**Interview with Hilliard Seigler**
**Interviewer: Justin Barr**
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**Interviewer:** This is an interview of Dr. Seigler conducted by Justin Barr in Dr. Seigler's office at Duke University on 27 February 2018. Dr. Seigler, we were talking about surgery at Duke.

**Seigler:** To begin with, the department of surgery at Duke, when it started basically in 1930, had a dean at the medical school who was adamant about providing good clinical care to the disadvantaged in Northern and Southern Carolina and in Virginia. That was what he was about. When the department of surgery started later on, there became a little bit of an issue between who came as department of surgery chair, and the dean. That was Dean [Wilburt] Davidson. Because the gentleman that they recruited to head up the department of surgery, that was interesting in and of itself, he came right out of being chief resident at [Johns] Hopkins to become chairman of this new medical school and new department. But great clinical care, that's what he was all about.

He also felt that to be successful you would have to generate income because remember, this was the time of the depression. He thought with Dean Davidson on how you could do that, and he established the PDC. The PDC was designed to do two things. One was to support medical school, and secondly to support these young surgeons coming down here to this new department, because they had no practice, there was nothing established. Under Deryl Hart's leadership, both of those things flourished.

They flourished through very difficult times of the depression, then along came the Second World War. The Second World War hit the faculty and a lot of them had to leave and go as they were trying to get established. Deryl Hart was committed to the clinical surgeon. He had to be jack of all trades; the residents were, 10-yer residency. They had to be great in thoracic, in general, in vascular, and indeed during the Second World War, he did some neuro, he did some orthopedics. But the whole tenure from 30 to 64 was: this was going to be a department that turned out this type of general surgeon who had this broad training,10 years. They were going to provide this superb clinical care and they will be able to do it because of the PDC paying part of their salary. But PDC also developed the faculty. Indeed, even developing the basic scientists. He set it up so that there was a fund both for building, it was called the building fund to expand the medical center, but also to pay for the non-clinicians so that we could both recruit and retain them. So he had just this marvelous vision, but then along comes Dave Sabiston in '64,

**Interviewer:** Can I interrupt for one second?

**Seigler:** Yes

**Interviewer:** So, Dr. Gardner, did he basically just continue Dr. Hart's trajectories?

**Seigler:** Yes. He just continued, he didn't change anything. He was his chief resident and that was his mentor. There was a lot of this mentorship as the faculty went from 30 to 64 because they were training these great clinical surgeons. It was across the board in terms of orthopedics, neurosurgery, great leaders. General surgeons, they had a lot of great visions and major types of contributions.

But when Sabiston came, Sabiston felt that even though he had a mentor, who was Alfred Blalock, that times had changed and what he wanted to do was to take this great clinical department and turn it into a great academic department.

**Interviewer:** Did Duke know that vision when they hired Sabiston?

**Seigler:** Yes. There was a lot of consternation about it because it wasn't uniform support for Sabiston. One, he was quite young, but two he was very clear about what he wanted to do. He had a lot of support with the medical school, and that continued with him during his very long tenure. He was a great educator. His formula was, "we are here to teach students first, we are here to teach residents second, we are here to support our fellow faculty members third, and lastly you are there to benefit yourself." He was very strong, very open about that and he got the teaching award from the medical students for years – several times.

**Interviewer:** How did they identify him since he was such a young surgeon scientist in 1960s?

**Seigler:** He was from North Carolina, in Eastern North Carolina, and at that particular time at Hopkins, it was going to be down to Dave Sabiston or one other individual to become chairman there. Sabiston had assessed his future career path: Duke if not Hopkins. And so, he built the faculty in a very different way. It was just what I told you, "When you come here, you are going to teach students. Students are going to be first, and secondly you are going to teach residents, and you are going to be involved in academics or you weren't going to go forward." And he turned out an incredible high percentage of academicians.

**Interviewer:** You mentioned there was some initial resistance to his hiring. Was there resignations? Was it just fights among the faculty?

**Seigler:** No. It was just discussions about what they ought to do, and some of them lived on he after got here, and they never resolved.

**Interviewer:** Like Will Sealey?

**Seigler:** Yes. Because he was a great clinical surgeon, Glenn Young, great clinical surgeon. Neither one of those were really making their career path research and that sort of thing. When Sabiston started, that was the type of individual that he recruited, was one that was going to be an academician and they were going to pursue research and teaching primarily, but yes, they had to be very superb surgeons. That's how they would go forward.

It was never designed or set out about compensation, and indeed, you didn't even know what you were going to make. You went in there at the end of the year, and you sat down in Sabiston's office and he'd say, "Look, you've done a good job, you published this and this and this and therefore, we are going to give you a bonus of $20,000 or whatever."

Indeed, a lot of the residents, I tell them when they are whining about one thing or the other, when I came on the faculty here, my salary was $8,500 [in 1967].

**Interviewer:** Was that competitive with other academic institutions or not even close?

**Interviewer:** Not even close. But I did it because I wanted to be here, and I wanted to pursue that avenue. When I went from the assistant professor to associate professor was the first time I made over $20,000.

**Interviewer:** What year was that, sir?

**Seigler:** I can't remember exactly. It was in the early '70s. That was the way that had developed, and the two years of research being an absolute requirement was – Sabiston was adamant about that. That was not going to change. He gave in for some other things, like we started out here every other night on call. Then it was every third night, so he gave in some of those ways, but he never would move away from the two years in research.

**Interviewer:** That was different from Hart's and Gardner's residency?

**Seigler:** Absolutely. Totally different. Indeed, that's what put us head and shoulders above our competition. The reason that people would come here, and, as a lot of residents said, suffer with the every other night and the prolonged training, was because of the two years of research. Indeed -- and I can give you a sheet in a minute giving you the exact number. Sabiston turned out academicians, that was it. When you finished here, you were either going to be on the faculty here as an academic surgeon, or you were going to go to another institution. We turned out some people that went into private practice, but that was not the intent.

**Interviewer:** Everyone wonders how Dr. [Greg] Georgiade got out of doing his two years of research.

**Seigler:** I think he probably got out of it because of his dad [laughs] would be how I think he pulled it off. Greg and I wrote a very early paper on breast conservation, and and immediate reconstruction. This was not met very nicely. I had been through this once before with the transplant issue. There were surgeons out there saying, "You guys are violating every surgical principle known to mankind. Breast contour is totally unimportant; you really ought to be kicked out of the societies for doing this." But we published that paper on immediate reconstruction, I think in 1972. Indeed, through the years, that became the norm.

