

## Sharing, caring and cutting shapes

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**V**irtual greetings to all assembled. The Oriens award was begun in 2010. The award is supported by an unrestricted grant from the Polk Family Charitable foundation. It provides the resident and fellow winners the opportunity to receive reimbursement for travel lodging and registration for the Eastern Association for the Surgery of Trauma's (EAST) scientific assembly. Applicants submit a one-page essay describing why they want a career in acute care surgery. The award was the brainchild of Dr. William Chiu one of my partners at the R Adams Cowley Shock Trauma Center who I am happy to consider a friend as well. Bill has dedicated his career to designing and implementing an excellent trauma critical care fellowship at our institution. It is wonderful to see the idea he brought to EAST thrive.

As I prepared my remarks, I had the opportunity to review and reflect on the prior Oriens keynote speakers. The list reads like the who's who of modern acute care surgery. Drs. Britt, Feliciano, Trunkey, Schwab, Rozycki, Fabian, Jenkins, Richardson, Meredith Peitzman and Bulger delivered insightful and inspiring addresses. I must admit that 4 months ago when I agreed to give this talk, I had no idea the surgical royalty that preceded me. I am humbled and honored to be given the opportunity to speak today. In addition, I also read the essays of the previous 18 resident and fellow winners. The future of acute care surgery is bright. It amazes me that year after year each recipient manages to inject their unique impactful perspective to answering the question, "Why I Want to be an Acute Care Surgeon."

I organized this presentation into three segments. First, I will share my personal journey, motivations and inspirations. Then, I will reflect on changes good and bad that I have witnessed through my education, training and career. Lastly, I will explain what the heck "Sharing, Caring and Cutting Shapes" means.

I was raised in a rural community on the Eastern Shore of Maryland called Berlin. Its most notable claim to fame is serving as the locale where the movie *Runaway Bride* was filmed. When I was growing up, it was town of about 4,000 people. There was one spotlight in the town, the major industries were the Perdue chicken factory and tourism as it was only 7 miles from the beach town of Ocean City. McDonalds did not reach my town until my senior year of high school. Most Blacks worked seasonally in Ocean City, were watermen, or worked at the chicken

factory. Like many other rural locales, family and church were the center of life. Many of the problems that plagued urban centers had not found their way to the area. However, there was poverty, lack of opportunity, teen pregnancy, and drug and alcohol abuse. My father, a kind, generous, hardworking man, left school in the third grade to work like many of his generation and circumstances (Fig. 1). He worked multiple jobs during his life from cook to handy man. My mother was a high school graduate. She went to night school to earn an associate degree and worked for the school system as a secretary. They both recognized the power an education had to change opportunity and circumstance.

Fourth grade was an impactful time for me. Integration arrived to our town. I left my small, colored only elementary school (Fig. 2) to attend the newly built and integrated middle school. That same year, my mother was involved in a serious motor vehicle collision. She was driving to work and was struck by a pickup truck that ran a stop sign. As was common at that time, she was not wearing a seatbelt. She was ejected sustaining a traumatic brain injury and facial fractures. She was not flown to a Level I trauma center but like most injured in rural communities, she was treated at our community hospital, 45 miles from where she was injured. For a few gut-wrenching hours, I was not sure if she would live or die. I did not know enough to worry about whether her injuries would all be identified and treated in a timely manner, whether there were rehabilitative services available to help her recover from her injuries or whether she would have scars or disabilities that would remain with her forever. She was left with a facial nerve palsy resulting from either a basilar skull fracture or her facial fractures, I never knew which. The crash changed her in some ways. It eroded her confidence. Usually outgoing, she now avoided the spotlight and often refused to have her photo taken or made sure only her left profile was captured (Fig. 3). Now, I cannot say from that moment I vowed to be a trauma surgeon but that was time I decided I would be a doctor.

You might have thought with the background I described I may have been encouraged to consider other pursuits by my family, but I was not. I was encouraged to follow my dreams. I did have one family member tell me they would never see a Black doctor, stating they preferred their undertakers Black and their doctors White. I pressed on. With the help of a supportive English teacher, I applied and was accepted to Duke University.

