.B.A. Clinical research has become more difficult due to IRB restrictions and failure of the health insurance companies to support studies. And now there's HIPPA and the additional problems of patient confidentiality gleaned from a database. From 1982 to 1984 I was able to conduct a randomized, prospective clinical trial of two operations that were considered equivalent, and found that one of these was far superior.¹ This, as well as several other supporting studies, led to a major change in the type of procedure performed for severely obese individuals. Level I or II studies are clearly important for optimal patient care. When I tried to do another randomized, prospective clinical trial of two different operations in 2000, we were, with some difficulty, able to obtain IRB approval but the health insurance companies all had clauses that would not pay for randomization of an operation as part of a research study; and the NIH does not have the funds to support the cost of surgical procedures in any prospective trial.

My greatest disappointments were that some of our basic research in ARDS and chronically increased intra-abdominal pressure never reached a point where there was a positive impact on patient care. These pathophysiologies were worth investigating and I am optimistic that some day some of this work will have clinical value. Many of these studies were presented by residents to the Western Trauma Association.²⁻⁶ My greatest medical rewards have been the impact some of our studies have had on the care of severely obese patients and those with ulcerative colitis and the first randomized,

prospective multicenter trial sponsored by the Western Trauma Association on the timing of tracheostomy.⁷ My interest in trauma and critical care has led to a better understanding of the pathophysiology of the co-morbidities caused by a chronically increased intra-abdominal pressure that so many of my severely obese patients suffered.⁸ It is so hard to predict where either clinical or laboratory research may lead you; what the payoff may be. Many of you are involved in clinical studies, whether in academia or private practice, and this is one of the greatest strengths of this Association. It takes time, effort and dedication to do either bench or clinical research and you should feel very proud of what you are doing. We want to leave the world a better place than we found it, and if we can do it for the many as well as the few, that is so much the better. That is what research, data collection and publication is all about. Depressingly, many studies end up in blind allies, but as Teddie Roosevelt once said, "It is hard to fail, but it is worse never to have tried to succeed."⁹ Many of us are in academic settings where we have the opportunity as well as the responsibility to imagine new and more effective therapies and find answers to perplexing questions. The Western Trauma Association has also provided the motivation and the opportunity for those of us in private practice to perform studies which will enhance the quality of care for our traumatized patients. Unfortunately, some or even many of our ideas will not pan out. Our dreams may flounder. But the joy is in the chase. It is invigorating and keeps us young and enthusiastic. And who knows, it may just bring about a significant improvement in our patients' outcome. Again, from Teddie Roosevelt: "It is not the critic who counts, not the man who points out how the strong man stumbled, or where the doers of deeds could have done them better. The credit belongs to the man who is actually in the arena: whose face is marred by the dust and sweat and blood; who strives valiantly; who errs and comes short again and again... who knows the great enthusiasms, the great devotions and spends himself in a worthy cause; who, at the best, knows in the end the triumph of high achievement; and who, at the worst if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat."¹⁰

Unfortunately, our residents and medical students are often exposed to negative images. They hear faculty and private practice surgeons complaining about their lives. Surgeons are failing to transmit the joys of practicing medicine and surgery and the ethics of quality patient care and integrity to our residents and students. The emphasis has been misplaced and we need to change it. We need compassion, empathy, honesty and love in treating patients and caring not only for their families but our own families. I am also concerned about the 80-hour work-week limit, not that I enjoyed working every other night as an intern or during several of my residency rotations. Although, as you have already heard, I have fond memories of my residency. This had changed over the years to every third night, which I felt was reasonable.

Now, with the 80-hour limit, residents have to leave the hospital when one of their patients, for whom they have been caring, has to undergo surgery with which they would like to be involved. Even though one study from New York, a state that has had these regulations in place for some time, did not find any deterioration in the residents' operative experience,¹¹ another study suggests that there is a serious concern regarding the adequacy of residency training and the quality of patient care with a night-float system.¹² An even greater concern of mine is the feeling of entitlement that is being engendered in many of the residents who are training under this new proviso; that, when they are in practice in small communities and a patient needs an urgent splenectomy BEFORE transfer to a Level I trauma center, the surgeon will believe they have worked their 80-hour week and triage the bleeding patient to the trauma center. In a previous multi-center study sponsored by the Western Trauma Association of deaths in the operating room, this problem was one of the biggest causes of preventable death.¹³ And I fear this could become an even more serious problem.