**Interviewer:** Was Sabistan supportive of his faculty when they were going out on a limb and challenging surgical dogma?

Seigler: Not always. I'll tell you a story about that in a minute. You don't need to worry about recording that. It's just an interesting story because he always wanted to protect the university. When we started transplantation, for example, in the mid and late '60s, there was a lot of negative feelings about that. Indeed, one of the professors in our law school came over here and had a meeting with the faculty, talking about how Del Stickel and I were immoral, non-ethical because we were taking normal organs out of normal people and put them in somebody else.

**Interviewer:** This is for a living donor?

**Seigler:** Yes. We started only with living donors. We went our first seven years with just living donors because we wanted [transplants] based on immuno-genetics. That's where Bernard Amos came in, he was recruited here as a mouse geneticist. The reason that I came here was because of Bernard Amos. I did my NIH fellowship in immuno-genetics, designed to try to identify tissue antigens and see what role they did or didn't play in the human immune response, in terms of the first organ rejection. Secondly, the goal was always towards tolerance.

Early out, our first 12 [transplants] were HLA identical, living-related, donor-recipient pairs. I wrote a paper in JNCI, and they don't like to take clinical papers, but this was based upon genotypically identical living related pairs and how morphologically and functionally did this support the idea of histocompatibility. Indeed, the very first histocompatibility workshop was held right here Duke where researchers from all over the world came here. We all looked at our different sera, our panel for identifying antigens. That led to recognition of an establishment of HLA, the nature of histocompatibility complex in man.

That was the theme of transplant here at Duke, and it drove it for many, many years. We weren't so much interested in great numbers, we were more interested in the immunogenetics and in how did that advance the field.

**Interviewer:** With such detailed genetic analysis, how did your organ survival rates compare to national data?

**Seigler:** It was incredible. Our first 12, for example, got no steroids. They got only low levels of Imuran and had little or no rejection.

**Interviewer:** Just for the record, this is before Cyclosporine?

**Seigler:** Yes. It was Imuran, azathioprine. Transplant developed that way here, and when we began to look at, perhaps, other organs, it was rocky to begin. For example, Paul Ebert and I were working in the lab with -- I had a group of dogs that I had typed the same way that we were typing the humans. We were doing heart transplants in the dogs following that work. Paul was the heart surgeon. I was more of the guy in lab

doing the typing and breeding the group of dogs. It came along in the late ‘60s that we were looking at trying to do this clinically, but it was thought that was a no-no.

**Interviewer:** Was this before or after Chris Barnard’s' transplant?

**Seigler:** It was before.

**Interviewer:** MCV was doing a lot of work with that just up the road. Were you in contact with Dick Lower’s group or was it two different projects?

**Seigler:** Yes, If you want to go back on this transplant business, Dave Hume had been at MCV, and he'd come down from Harvard. He didn't get along with people at Harvard at all. Joe Murray and that crowd that had despised David. Bernard Amos and myself and Del Stickle drove up to Richmond and we talked to Hume because Hume was just turning out transplants but was having a lot of rejection. When you have a lot of rejection you get a big pool of patients that have rejected, and they're very difficult to do a second, or third, or whatever number transplant.

He was very sensitive to the fact of, "Look, I'm a force, but I need a way to get these difficult patients off of my list so we can go forward, and you guys down there at Duke are all about this typing business, maybe we ought to pony up and get together." We established what was what we called "The Southeastern Organ Procuring Program" or SEOPP. We recruited other people, we got the University of Virginia involved, the University of North Carolina was involved. We had as a great donor source the pathologist down at Grady in Atlanta because they had a lot of potential donors, and so we got together as this group for Organ Sharing. SEOPP eventually became UNOS. That started here also just like the histocompatibility did.

**Interviewer:** What was Hume doing to pick this donor recipient pair as if he wasn't doing histocompatibility testing?

**Seigler:** Blood type. That was it. Indeed, another guy, he was a little bit older than I was, but he started doing hearts, Denton Cooley. He made a famous statement: “If I needed an immunologist, I’d buy one.” He just did transplants, and his first 22, all were failures.

I mentioned him only because he came into play in a positive way later on when Dr. Walter Wolfe was looking at managing aortic dissection. That was a major contribution here. It started with Wolfe because that was in opposition to what was going on in Texas. Nobody could repeat the results that they had in Texas. It was first Wolfe then it was pursued on a whole channel of people all the way to Chad [Hughes]. They each make their contributions coming along on how you manage dissections.

Similarly, Will Sealey was the first to do Cardiac Mapping. He and I were working together because Paul Ebert and I had moved from dogs to chimps. I had a colony of young chimps behind the VA. These young chimps had the anatomy of a child. So the mapping that he did for W.P.W. coincided. Will was the first to do surgery for arrhythmia and then that was followed on by Jim Lowe and going on forward to what

we're doing now with the intravascular approach. So that has a nice story it. Also a major contribution.

**Interviewer:** Going back to organ transplant, how did we diversify from kidneys to livers and hearts?

**Seigler:** Well, actually, originally, the first thing that we were doing was bone marrow. We had Becky [Rebecca H.] Buckley here and she's still here. She is a fabulous investigator. It was Becky Buckley here, and Bob Good, those were the two big bone marrow transplanters. Indeed, if you look at the registry at NIH today, on bone marrow transplant for kids with immune deficiency, 75% or 80% of them are Becky Buckley's patients. She is phenomenal.

We started with kidney. Around -- I think it was around the 1970s, Sabiston came to me and he said, "Look, you recruited a young guy that you really liked that had a military background, he's come in our residency and I want you to mentor him because the one thing that's beginning to appear in surgery is oncology, and be thinking about surgical oncology and how we might do that."

I had published a couple of papers on how escaping immune surveillance had an immunologic basis, I felt. He said, "Since you are interested in all of these transplant antigens, and you're talking about tumor-associated antigens, be thinking about surgical oncology." The individual that we recruited, who I really liked, came out of the Air Force. Indeed, he was in that original group that was doing human centrifugation, even himself, and that's Randy Bollinger. Randy stayed on, and I started giving the responsibility of transplant to Randy.