My parents were pleased but could never have afforded the tuition. I received a generous financial aid package and with a part time job, we were able to make it work. I moved off campus to save money. The apartment had a 500-gallon oil tank for heating and I remember buying 10 gallons of oil at a time, climbing a ladder to pour it into the big empty tank to have heat in the winter. I was exposed to both the clinical and research

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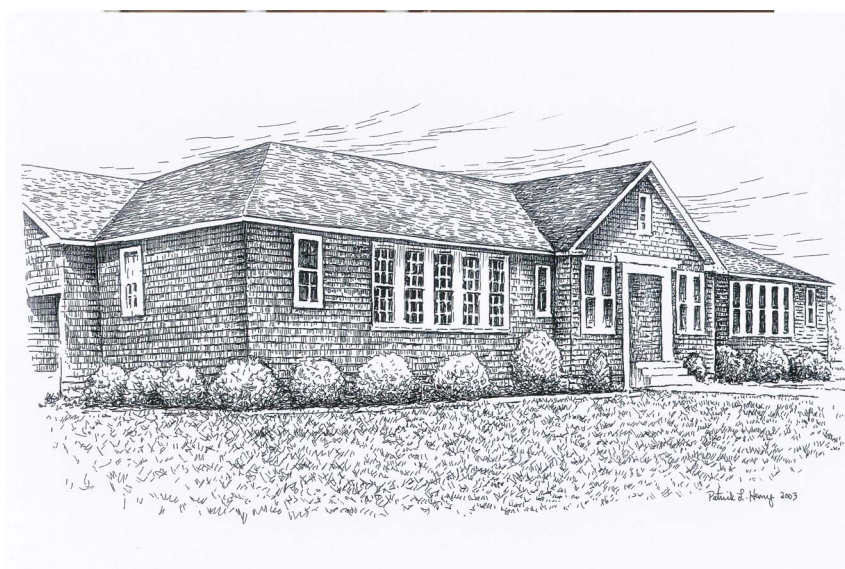
**Figure 1.** My father, Clifton Osborne Henry.

aspects of medicine. I was accepted to the University of Maryland School of Medicine and Vanderbilt. The in-state tuition could not be beat, so I decided to come back to Maryland. My table mates in Gross Anatomy predicted I would become a surgeon as I immersed myself so thoroughly in dissecting and identifying every anatomic structure we studied. However, it was not until I completed surgery, my last rotation, that I realized this was for me. Even though I thought I wanted to be a surgeon, I feared rotating on some surgery services. I saw few African American or women surgeons and none that were both African American and a woman. I felt I lacked the courage to blaze a trail. I had several African American classmates share stories of being dismissed or frankly discouraged from pursuing surgical careers by their professors. As luck would have it, my major surgery rotation was at a large community hospital. I was supported, encouraged and embraced. I also

rotated on the cardiothoracic surgery service and was again supported by a seemingly unlikely advocate. Dr. Joseph McLaughlin, the division chief provided a supportive letter for residency and even remembered me a decade later when I returned to join the faculty. I had the privilege of attending his 100th birthday party (Fig. 4). He held it when he was 97 years old, just in case.

On to residency in Brooklyn NY at State University of New York Downstate Medical center. I fell in love with Kings County Hospital, the municipal hospital the moment I saw it. After all, the county is where we really learned to be surgeons. The program was unusual for its time in that half of the 10 chief residents in my class were women. It was an interesting and busy time on the trauma service because violence was epidemic in the neighborhood. In fact, during my intern year, the Chief of Surgery Dr. Tom Pollack was killed in his office by a patient unhappy with the care he received at the Veteran's Administration Hospital. It was a different time. Duty hour restrictions had not begun. In fact, while on the Trauma Service the chief spent 6 weeks continuously in the hospital. It was not until my chief year that women were allowed to rotate on Trauma. It was assumed they were not interested and could not handle the rigor.

At Downstate and Kings County, I saw confident, young, energetic woman surgeons. Dr. Heuldhine Webb, Dr. Kim Kahng, and Dr. Monica Morrow were young attendings I watched present, operate, teach, lead, and defend their decision making in conferences. I was drawn to the care of the sickest patients. I found a challenge in caring for complex and acutely ill patients. Changes in the management of trauma patients were occurring rapidly. Computed tomography scans were replacing explorations for injury and observation for solid visceral injury was being investigated. As a junior resident, I was awed by the ease and comfort my chief resident displayed in performing a thorough, nearly artistic exploration of a patient with an abdominal gunshot wound. Dr. Carlo Vitelli effortlessly mobilized the viscera for proximal aortic control. Seeing the talent of my chiefs and the attendings I worked with made me want "to be like Mike." It was not only the technical prowess I admired about these