It is interesting that as the Western Trauma Association has become more and more academically involved in its membership, meetings and published studies, it has also become more and more humanistic in its outlook. Presidential addresses from the view of the patient by Jerry Jurkovich in his wonderful "Paint the Ceiling" talk¹⁴ and Scott Millikan's personal but critical view of a terminally ill patient's family, "On the Other Side of the Waiting Room Door"¹⁵ were inspiring to us all. We need empathy for our patients and their families. When I was a medical student in the physiology laboratory, we all had to swallow nasogastric tubes for a study of the effects of alcohol ingestion on acid secretion and as an intern we had to undergo sigmoidoscopy (as part of a research study that was probably unethical). These unpleasant experiences were profoundly educational. And although I wouldn't recommend routine use of NG tubes and sigmoidoscopy in all medical students, they certainly increased my empathy for the unpleasant things we have to do to help our patients recover. Being a patient certainly gives one a different perspective on health care. I can certainly attest to the fact that as a surgeon it is better to give than receive.

I realize that some of my comments seem pessimistic. However, I do have a sense of optimism. Just as in the economy, the pendulum tends to swing from one extreme to the other, but eventually it will oscillate toward the middle. I believe that we are at one end of the extreme now and things will only get better. Our younger colleagues will have a return to better lives as physicians and surgeons. But it is our responsibility to help this happen. The malpractice crisis has reached its limit, and states and the federal government are finally being pushed to address the issue of outrageous settlements as the trial attorneys are at last beginning to lose their overwhelming influence on the legislatures. This has required and, unfortunately, will continue to require job action resistance and physician involvement in the legislative

process. Managed care extremes limiting patient access to care while absorbing enormous profits and management income are coming under control. Medical insurance companies have enjoyed the benefit of medical research; now it is time for them to step up to the plate and meet their responsibility to support research studies that don't offer a profit to a pharmaceutical firm; they certainly cannot be obstructionist in their behavior. IRB's suppression of research with excessively restrictive criteria needs to be modulated. Our current residents won't feel entitled to huge incomes and become angry as have some of their older, gray haired colleagues because their economic status has been reduced. With fewer surgeons becoming general surgeons, supply and demand, as in any capitalistic system, will begin to improve the income for general and trauma surgeons.

The Western Trauma is the most wonderful organization because it provides everything: multi-institutional research studies, a progressively excellent scientific program in which most of the presentations are published in a respected, peer-reviewed journal; but most importantly the opportunities to get to know colleagues and their families in a wonderful environment, riding up chair-lifts with them, their "significant others" and their children, competing in a NASTAR race with friendly side-bets. We need more of this approach in our lives. During my residency, there were frequent social gatherings, often in the Egyptian room at the University of Pennsylvania Museum. There, the mummies viewed our gathering of friendship with our mentors. Except for Dr. Rhoads, all were on a first-name basis.

Dr. Rhoads' Quaker background must have given him a great deal of equanimity, and this was part of his Department's mystique. I have tried to give residents and students this approach to patient care. While imparting "pearls," I try to leave them with a sense of humility and love for their fellow student, physician and patient. I have tried over the years to council the arrogant young doctor and remember Dr. Rhoads' admonition to a particularly difficult resident who was nasty to the nursing staff, that "Doctor, we have many applicants to our residency program but have a terrible time keeping nurses."

I tried to impart the importance of family in our lives to residents and medical students. Many of us get so involved in patient care and our research, writing articles and applying for grants that we may forget or neglect our other responsibilities. But your family doesn't really want to look at your C.V. They know you've worked hard, that you belong to societies, go to meetings and give talks. It is easy to forget to come home early enough for dinner to be able to sit down with your spouse and children or "significant other" and listen to how their day had gone. That happened in my life on more occasions than I would like to admit. You can't pick your parents but you sure can choose your spouse, and that was the best decision I ever made. It took about two weeks, we were engaged in 2 months and married 6 months later—and still are 35 years later. Betsy was not only tolerant and

understanding of my career and my interests but she also insisted that I live up to my commitments to our family. This, by the way, is a view of our kitchen. Betsy would often call and ask what was I still doing “down there” and wasn’t it time to come home? The children were waiting to have dinner. Sometimes I had an elective procedure to perform, such as a non-perforated appendicitis, and with her gentle persuasion, postponed the case until later in the evening so I could first come home and be with the family and then return later that evening for the operation. Occasionally this led to operating in the middle of the night. But no patient suffered from this approach and, when they knew why I was doing that, it gave them a feeling of support and empathy for me. And now this is my greatest joy, my children are healthy, both physically and emotionally and are living very productive lives. They also have loved the Western Trauma Association. It was our plan, for both financial and personal reasons (skiing was not Betsy’s favorite activity), that I would take one child, when they were allowed out of school, to this meeting. We often had to fight with their teachers. But they brought their homework with them. Their schoolwork did not suffer and, I believe, it had a profoundly positive influence on their lives. Here I am with Kathryn in Crested Butte, Andy at Snowbird, David at Big Sky, and Elizabeth at Grand Targee Western Trauma gatherings. These times were a wonderful opportunity, to which I am forever indebted to the Western Trauma Association—to bond with each child during their formative years—and teach them how to ski. Now, they have to wait for me coming down the mountain—fair is fair. Our families need nurturing, but in so doing, we get nurtured.