My feeling with Dr. Sabiston was if we were going to start surgical oncology, I wanted it based on a multi-disciplinary approach. One of mine and Bill Shingleton's patients was Mr. Morris, and he gave the matching money for the Morris Building, and we were going to open that as the Clinical Cancer Unit. Sabiston said, "well you pick from the faculty, orthopedics, urology, thoracic, head & neck, general, and we'll move ya'll all over to the Morris Building." He went along with this idea of multidisciplinary approach. At that time I was telling him how we had to recruit a superb radiation oncologist because we didn't have it. Radiation oncology was part of radiology, believe it or not.

We recruited Leonard Prosnitz who was a strong supporter of this. And so in these clinics, they were headed up by the surgical oncologist, but the patients were also met at the same initial clinic visit by the medical oncologist and radiation oncologist. They got the combined approach. We had that for all of the different subspecialties.

**Interviewer:** Was there a division of surgical oncology at this time?

**Seigler:** We just called it part of the department of surgery because everything was part of the department of surgery, then. Nothing was independent, but it was surgical oncology and that's the way that we developed it. Bill Shingleton, myself, Danny Bolognesi, Leonard and a few others got together and wrote the original grant for the comprehensive cancer center.

Ours was one of the first 12 comprehensive cancer centers. Bill Shingleton was the original director and had a national and international reputation in oncology. He was sort of the generation- the role of chemotherapy and surgery. Marvelous person and did a fabulous job as head of the comprehensive cancer center.

**Interviewer:** Was this when your work began to transition to melanoma?

**Seigler:** Yes. Well, originally, I ran the breast cancer planning, and then eventually we had George Leight to come in with us. I did breast and melanoma and we had different people doing all of the other organs, Walter [Wolfe] was thoracic, Sam Fischer and Boyce Cole were head and neck. We had somebody in all of these specialties. John Harrelson who was orthopedics and then eventually we got him. As we developed these multi-disciplinary clinics, the two glues, the one clinical glue, we had started this idea of the nurse clinical specialist. We worked with the school of nursing to advance that idea because we did it in transplant. That was where our very first nurse clinical specialist came along.

But that was from the clinical side and then from the research side, was to tell each of these multidisciplinary specialties that you had to pony up with somebody in the comprehensive cancer center.

It could be somebody in cell, it could be somebody in immunology, it could be somebody in genetics, it could be somebody in tissue…it didn't make any difference. But someone. Because we wanted the comprehensive cancer center and its 16 cores, that's a requirement to make it comprehensive as opposed to just a cancer center, to make it be something that generated support for the comprehensive cancer center, but generated academic support for the multidisciplinary approaches to the different malignancies.

**Interviewer:** So initially, this is almost entirely funded by that grant?

**Seigler:** Yes.

**Interviewer:** How did you all sustain funding over the years?

**Seigler:** Well, it began to go away. And we still right now don't have good funding for biometry and biostatistics. It's required for a comprehensive cancer center, and they used to fund it, but they don't fund it anymore. So you have to go out and get funding for it. But there are ways to do this. For example, I had a program project grant in melanoma and at that time that grant, I think it was about $9 million. Back then in the '70s, NIH gave 80% to support the labs. So, if you take 80% of $9 million, that paid for all of the research support and research space for the department of surgery. There were ways and we always required anybody that was writing a grant had to put support for these different avenues in their grant.

Sabiston's era was all about academics and he got the original NIH teaching grant and that's what supported the fact that all of our residents could spend the two years in the lab. So, before he came, the research support in the department of surgery was

miniscule, but under Sabiston it grew to $400 million. Huge. He was so impactful; it's just hard to explain. He was recognized as the premier surgeon on the continent. But he had of course a huge international presence. He was the first one invited to Japan, first one to etcetera. All around the world.

**Interviewer:** When people talk about Sabiston, nobody credits him as a technical wizard like Dr. Cooley and in the same way, I think you can look at other members of Duke Surgery faculty whose specific research contributions are greater than maybe Sabiston's individual efforts. So, how did he achieve this remarkable international reputation as one of the leading surgeons in the country?

**Seigler:** I think it was based on his concept of residency, and it was the envy of many medical schools, I'll tell you. Indeed this department, this relatively small medical school in Southeastern United States has turned out 22 chairmen, that's big.

**Interviewer:** That's remarkable.

**Seigler:** It's going to be more and more and more, obviously. But after Sabiston came Bob Anderson. Bob, he was a graduate of the Wharton Business School. Even though he had been one of our students, and then one of our residents, when he came, he established the business aspects of the department of surgery. I told Bob many times: big mistake! Because once you start tying the business aspects of it, human nature being what it is, that's going to drive a lot of people.

**Interviewer:** In terms of financial remuneration for procedures?

**Seigler:** Yes, what you make. In other words, they establish the billing, and what you actually took in for each person.

**Interviewer:** Whereas for Sabiston, you got a base salary and then a vague bonus at the end of the year.

**Seigler:** Yes, and it was very vague. But it was based on your academic --

**Interviewer:** Productivity, not your clinical productivity.

**Seigler:** Not the clinical. Not at all. Indeed, that was what happened. There was no question about it. Then they tried to revert a little bit of it, make formulas about how did you decide salaries at the end of the year, and you had to write one paper or you had to be a member of this society. It got to be ridiculous.

Under Sabiston we had a giant board, and if you came, you were going to start out in the Association of Academic Surgery, and then you were going to be a member of the Society of University Surgeons, and then you were going to be a member of the Southern Surgical, and you were going to be a member of the American Surgical.

Then, if you wanted to be off on your other things – like I was a member of the Society of Surgery of the Alimentary Tract, I was one of the original members of the transplant society – if you wanted to be off on those, fine, well and good. But you were going

take that route, and he kept the big board in his office, and so he knew when it was your time to come out and you'd better be ready. You better have the publications to be competitive. He used this for promotion and tenure.

**Interviewer:** Did people take advantage of Sabiston and say, "If you're only judging me on academic productivity, then I'm not going to see that many patients" or were people pretty responsible?

**Seigler:** Oh no, very responsible. Extremely responsible because you're being driven by each other. There's no question about that. After Sabiston and Anderson, of course, came [Daniel] Jacobs. And Danny kind of, in a lot of ways, got the short end of the stick because some of the requirements under Sabiston and the rigidity had been somewhat softened with Anderson, but then Dr. Jacobs was being hammered by this big business conglomerate. You have hospitals all over -- every time you went to turn left or right, there's another Duke medical building. He had pressures to fulfill that requirement. I think he always wanted to fulfill the requirements of Sabiston, the academician, but it was harder and harder for him to do. I give him some credit for that, He hadn't been a great academician.