**Figure 2.** Drawing of Flower Street Elementary circa 1960 by Patrick Henry.





**Figure 3.** Family photo years after my mother's motor vehicle crash. Left to right sister Debra, father Clifton, sister Edna, mother (marked out facial deformity) and me.

surgeons; they were problem solvers. They were always the ones called to assist another surgeon who needed a pair of hands. I was not always the best organized planner so it may not surprise you that I found myself at the end of my chief year without a fellowship. Dr. Tom Scalea phoned a few friends, and before I

knew it, I was loading a U-Haul and heading for Minneapolis. Dr. Frank Cerra and Dr. Rob Bart were amazing intensivists and researchers that provided perspectives and opportunities that differed from those I experienced in Brooklyn. Nothing, however, prepared me for the cold Minnesota winters.

Following fellowship, I eagerly returned to Brooklyn to join the trauma faculty. In 1997, after spending a few years as a trauma and critical care attending, the opportunity to join Dr. Scalea in Baltimore at the Shock Trauma Center arose. Leaving New York was hard; I planned to live the rest of my life there. There is nothing like eating a real New York City bagel and the ability to have Hungarian food at 3:00 AM simply does not exist many places. However, the opportunity to join Dr. Scalea, one of my mentors and to work at "The Intergalactic Shock Trauma Center of the Universe," as Dr. Aurelio Rodriguez called it, was too powerful a draw to say no.

I was a staff surgeon, rotating on the Trauma Service and in the Intensive Care Units. The cases in Brooklyn had seemed so challenging at the time but I encountered even more complexity and severity of injury at shock trauma. The resources dedicated to trauma care were impressive. Imagine an entire hospital dedicated in injury care. There was no mission creep, everyone knew why they were there. There was and is great dedication to teamwork and to being sure every patient, regardless of their circumstances receives "Cadillac" care. Initially, I had no administrative responsibilities, which was fine. Then, that changed.

On January 1, 2000, I became Chief of the newly created Soft Tissue Infection Service. We had always been a referral center for soft tissue infection, but this was the first time the patients were all on a designated service. Before this, patients with soft tissue infections were scattered among at least four general surgery services. Care was fragmented and certainly not uniform. There was a need. I was willing to fill that need. I had an interest in wound healing and metabolism, fostered by my critical care training in Minnesota. It made some sense both for me and the institution.

However, I was the entire service. There were no house staff or advanced practice providers (APPs) assigned. Many of the consults initially involved sacral decubitus ulcers, perhaps not the most appetizing of cases. I made rounds at several of



**Figure 4.** Dr. Joseph McLaughlin Cardiothoracic Chief while I was in medical school at his 100ish birthday party.

our long-term care facilities, helping with wound care. I am sure many people asked why this was a good idea. However, I was determined to be successful and persisted. I was drawn to the patients who needed good care and needed a champion to care of them. That was me. The volume increased and the diversity of problems grew exponentially. I added one nurse practitioner. The service has now grown to be four faculty members, one per week, four nurse practitioners, and rotating residents and/or fellows most months of the year. We care for soft tissue infection throughout the body. We do abdominal operations, operate on the neck, all extremities, and the perineum. Frankly, consult services who specialize in these anatomic areas call us. We rarely call them. We are true acute care surgeons, performing all typical general surgery operations on these patients, as well as Girdlestone procedures, hip disarticulations, abdominal, perineal, chest wall and upper and lower extremity debridement and reconstruction. Some of these are highly challenging. We use a lot of vacuum-assisted closure devices (VAC). Being able to sculpt a VAC sponge to treat a complex perineal wound is no simple task, but we do it routinely. It is a great educational experience for the house staff.

Several years later, the Maryland state Committee on Trauma (COT) chair relocated to Florida. I was nominated to serve out the remainder of his term. Frankly, I did not see this as a great opportunity but my boss, Dr Scalea asked me to try. He saw this as a great opportunity for me. I agreed to serve out the current term and said we would talk as that ended. Then, I had to convince the region chief, Dr. Glen Tinkoff, I was up to the task. If I was going to do this, I was going to do it well. Our Advanced Trauma Life Support (ATLS) program was audited almost immediately after I took over. Things were not good at all. I dedicated myself to fixing the problems. Our program is now exemplary. I really embraced ATLS and its mission. In my role on the national COT, I joined the ATLS and Surgical Skills subcommittees and became as involved as possible. I worked hard at it and taught and directed courses nearly continuously. I directed over 100 ATLS courses and then won the Meritorious Service Award. I was working hard but could not have been more surprised or thrilled when I was appointed Chair

of the ATLS subcommittee by Dr. Michael Rotondo. I was honored to be able to oversee the 10th edition revisions.