I believe strongly in the Golden Rule, not to do anything to a patient I would not want done to myself under the same circumstances. We often discussed various management scenarios in our General Surgery Conference. Some surgeons have a surgically aggressive nature, the bigger the operation the better. What do you do for a patient with a perforated duodenal ulcer? Some recommended antrectomy, vagotomy. If I was the patient, I would want an experienced laparoscopist to place a Graham patch and then treat me for *Helicobacter pylori*. Should I have a recurrence (quite unlikely), then a more aggressive procedure might be indicated. Once tissues are removed, they can’t be put back again. CT scans, MRIs, percutaneous drainage of abscesses have profoundly reduced the morbidity and mortality of our patients; I feel fortunate to have witnessed and been involved in these changes since completing medical school in 1966. I can only wonder what the next 40 years will bring.

The types of diseases I have come to treat require long-term follow-up. They are your patients for life. And with that has come one of my greatest joys, getting to know my patients, their families, their trials and tribulations and their successes: marriages, divorces, births, deaths, new jobs, children. Being able to communicate with your patient on a very personal level lets the patient know that you care, that you are compassionate and concerned. If you are arrogant and treat

them in a subservient manner, they will rebel against you. If you treat your patient with love and compassion, they will return that love and compassion. I have visited some of my patients on their farms and in their homes. I have gone fishing on the Chesapeake, hunting deer (didn’t see any!), and joined them for a hard-shell crab feast. I consider them to be friends and believe that they feel the same way about me.

There have been a number of articles on “professionalism” and medical students now have formal courses in medical ethics.¹⁶ But our children learn from example. The “do as I say but not as I do” never worked for our children and does not work for our residents or medical students. This is a closer look at our refrigerator – on which is taped one of the credos of our family. Those of us who are or will be in administrative positions in academic institutions or private practice have a responsibility to our junior colleagues, residents and students. They all need to be thought of as our children. We need to support them, nurture them and guide them. We must have integrity. As an administrator, I have seen colleagues fall into the abyss; they need our compassionate support. We in the Western Trauma need to lead by example. We need to maintain our skills and practice quality medicine. And when we feel that it’s time to pass the baton, then it’s time; I have known surgeons who have continued operating far beyond the time when they should have hung it up. We must feel and show compassion, empathy, and concern for our colleagues, our patients and our families. Although these qualities may have been taught to us by our parents, in some instances they need to be learned as adults. Our profession demands this. We must be available for those who need us. Whether it’s called ethics or values or moral duty, these are our responsibilities. A surgeon is a physician who operates. These qualities are what it takes to be a real physician. I have tried my best to emulate these attributes—some given to me by my parents, many by my teachers, some during my residency at Penn, others from colleagues with whom I have worked and certainly residents and students I have taught, but who have also taught me. I have not always lived up to these qualities, but have had help from my wife and others. Betsy has been my guide, my confidant, a source of strength and beauty, both inside and out; I thank her for helping me live a wonderful life.

And this is a closer look at the guide for our family Betsy taped to our refrigerator—so that we all would know what is truly important in our lives. The author is anonymous. It’s entitled “The Man in the Glass.”

“When you get what you want in your struggle for self and the world makes you king for a day, just go to the mirror and look at yourself, and see what the man has to say.

For it isn’t your father or mother or wife whose judgment upon you must pass, the fellow whose verdict counts most in your life is the one staring back from the glass.”

“Some people may call you a straight-shooting chum
 And call you a wonderful guy,
 But the man in the glass says you’re only a bum
 If you can’t look him straight in the eye
 He’s the fellow to please, never mind all the rest,
 For he’s with you clear up to the end;
 And you’ve passed your most dangerous, difficult test
 If the man in the glass is your friend.”
 “You may fool the whole world down your pathway of
 years and get pats on the back as you pass
 But your final reward will be heartache and tears
 If you’ve cheated the man in the glass.”

Optimal care, research, integrity, concern, and compassion are why I love the Western Trauma Association; it has been there for me and my family. You are some of my best friends. I look forward to being with you in the years to come. Thank you for giving me this opportunity to talk with you about issues I feel deeply.

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