**Interviewer:** Doctor Jacobs?

**Seigler:** Yes. He had come from an institution that had no academics, Creighton, which probably is the bottom of the pile.

**Interviewer:** So how did he get selected?

**Seigler:** Well, you'll have to turn that off…

[sound cut; picks up discussing race and integration at Duke]

**Seigler:** I was walking along with Dr. Sabiston and my friend Dr. Claude Organ, who was one of the leaders, and in fact, he was a member of the ones that organized the Black Surgical Society - and we're walking back. So I said to him, "Claude," I said, "I'd like to be a member of the Black Surgical Society."

I was just kidding to him, and Sabiston about fainted. [laughs] I thought he was going to fire me. He told me later that afternoon, "You are the worst for running your mouth," but Claude thought it was funny as hell. Anyway, that had the first one you hear the Black Surgical Society and we had some outstanding residents that were recruited that were African American. Indeed, our first one, Eddie Hoover, became chairman at Buffalo.

**Interviewer:** What year was that, roughly, when he became a resident? What years were the residents?

**Seigler:** I've got it in my drawer here, I'm not quite sure. I can make you a copy of some of it. In fact, you may want a copy of the chapter of the beginning that I wrote for the history of the department of surgery.

**Interviewer:** Yes, sir.

**Seigler:** I'll pull it out and we'll make you a copy. It's got it in there.

**Interviewer:** Did they face much discrimination from either staff or patients that they were seeing as black doctors in the South?

**Seigler:** No, no. I don't ever remember it being any issue at all. There was a lot of worry about it, but actually, the University of North Carolina had done this years before, and so, it was a non-issue by the time we did it.

**Interviewer:** Why do you think Duke was behind UNC?

**Seigler:** I guess because it was a private university. It didn't have a lot of the requirements that state universities have, would be my bet, more than likely. Those were sort of the eras. They were always driven from top down if you'll notice. It was Jacobs and his influence; Anderson and business, his influence; Sabiston, academics and his influence. Hart brought great clinicians, great technical surgeons. They were able to do everything.

**Interviewer:** So what mark did Jacobs leave on the department? He was here about 10 years.

**Seigler:** This expansion outside of Duke, which I was always against. Adamantly, against it. I think that it dilutes. Really, if you want to talk about Duke Raleigh, that's not Duke. Give me a break. For us to send people over there, it takes them away from here and the students don't have the interaction with the residents and the clinical problems that are going on here. And some of the faculty, they get pushed out there. I can tell you, and you can put this on the record, I don't care- is one that I was the strongest supporter of was Lisa [Pickett]. Lisa, we recruited her from Harvard, bright as everything, smart as everything. She wanted to be an academician, and she gets put over in Durham Regional. Well now, she's back, but to me, that was never fair to Lisa because she wanted to be an academician. She ought to have been here and supported here and encouraged here in her academic pursuits, here. Because this happened more than once. To me was not right if those people really wanted to be an academician.

If they wanted to go over Regional and build a clinical practice and balance the amount of money that Durham Regional made and that they made, fine. Have at it. But if you wanted to be a part of the parent institution, this is where the teaching and research was going to go on. Building all this stuff out there…you see, our competition under Sabiston, was very clear. It was Harvard, it was Yale, it was Hopkins, it was the University of California, and it was the University of Michigan. That was our competition.

Under what was going on under Jacobs, it was the surrounding 18 counties. Could we bring all of them in and could we have institutions in those 18 counties so we would control them, that was the plan. That was what we were building, was all these

associated hospitals. To me, it was very short-sighted. I went along, saying "Okay, if that's where we are and they're trying to [unintelligible], so be it. But you're all going to be saddened by, if when we get his replacement and you want to regain what Sabiston had."

[sound cut]

**Seigler:** He made the shortlist down to the end of three, and a lot of people here were pushing him because he had a great reputation in Whipple's. I said, "Look, guys, it's the last time you're going to hear from me. I know you're all sick and tired of hearing it from me. You're tired of me. I understand that, but that guy is in his 60s and he hadn't done anything for pancreatic cancer that's worthwhile. Period. And if that's what you want, some old guy that's got a one trick pony, fine. But if you want a Sabiston, you better do it now."

And of course, my candidate was somebody that had been in my trail, which was Allan [Kirk].

**Interviewer:** What was he like as a resident?

**Seigler:** He was great. Really good. I rode him, and he'll probably tell you some stories about it, and pushed him and was ugly to him, but he came through that whole line. He's transplant. He believed in that model, even though he was right at the end of Sabiston. It was him, Keith Lillemoe], and then one of our former medical student who is great guy, who I love to death, who was a real teacher but he wasn't a researcher, great guy. Of course, the one I was pushing was Allan because I thought that he would try to regain the Sabiston Model, which he has. If we hadn't taken this route, we were never going to do it, it just wouldn't be successful.

**Interviewer:** As someone who only knows the Kirk years, what were some of the changes that he implemented to get us back to a more Sabiston-like experience?

**Seigler:** Well, he started spending more time -- like the Friday afternoon conference for example – more time with the students. More time, even though he's got a lot of push against him…he has to drive this economic train. There's no question about that.

If you require now than anybody you're recruiting, to write a grant and to have a grant, you'd have trouble getting the faculty. He's trying to recruit people that are in that vein. A good example is people like [Andrew] Barbas, who, of course, we trained. People like Stuart [Knechtle], who we trained. That's his wish, that's his driving force and he will be successful. It'll be harder. We'll have to, of course, have a lot of people that are just here doing cases and that sort of thing, but he's trying to maintain getting the faculty to realize the importance of being in societies, and being a contributor to the society, because that's very important for the university. He's just doing a great job, marvelous job with it.

**Interviewer:** When he first came, was there much resistance to some of the changes he was making? I know a few prominent faculty members left shortly after his arrival.

**Seigler:** No, I don't think so; we had always turned out chairman. Now, we happened to have lost, in a relatively short period of time, some of our middle established faculty, but of course those are the ones that are going to become chairman [laughs]. We lost [Doug] Tyler, we lost Mark Onaitis, we lost Becky White, and I just hated when we lost Becky because I worked for Becky since she was in the eighth grade. She was part of the TIPs Program, Talent Identification Program. They're all doing wonderful jobs where they are. That's their advancement, but yes, we've lost people that are…they're going to be very careful replacing them because you can't just replace them with somebody that wants to do a bunch of this or that, that's not going to help us any.