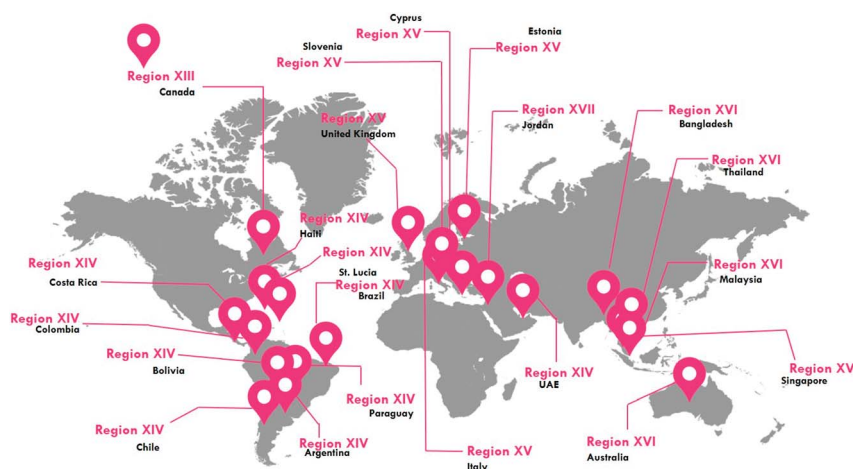
I am now finishing my COT responsibilities by heading up the global ATLS effort thanks to Dr. Ronny Stewart. This has given me the opportunity to travel worldwide, to meet people I never would have, and to see trauma care throughout the world. There is a pin for every place I have traveled as a result of my affiliation with the COT (Fig. 5). It has taken me places I literally had to look up on a map!

Both assignments have really shaped the middle part of my career. I was given an opportunity, I took it, and I put my heart and soul into it. As I reflect, neither of these were perfect jobs when I started them. My local, regional, and national “bosses” saw something in me and believed I would be successful, perhaps even more than I believed. I am grateful that I said yes and would suggest to you that while every opportunity may not work out equally well, all opportunities are worth serious consideration. Sometimes, others know more about what will be good for you than perhaps you know yourself.

Surgery, particularly injury care has changed a good deal during my career. How we care for patients is at the forefront of those changes. Advanced imaging has revolutionized our ability to understand injury anatomy. We treat many things nonoperatively that were treated with a laparotomy when I first went into practice. Endovascular care including the use of catheter techniques to treat vascular injuries and/or to provide hemostasis has become routine. Innovative techniques, such as the use of REBOA, while controversial continue to evolve and to be investigated.

One of the biggest changes, however, is how we train residents and fellows. I trained before the 80-hour work week. The ability to immerse myself in the care of badly injured patients for that time, while perhaps unreasonable, was also a powerful educational experience. I developed real sophistication in both the evaluation and operative treatment of injured patients. In a short period, I got a lot better. I did not question this. It is the way it has been forever at the county. I expected it, I embraced it, and I actually really enjoyed it.

Those days are, obviously over. Young surgeons now value life/work balance. When I was a resident, I had no idea that



**Figure 5.** Map with a pin representing the places I traveled during my time on the American College of Surgeons Committee on Trauma.

**TABLE 1.** Wilson Ways: Win Do Not Whine.

Have a vision for where you want to go
Work hard
Be honest
Know your strength and weaknesses
Put yourself in the other guy's shoes
Do not waste valuable time complaining
Exceed expectations

existed because it did not. As the 80-hour work week became the norm, program directors struggled to create a schedule that provided reasonable clinical care with some continuity but satisfied the rules, a real challenge.