I think Allan will be successful in this because its being very quickly realized that that model, in the long run is our birthright. That's where we came from and these other things are too tenuous and we don't have any control over them. We don't understand what the Affordable Healthcare Act, what that's going to do to us or what they ever replace it with, what that's going to do to us. We always want to maintain our strength being right here.

**Interviewer:** In the 1994 interview, you talked a little bit about the surgical residency and today you talked about how that's one of the strongest legacies of Sabiston both here and nationally. In the 1994 interview you talked about how proud we were as Duke that there was a strict dress code, that there were very high expectations, that everyone did two years of general surgery before doing orthopedics or neuro…., and how the Q2 call was a feature of our program that selected people who were truly dedicated.

Residency has changed a lot in the last 25 years, some out of our control some within our control. How have you seen those changes implemented, what has that meant for surgical education and the future of our profession?

**Seigler:** I think it's hurting us, it's hurting us. For example, plastics. At that time, they had a plastic chair. He was a friend of mine, one of my former residents. He came and was talking to me, he said, "I'm getting a lot of pressure to do two and three. Some people even wanted to be O and five." I said, "If you do that, you will end up with people that you're cranking out that are going to have a cosmetic clinic over the drugstore. You just aren't going to have the type of plastic surgeons that are doing things that you do, that we've done historically, here. Things like developing microvascular surgery." We did that here. Things like head and neck reconstruction, reconstruction for children with head and neck deformity.

These are not things that are going to make you a lot of money. In plastic surgery certainly they are not like augmentation or facelifts and that sort of thing. "You will attract residents that want to go out and do that crap." He started out not requiring as much general surgery and indeed that's what happened to him. He got a bunch of people he couldn't stand.

**Interviewer:** Who was chair of plastics at this time?

**Seigler:** That was Greg Georgiade..

**Seigler:** When he tried to go back, he got a lot of resistance and there's even more resistance now. Orthopedics came into the same thing. Right now, our joint replacers are booked out through the summer, and they can crank those things out like that. And sure they're making some minimal contributions in joint replacement, but they aren't doing anything else. They'll hire somebody who has a PhD, but they don't have any research lab.

Jim Urbaniak had a funded NIH research lab for 30 years. You just get a different type of resident and then you're turning out a different kind of individual. They're both all right, but it's what do we want to be?

**Interviewer:** It seems like these early tracks are becoming even more common now with cardiac surgery and vascular surgery starting in O and five next year. How do we maintain an institution of academic excellence while the general trend in surgical education is moving towards shorter, more focused pathways?

**Seigler:** Well, it's got to come bidirectional. It's got to come from the chairman here, and it's got to come from the national organization, the American College. The American College has already realized that this idea of us not turning out general surgeons is a disaster. If you look right here at our so-called acute care surgery, it's crap. And it's crap across the country. They have far higher morbidity, they have higher mortality, and it's ridiculous. It's just absolutely ridiculous. They've said, "Well, that train has left the station. [Ted] Pappas tells me that over and over and over. We are never going to be able to go backwards. I said, "Well, Ted, just look at yourself and what your own impact is, your impact on students, residents and your patients for God's sakes" because acute care surgery doesn't develop a continuity of care, they just don't do it. It's not good for the patients, it's not good for them.

The College knows this, and they're trying innovative ways to start trying to enhance general surgery and the training of general surgeons. I don't see why we don't want to be a part of that and take a leadership role. We did it for a generation. That's something that we can do to be beneficial. Indeed, it helps in terms of the diversity of the training because you can say aye or nay all you want, but female surgeons are more attracted to taking care of problems that are chronic, problems that are family, following people for a number of years. They get a lot of satisfaction out of that, whereas males are more involved with self-importance. They are.

If you just take the two genders and say, "Who is driven by security, and who is driven by opportunity?" The males are driven by opportunity and the females are driven by security. They like this. They don't look at things like prestige and competition, and they also don't look at things like, "I'm going to do this for the next 35 years." They may do it for seven, or nine, or 10, or 12, but males are more likely to do it for 35 or 40.

If you're talking about other diversities, you can take different backgrounds of trained African-Americans or the African-American communities. Because like it or not, as long as you and I are alive, we're going to have African-American communities, and they're very sensitive to that. They [African American surgeons] will advance it, and they'll be role models for the kids coming along and that sort of thing, I just think it would help everybody.

**Interviewer:** Going back to acute care, even people who do a general surgery residency today, over 80% are going to fellowship. How do you get a thyroid surgeon or a breast surgeon taking general surgery call doing a Hartmann's in the middle of the night if they haven't done one in five years?

**Seigler:** Well, I can tell you, I did breast surgery here for a generation just as good or better than all five, or six, or how many of them that are breast surgeons that are here right now. I've done a right colon while one of our colorectal surgeons was getting set up to do the case. Mine was already in the recovery room. The thought that the general surgeon can't do more than just breast surgery or more than colorectal surgery is ridiculous.

You just have to make general surgery more attractive to people, train them, and turn them out We always did that, and indeed, we were the very first ones, and Sabiston recognized this. We were a big heart program, no question. That was what defined another part.

**Interviewer:** That came before Sabiston or with Sabiston?

**Seigler:** No, with Sabiston.

**Interviewer:** Because of his CABG research?

**Seigler:** Yes, it was with Sabiston. Sabiston was very smart. What he did, he had already gotten this huge NIH grant for the teaching of residents and attracting residents to teaching and research. That was the big teaching grant that was hundreds of millions. He decided that he would add on two years, but he didn't call them a fellow. He hated fellows, he hated fellowships, he felt that detracted from the training of residents.

He called it, those two years, "teaching scholar," and he got funding for that. We could have them for that much longer, we could have them for two more years, and they were teaching scholars. They were going to be only academicians, no question about that. But it could be a teaching scholar in terms of arrhythmias or pediatric or the different techniques for reestablishing flow because there were a lot of things that were coming along then.