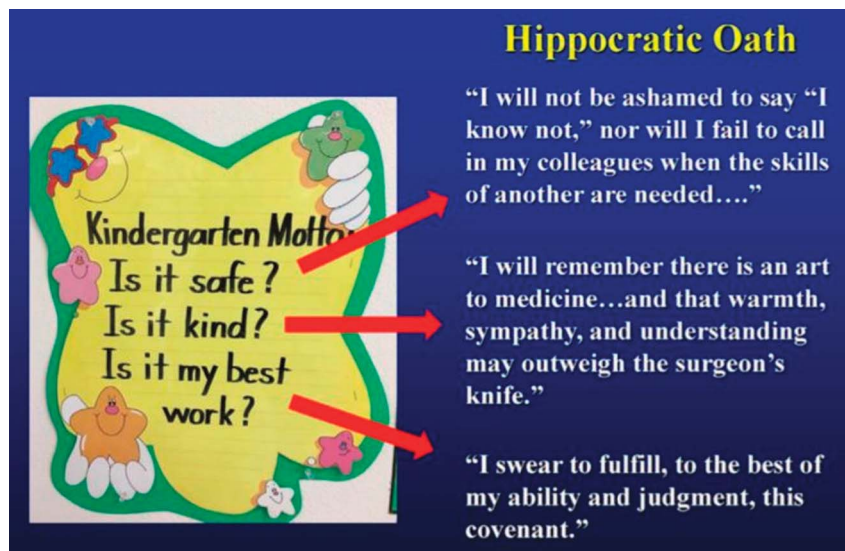
Early on, there was great debate as to whether one system is better than the other. Older surgeons bemoaned the loss of training rigor. The discussion became moot. The old system was gone. The new system was here to stay, and we are still training talented young surgeons. Those of us charged with educating residents and fellows have tried to learn how to provide good education differently. However, residents are still responsible, at least in part for the own education. If a patient on whom you operated has a complication, you may not be there to treat it, even if the patient goes back to the OR. This does not, however, mean you should not accept responsibility for the complication and learn from it. Interrogate your fellow resident to understand the operative findings. Spend time reviewing the case to understand what you could have done differently. Read so that you fully understand the disease state. Take every opportunity to get better. It will not be by spending 6 weeks straight in the hospital. That does not, however, change the fact that all of us, chairs, program directors, faculty, and residents, are all responsible for producing the highest quality surgeons that we possibly can. Simulation plays an increasingly important role in training. This very challenging year has taught us that we can improvise and use technology to help train, teach, and update. The challenge will

be to identify the best places and practices to use distance and virtual technologies to educate. Dean Donald Wilson, one of the first African American Deans of a medical school and a friend, wrote a book called *Wilson's Way: Win do not Whine*. He outlined seven principles that led to his success.<sup>1</sup> They are simple yet important (Table 1).

As a specialty, trauma, as a discipline, surgery, and as a medical community, we have failed to fully commit to the principles of diversity and inclusion. I have been fortunate as our group at shock trauma is indeed diverse. About 45% of the faculty are women and many are minorities. All faculty are treated equitably. There is a uniform pay structure, and all faculty are given opportunities for advancement. We have three women that are professors, all with substantial administrative roles. This has not been the case everywhere. Women have not been promoted at the rate that men have. There are disappointingly small numbers of leaders in trauma and surgery that are female. Women often get paid less than their male counterparts. Minority women are even more affected. Trauma surgeons work more clinical hours than do other surgical specialties and are less likely to attain academic promotion. At the University of Maryland, data about gender, ethnicity, academic rank, and salary are collected and publicly displayed. Our track record is far from stellar, but I applaud the Dean for shining light on this issue and acknowledging it. Every institution should follow suit. As a medical community, we are more aware of these issues now and are somewhat better, but we have much more work to do. Eastern Association for the Surgery of Trauma has been a leader among trauma organization in this area.

I include the details of my journey to illustrate a few points. Everything I needed to know about surgery, I learned in kindergarten, caring, sharing, and cutting shapes. Dr. Clay Burlew in her 2017 Southwestern Surgical Congress Presidential address likened the kindergarten motto to the Hippocratic Oath.<sup>2</sup> I think it is so fitting (Fig. 6).

Sharing, many hands make light work. I am privileged to work with the most amazing group of people every assembled.



**Figure 6.** Comparison of Kindergarten motto to the Hippocratic Oath.





**Figure 7.** My work family.

Everyone recognizes the role that they play in assuring our patients get the best care possible. This extends from the operating room or trauma resuscitation unit tech, to the housekeeper, to the bedside nurse, therapist, pharmacist, dietitians, to APPs, to physicians. Sharing a vision of the care we want to provide to our patients that reflects the care we would want any of our family members to receive. Sharing knowledge, compassion, and expertise are our guiding principles.

Caring not just for our patients but about our patients. Often, we see them at their most vulnerable. Immediately after

injury, they are anxious, upset, and in pain, perhaps not their best selves. We likely would have a similar reaction if it was us on the gurney in the trauma bay. It is important to put all of that aside and continue to be kind and compassionate. That is sometimes easier said than done.