We even had people here right with the original team for the mechanized heart. We had a guy here that worked with the initial artificial heart, for example, Chitwood, who finished here and was chairman down at East Carolina. He was the original one for doing robotic hearts. All that came out of the teaching scholars. The ones that we

turned out around the country all were in academic institutions, everywhere. It was Cornell, it was San Francisco, it was Utah, it was Wash. U, it was Northwestern, it didn't make any difference. He did this.

They weren't called fellows; they were called teaching scholars and they were defined that they were going to be scholars. They were going to run a laboratory, they were going to be somebody like Carmelo [Milano].

**Interviewer:** When did we have our first fellowship?

**Seigler:** Well, the first fellowships were actually in transplant. When [Richard] McCann was coming along, he was finishing, and he was one of my favorite residents and he worked with me a lot. He said, "I want to do vascular." I said, "Well, we don't have vascular fellowships, but we have transplant." I said, "Down the road, you are not going to know which way it's going to go. Why don't you do transplant? You'll like it, because you do understand, Dick, that we're sewing an artery and the vein together, right?" He did that, and he was in transplant and vascular. Of course, he was the driving force along with guys like Walt Wolfe, and Donald [Glower], and Chad [Hughes], that were working on the aorta, the heart, then, valves. He was the original one who was pushing EVAR. Down the road, when they finally pushed him out of transplant, he was doing vascular, he was our vascular guy. You don't know. He took that route and he was the first one.

**Interviewer:** We've been going about an hour and 15 minutes, I don't know if you want to take a break and just continue it next week or if you want to keep going.

**Seigler:** It's up to you.

**Interviewer:** I'm happy to keep going. I'm a little curious about your personal story and how you got here. I know you were born in Asheville, North Carolina. Were your parents are in medicine, were your siblings are going to medicine, what drew you in the medicine as a career?

**Seigler:** No. I was always intrigued by the idea of transplantation with tolerance being the goal.

**Interviewer:** You went into medical school with that as--?

**Seigler:** Yes.

**Interviewer:** That's pretty uncommon in 1950s. How'd you hear about this and get that idea as a career trajectory?

**Seigler:** Just reading. I felt that there would be no better feeling in the world than sewing a kidney into somebody and see it start making urine, meaning that they wouldn't have to be on dialysis for the seven to nine years, if they were one of the few lucky ones who could even be dialyzed. I don't know, that has always attracted me as something that was going to grow because we were going to have techniques that

were going to come along and be developed. The ultimate goal, to me, would be trying to be able to establish tolerance, that was my driving force.

**Interviewer:** What was it like growing up in North Carolina at the tail under the Great Depression?

**Seigler:** Hard. Yes, it was a time that you better have a good work ethic.

[laughter]

You just should. If you worked hard, you could get a career path no matter what your socioeconomic background was. The state of North Carolina was very good, it is. I always loved the University of North Carolina from the standpoint that it was not that expensive. My medical school was $500 a quarter. [laughs] Duke just pushed their tuition to $77,000, that's just tuition. If you don't think you aren't ruling out a lot of people… But I always had real respect for the University of North Carolina that some poor kid whose father had been killed in the Second World War and see that he got a great education and that medical school was doable.

**Interviewer:** How did you end up there for college first?

**Seigler:** I just liked the University of North Carolina when I was looking around.

**Interviewer:** Did you choose chemistry as a major because it related to the chemicals of immunology?

**Seigler:** Yes, absolutely. Then, when Bernard [Amos] had come to Duke, I wanted to work with him.

**Interviewer:** How did you hear about him at Duke when you were in medical school?

**Seigler:** Just reading. He was very well known, very broadly published. The other thing is he was just a wonderful down-to-earth great person, he really was. He lived on a farm out in Hillsborough, and he did a lot of fun things. He took a lot of time with students. He loved to teach, and he loved to encourage any young people to do things. For example, it came time for a big conference in transplant in Brazil, and Bernard said, "Look, you ought to go down there and represent us." He talked to Sabiston and Sabiston said "He's young, why don't you still go?" because he was supposed to go.

Bernard said, "Well, if we get him support, would you support that?" Sabiston, I guess, was non-committal about it but he sent me down there as his representative. Well, that was big for me.

**Interviewer:** Huge.

**Seigler:** Yes, huge for me, it wasn't any big deal to Bernard.

He did the same thing with people when I was first starting in transplant. People that were the great immunogeneticists. He had his farm in Hillsborough, and we had meals

out there. We went to meetings together and stuff like that, so you got to know-- I got to know all of the original greats through Bernard. The way we just related to each other. He sent me, a couple times, to different labs so it was a bond that lasted until the day he died.

**Interviewer:** Did you ever think about pursuing a PhD in immunology instead of going to medical school and what helped you make that decision?

**Seigler:** No, I always wanted the ability to be able to do the clinical part of it, but I was never driven by letting the clinical thing be my major driving force. Indeed, at a lot of the meetings I went to early out, people at the meetings like the Federation, I would go to that. Well, most surgeons didn't go the Federation. We'd be talking as a group at the table, and I would be there with two immunologists and two geneticists. They would start deriding clinical people, "They're so stupid. What are we gonna do with these clowns? They don't know even about the science of transplant." I heard a lot of that.

When I was on the immunobiology study section at NIH for several years, I got to know…of course, everybody else at that table was a PhD. But they appreciated the impact of somebody that was doing the science but also doing the clinical part because they had no idea about the clinical part. It was really good, I enjoyed those years a lot and have PhD colleagues that are my closest friends today.

**Interviewer:** Did you ever think about taking a more internal medicine route like nephrology? What about surgery appealed to you?

**Seigler:** Being able to do it, to do the procedure and to control it.

**Interviewer:** Today, nephrology is involved with daily rounds with the transplant team. In the early days, were they as involved or was it more of a surgeon job?

**Seigler:** No, when we sat down, every patient was presented at the transplant conference. Then, around that table was Bernard and Del Stickel; Everett Anderson, who was the urologist; we had three nephrologists, and they were sitting there at the table; Fran Ward, Frany was the geneticist; and Bill Wilson. Bill was a psychiatrist that was also a minister. So you had to pass muster with that whole group, because they were all involved.

**Interviewer:** What was your surgery clerkship like when you were a medical student at UNC?

**Seigler:** It was good, very good. Great clinical people, clinical leaders. They're all dead now, of course, really good. When I came here, they were very accepting of me because transplant was just going to start. So I wasn't competing with them for anything. It was really good, it was very enjoyable.

In fact, one of the things I miss now, the most about the department and about the fact that we are all over hell's half acre is that we all knew each other.