It is also about caring about our colleagues. Trauma is the quintessential team sport. We are only as good as our weakest link. This includes our physician colleagues, but sometimes, more importantly, it is the nurses, therapists, and techs that make the system work. They look up to us, and we should always



**Figure 8.** My family.

remember to thank them for their efforts. Providing treatment without caring is hollow. Too often, we underestimate the power of a touch, a smile, a kind word, a listening ear, or an honest compliment. One of the techs in the resuscitation unit once said to me “I cannot do what you do but I can do what I do well.” Benjamin Franklin said, “want of care does more harm than want of knowledge.”

We must care about our profession. It is a privilege to be able to care for our patients and their families in their time of need. That can be hard to remember when we are really busy, and a patient’s family wants to ask the same question for the 10th time. We need to embrace and love what we do. That will mean something different to each generation of promising surgeons and likely something different to each individual surgeon. That is fine. If we truly care, our profession will be in good hands.

Cutting shapes can mean many things. It can stand for practicing the craft of surgery. Each of us has invested thousands of hours in becoming as good as surgeon as we possibly can. Cutting shapes in some ways is a no brainer. Taken literally in my case, how else can you possibly learn to successfully apply a VAC to a perineum or an open abdomen with a fistula without cutting shapes? Putting a VAC on these complex wounds takes artistic ability, dedication to spend the time necessary to do it well, and the discipline to stop and start over again if it does not work. Creating the Soft Tissue Service was another opportunity that I took even though it was hard to understand why it was a good idea at the beginning. It took years for things to mature, but now, I am incredibly grateful for that opportunity. It has allowed me to develop real expertise. It has also allowed me to recruit a band of like-minded faculty and APPs. It is not possible to make it too hard for us. I recognize we, as physicians and clinicians, are diverse; there is room for all shapes. We fit together somehow our patients are just as unique, from differing backgrounds with different beliefs and cultures. These unique shapes need to be acknowledged, accepted, and respected.

So, I would say to stay flexible. There are nuggets of gold in unexpected places. Continue to put your patient and their needs first, get involved in the process, stay strong, work hard, and appreciate all you have. You have gained an enormous amount of knowledge throughout your residency, but it is more difficult to develop that knowledge into wisdom. The wisdom to know when to cut and not to cut, how extensive an operation to perform, when to say yes to a new job or assignment or who to collaborate with on a project. We must know when it is time to oppose the status quo and do what is right but may not expedient and when it is time to go home.

We need to share ourselves. Virtually, all of us went into this business to make patients better. We usually do this one patient at a time. But the system of providing care is so much more complicated now than it was when I first started practice. Large

medical centers, even smaller medical centers, are complex organisms. Physician decision making counts for less than it did. There are a myriad of committees, some more important than others. It is vitally important that we share of ourselves in the process of deciding how care will be delivered. If we do not, decisions will be made around us, not through us. It is highly unlikely we will be happy with the results.

We should share our energy to help further our global mission of serving those who are injured. I recounted several opportunities I was given that, at the time, did not seem particularly appealing. I was wise enough to give them a try, and they have enhanced my career allowing me to do things I never dreamed I would be able to do.

I started my career wanting to be a good surgeon. While in New York, I was bitten with the “trauma bug.” I am lucky. I have only worked in two institutions and both have been supportive and nurturing. They have been supportive and nurturing in different ways but both wonderful institutions. I have had the opportunity to meet an uncountable number of wonderful people as I have traveled this journey.

Being an African American female surgeon has certainly not been easy all the time. However, I believed in me, and others believed in me. That allowed me to become involved in leadership positions in national organization and to be one of the few African American female surgeons who is an endowed professor. We have many hurdles to overcome to create real equity and real inclusion. You, the members of EAST, the young people who are the future of our specialty are leading this effort and must resolve to continue those efforts.

I am incredibly grateful for the support of my work family. I would have been unable to reach any of the achievements I have without their support and covering for me when needed (Fig. 7). Lastly, I say thank you to my family for their unconditional love and support (Fig. 8). I thank you for the opportunity to give the Oriens Lecture. It is another thing I never dreamed would happen. I am hopeful that my remarks will provide you with some areas on which to reflect, and I thank each and every one of you for your attention.

I wish each of you continued success and hope you never stop reaching for the stars.

#### DISCLOSURE

The author declares no funding or conflicts of interest.

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