**Interviewer:** How many were there when you got on the faculty, roughly?

**Seigler:** I was the fourth general surgeon. There were only three others, and they were very supportive, tremendously supportive. Probably, my closest friends were orthopedists. We just related together, and they still are today, Jim Urbaniak and Bob Fitch are my two closet friends. We all knew each other. The rules were this way…they were subsequently changed, but for you to become a member of the department of surgery, and that was everybody, the person being proposed was proposed before the members and you voted. Now, six guys appear, they might be good, they may be clinically oriented and not academically driven.

**Interviewer:** When did that change?

**Seigler:** That changed probably around 1980, I guess, somewhere in there. I miss that because I enjoy my fellow faculty members, I always have. When somebody comes on the faculty, I always take them out to dinner because I like to get to know them, who they are. The fact that now we're so large, in fact, some of our orthopedists don't know our other orthopedists.

I'll ask Bob, and I'll say, "Bob, who's your favorite joint guy?" "I don't know, I don't know a half of their names. They're off on Paige Road." There is not as much bonding at the faculty level as there has been just out of sheer numbers.

**Interviewer:** On your CV, you said in your residency, one year was a year of plastic surgery. Was that pretty common in that day? How was that year different from your other years of general surgery?

**Seigler:** You see, at that time, Joe Murray was a plastic surgeon. Our chief of plastic surgery always thought that plastic surgery was surgery of the skin and its contents. He was a great teacher, great leader.

**Interviewer:** Who was chair then?

**Seigler:** This guy named Earle Peacock -- Actually, he went out as chairman at the University of Arizona. He was telling me that, "If you're going to be doing reconstructive things, this would be a good year for you to take." Then, he said, "When you're a chief resident, we'll give you all of the big plastic surgery cases," which they did. I did all the reconstruction. I think that is a lot of why I got into breast conservation and immediate reconstruction, because that was something I trained in.

**Interviewer:** There were no fellows to compete for cases?

**Seigler:** None, none.

**Interviewer:** What was the autonomy that you had as a resident? How is it different from the autonomy the residents have today?

**Seigler:** A lot lower because then, in terms of the public patients, you had complete autonomy. In terms of private patients, the only autonomy you had was if you got there

first. That was what always drove me to get to the OR and get prepped and ready. In fact, I started doing it before the attending got there, [chuckles] then, he might go ahead and let me finish. That, I guess, was the mark of why I felt that I ought to be in control, and I ought to be able to do it all. It's the way I was trained.

**Interviewer:** How do we train surgeons today if they don't have that opportunity for the decision making or the independence as the previous generation?

**Seigler:** I think it's very, very hard, and that's why I started very early at the VA for two reasons. Number one is I felt that veterans deserve the best health care that we could give over and above anybody else except maybe children, and stayed with it. I've been at VA for 50 years. I stayed in the military for 31 to try to impact them, going around teaching in different military institutions.

I could do it at the VA, and the residents used to really appreciate that because they knew that I would rather be in the lab. For five years, I was just in the lab, but I was the senior person that was on the faculty. If it was an esophageal case, they'd call me, or if it was a total parotid they'd call me. If it was liver resection, they'd call me, and so I'd bonded with the chief residents for that five years, which was nice for me because it gave me a lot of clinical stuff, but I didn't have to do everything else. I could be in the lab, it was good.

**Interviewer:** Speaking about the military, did you join voluntarily, were you drafted?

**Seigler:** No, I joined.

**Interviewer:** Then, what made you stay in for 31 years? It was pretty uncommon, as we discussed, in academics.

**Seigler:** I always felt that that was a section of our population that deserved for us to interact with on a very major basis. I felt that if I was going to have any impact at all, I ought to do these career paths. I've taken BOBC, BOAC, Industrial College of the Armed Forces, War college, it's not that I would be competing with them, but I would interact with them.

I wanted to understand how the Armed Forces work with our industry. They were all line officers in the courses, everybody in the War College. In fact, when we were at the War College in Pennsylvania and you were getting your diploma, you were walking across the stage. There was a four-star general passing out the diplomas, and it was all alphabetical.

We were sort of in a cadence by the time they got to “S”. When it came time for me and he said, "Colonel Seigler," and, "Goddamn, who let this doctor in here?" and just broke the audience up.

[laughter]

Of course**,** I stopped halfway across the stage, because he was a four-star general. They were all line officers.

**Interviewer:** What did you write your thesis on?

**Seigler:** Mine was on NORAD, and I was a NORAD commander. I was trying to say how the NORAD ought to function within our military planning in terms of the theater of operations.

**Interviewer:** Not a medical thesis at all?

**Seigler:** No, no.

**Interviewer:** Then, you were in undergrad during the Korean War, then residency during Vietnam and at the VA when all these veterans were coming back. How did that impact your military service?

**Seigler:** Not at all really. No.

**Interviewer:** Was your military service supported by Duke Surgery and Dr. Sabiston?

**Seigler:** Not really because when it came time…the way it works in the military, because I've been through all of the educational things, and I've been the commander of the 3274th, which was a 1,000-bed, and now 1,500-bed, general hospital, when you get to a certain point as a bird colonel, you make the next step or you're done.

It came time for me to be general, and they told me, they said, "Yes, we now have a slot for you, and it's at Fort Gordon." Of course, it's in Atlanta. I went to Sabiston and I said, "I'm getting a star but I will have to--" Up to that point, he was very supportive because he had been in the military himself. He said, "You have so many responsibilities here now, and you're going to be flying down to Fort Gordon twice a month for two weekends? I don't think so." I had to make a decision, whether I got my star or I was O-6. I decided, "Okay, that's it."

**Interviewer:** When you talk about David Sabiston in the military, that generation had a doctor draft that ended up pulling just terrific physicians and surgeons in the military for two or three years, and that ended after Vietnam. Some people would argue that the military has struggled to recruit the same caliber of Medical Corps officers. How do we, as a military and medical profession, heal that rift and get better doctors into the armed services?

**Seigler:** I don't think anything is working right now because their medical school and their graduates are not of the same caliber. That's all just all there is to it. They are very good at doing certain things. They can triage, they can do a lot of things that we don't do very well like different kinds of wounds. They are very good at doing vascular things because they have a lot of—as you would imagine with the type of injuries that they get, there's a lot of torque, a lot of heat – so they're very good at vascular, but they don't crank out much of anything in the way research.

They, through DOD, will fund it, but they're never going to be able to…they thought that having the Uniformed Services University of the Health Science would attract it and do it but it doesn't..

**Interviewer:** It seems like they're moving more towards a purple Medical Corps, where they're trying to unite the medical services of the Army, Navy, and Air Force.

**Seigler:** Yes.

**Interviewer:** What are your thoughts on that union or proposed union?

**Seigler:** I don't think it's going to work. It's just like taking care of veterans, this idea about the Choice Program is ridiculous. It's not going to work. I don't like this idea that you make it totally free. I have never been a big supporter of that. I think that the veteran needs to cherish those things as much as we do as the ones that provide the health care, but when you make it totally free, they don't cherish it at all.

In fact, they misuse it, and they abuse it. They have no stimulus to behave in a responsible way. In a lot of ways, we enhance the other way. For years, we gave them free cigarettes, which I thought was totally stupid. We made beer and booze immediately available and free, which to me counteracted everything we were trying to do. The same thing with food, we just made all the food in the world available, then had to set up programs to get them to lose weight. It's stupid.

Making it free is not a good idea. If we made it where they had some dog in the fight it would be better off. It wouldn't have to be oppressive, but it could just be if you're going to be seen in the clinic, it's going to cost $10, just so you'll be there.

[laughter]

If you don't show up for your surgery, don't just say, "We'll reschedule you." Say, "Well, you'll now go to the end of the line, so instead of getting your hernia fixed the next open slot, we'll see you in four months." There's got to be some respect, and I think they would appreciate it.

**Interviewer:** When did you stop operating?

**Seigler:** Oh goodness. It's not been that long ago. I can't remember it exactly. I talked to Allan about it somewhere, I think, the day after he was chairman, sometime, I don't know exactly.

**Interviewer:** One question that the profession is grappling with is when should senior surgeons stop going to the operating room? What are your thoughts on how we should make that decision? Should it be that the surgeons, does the department have a responsibility?

**Seigler:** I think it's both. When I was talking with Allan about it, I could have kept on, and I love to teach the residents, doing hernias and stuff like that. I really like it because it's anatomical, and they appreciated it. I said, "There comes a time."

Because I've done big surgeries here, transplants, the esophageal surgeries for years and years. There comes a time that you shouldn't be doing that because one, you don't see as well and you just aren't as good as you used to be, that's just all there is to it.

I could have done that [hernias], but I thought that there were people coming along that needed to do that, so it would be better if I just said, "Well, I'm not going to do any of that but I'll still teach," I'll still go to the clinic because you need to have your input there because they would appreciate it. I've always thought that the residents appreciated talking to me about clinical cases, and they weren't just saying "That's an old geezer, he doesn't know what the hell is going on." I think that if you ever feel that you probably ought to stay at home [laughs]

**Interviewer:** Well, here you are 60 plus years later, you're coming in, you're at M&M every week, you're at the VA clinic, you clearly have a clinical role. What keeps you coming back every day at an age when most of your colleagues are sitting at home?

**Seigler:** Something that made me want to stay in academics, to begin with, is I love teaching, I love the students. I really like the students, I love the residents. I have more of a relationship with the residents. They know I'm kidding them, and they're kidding me, I like that. I like that attitude rather than I'm going to be punitive and whatever, I don't like that. You don't help anybody, either yourself or the resident that way. That's not to say I haven't fussed at a chief resident to the point that they fainted and fell on the floor because they did. Then, they expected me to help them get up. I wasn't going to do that. They need to respect that you're going to call them to task if they need that.

Also, I always felt that we ought to be developing the students at every level and recognizing who needed to go from 1st year to 2nd year, to 3rd year, to 4th year, and don't wait until 3rd year and say, "Well, you need to be out of here."

The same thing is true of the residents. If we can't identify if the resident is having trouble and get him to be able to advance at every level and be successful, that's on us. When they kept reducing, on the in-service…under Sabiston, if you were below 75%, you didn't go to the next level. Then, they reduced it to 50, then 40, then 30. That's crap. Go the other way because if you help the resident, the next time, he's not going to be in the 60%, he's going to be in the 80%. Don't wait until they're coming up to be chief resident and call them in and say, "You can't be the chief resident." That's not fair or not right for anybody.

I've always enjoyed that. I really do love walking down that hall, looking at the pictures [of the residents], recalling a lot of good times, and the interactions, good and bad. That's been very meaningful to me. That's a very impressive group of people if you look at it. I really did. I had one guy that called me when he'd been out 20 years. He said that he just wanted me to me know that he was practicing surgical oncology in the State of Florida, and it had been a great career path for him. He said, "You know, what I was going through out there, and you were on my case, I hated your guts, but

I want you to now know, 20 years later, that this has been wonderful for me, but I also wanted you to know, I still hate your guts."

[laughter]

I know him very, very well. To me, that's what you get out of general surgery. You get out of that that you're taking care of the woman's breast cancer, her gallbladder, and her right colon. You saw her when she was 34, when she was 44, and when she was 64. I think you get more out of it that way, the same thing is true of being at a university. You see them as students, you see them as residents, you see them as faculty.

That's what leads to the longevity, I think. That's what is rewarding. Otherwise, if I did nothing but a total knee and had to do that, or just did CABG, I'd just as soon go out and work for Exxon and lay pipe. At least you'd be outdoors. I like the variety of it all. It's, to me, a much more rewarding than just doing one little thing. That would get very boring, I would think.

**Interviewer:** We've covered a lot of territory, is there anything that I haven't asked you that you want to make sure that we talk about?

**Seigler:** No. You can look it over. **[01:45:25] [END OF AUDIO]**

The following conversation occurred after recording stopped; however, notes were taken and its inclusion was deemed important:

This concerns the establishment of the Sabiston Professor of surgery. Historically, named chairs for surgery were funded by having residents purchase life insurance policies that would eventually mature and fund the chair. The orthopedic residents were particularly involved in this practice. Problematically, it required several decades to go from the idea of a chair to its actual creation using the strategy.

When David Sabiston and retired, Dr. Seigler and Dr. Wolfe wanted to create a surgical chair in his name during his lifetime. To do so, they went to the Sabiston Society and raised $1 million in cash for the Sabiston in chair. This was a remarkable testament to the feelings of loyalty and dedication of Sabiston's prior residents.