REFLECTIONS

# Not Taking "No" for an Answer

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Whenever someone asks for specific or remarkable events in one's surgical or professional career, many special moments may arise in the mind. The flashes that I share here are quite significant to me and were very special moments of my life. They tell about the history of women in what used to be the men's world of surgery, about innovations in what used to be the traditional world of surgery, and, last but not least, about being altogether a woman, an innovator, and from Latin America!

## FIRST ENCOUNTER WITH COLORECTAL DISEASES

My family came to Brazil from Lebanon without knowing what we were going to find there. My father was a merchant while my mother took care of all 7 of us on the island of Marajó in the middle of the Amazon river (Fig. 1). School was reached only by boat, and except for a significant population of buffalos and birds, there weren't many people around. There I learned how to sew basic fabrics together with Mom and the rest of the crew.

My first encounter with colorectal diseases was rather dramatic. One of my older brothers (I was the youngest) died of acute appendicitis before he could get any kind of proper medical attention. My parents were devastated, and this was enough for them to decide to leave Marajó (Fig. 2). Indirectly, this was decisive for my future, because we moved to São Paulo, where education was far more developed, and there were multiple opportunities when applying to university.

## UNIVERSITY OF SÃO PAULO SCHOOL OF MEDICINE AND SURGERY

After completing my undergraduate education, I was accepted into the University of São Paulo School of Medicine. I was not the first woman to be accepted there, but there were very few of us. None of them were interested in surgery at all. I was. My initial interest was in obstetrics, and, by scrubbing in, I was able to experience the basic principles of surgical skills and suturing. It felt like sewing clothes, just as in the island of Marajó. It was my rounds in emergency surgery that made me decide to go into surgery. However, there were no women in surgery residency at that time–ever! My colleagues were surprised (and a bit scared) with my decision. They were surprised to see that I was going to challenge the tradition (of men only) in the surgical world. They were also scared, because they already knew me well enough to know that I was going to be tough competition for them!

I was accepted and became the first female surgical resident at the Hospital das Clinicas of the University of São Paulo School of Medicine, which was the largest surgical residency program in South America at that time. However, becoming the first female surgical resident was not easy. Believe it or not, even the women on staff were against me in the beginning! Nurses simply would not help me with the surgical scrubs, which at that time were made of thick cloth; they only had very large ones that could never fit me. I asked that smaller scrubs be provided to no avail, until I decided to cut them myself with a pair of Mayo scissors. That was the day everyone understood that this was for real: I was there to stay. Therefore, adjustments would simply have to be made. In the end, the women on staff became close friends of mine.

## SÃO PAULO TO LONDON

I immediately became interested in colorectal surgery during my residency training. At that time, anyone who wanted to become somebody in colorectal surgery had to go visit St. Mark's Hospital in London as a visiting fellow (Fig. 3). Many letters were sent back and forth (this was long before the era of e-mails or Internet) before they accepted my application…but wait! They finally realized I was a woman! All of those letters were sent without even considering that this Dr. Habr-Gama could well be a woman! So came a postacceptance letter saying apologies, Mrs. Habr-Gama, but this hospital is clearly a men's hospital. My reply was rather simple (as simple as my English at the time would allow): Do not worry. You will like me. I am a different kind of

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**FIGURE 1.** Family picture in Marajó Island (Angelita, at far right).

woman than you are used to. So I packed my bags and went! I had very little money and knew minimal English, but an incredible enthusiasm took me to the other side of the Atlantic Ocean and to the cold. Imagine a Brazilian (originally from the northeastern part of Brazil) arriving in cold and rainy London–not easy! And like me they did! I became friends with Sir Alan Parks and Ian Thorpe and joined tea time with Sir Cuthbert Dukes and Basil Morson. This was a fantastic experience and changed my life forever!

## BACK TO SÃO PAULO AND MOTHERHOOD

Immediately after coming back from London to the Hospital das Clínicas at the University of São Paulo, I decided to study the outcomes of low anterior resection for the management of distal rectal cancer. I was not alone, because I was already married to my lovely and supportive husband, Joaquim Gama-Rodrigues. He was also a surgeon dedicated to upper GI diseases, and we were (and

**FIGURE 2.** Shortly after the death of my brother, last photograph in Marajó Island before moving to São Paulo.


**FIGURE 3.** External view of the St. Marks' Hospital in London.

still are) a perfect match! Because he was concentrated in gastric cancer, I had my mind set to rectal cancer. We had a tough decision to make: children or no children? At that time, we both recognized that our choices were in the exact same direction and that we had to concentrate on our professional life. With the support of each other, we kept on going! Life would later on present me with many more daughters and sons than I could ever imagine to have.

At this time, I did not yet have radiation therapy in my mind because I was still trying to figure out the best way to access the distal rectum through a transanal incision of the rectal wall. Although Dr. Bill Heald's brilliant

**FIGURE 4.** Explaining the concepts of surgical management of distal rectal cancer described in my postdoctoral thesis in a locoregional meeting.

**FIGURE 5.** Medical students gathered around during the official announcement of my position as the first colorectal surgery chair at the University of São Paulo School of Medicine (inaugural lecture).

description of total mesorectal excision was not yet available, we were already performing sharp dissection of the perirectal fat very similarly to what he later standardized most elegantly.[1] This became the theme of my postdoctoral thesis in 1972 (Fig. 4).[2]

## CHAIR OF COLORECTAL SURGERY

No woman had yet become the chair of any surgical division or department in São Paulo, but that had not stopped me before. In fact, at the time, colorectal surgery was not even a specialty at the university, it was merely a subspecialty of the GI surgery department. It was time for a change, so once again I charged forward. At first, the chair of GI surgery was not happy, but the university decided to create the colorectal surgery division with its own chair, independent of the GI surgery division and all within the gastroenterology department. When they opened the chairperson application process, I applied and shortly became the first woman to chair a surgical division at the University of São Paulo School of Medicine (Figs. 5 and 6)!

## WATCH-AND-WAIT CONCEPT

I was aware that a group in New York at Memorial Sloan Kettering was doing combined multimodality treatment in rectal cancer and decided to visit.[3] I met Drs. Stuart Quan and Bruce Minsky and learned about different strategies incorporating radiation and chemotherapy during the perioperative period for the management of rectal cancer. I also met with Dr. Gerald Marks from Philadelphia, who was doing similar things with the help of Dr. Mohammed Mohiuddin, delivering treatment before radical surgery to these patients (Fig. 7).[4] I brought back to São Paulo these ideas and began to replicate their experience in our institution. Medical and radiation oncologists were excited and all seemed very promising.

Then, I began seeing something that made me question what I was doing: I began to see some of my patients in whom I had performed mutilating abdominal perineal resections have pathology come back with no cancer! How come no cancer? Is this really possible? Was I violating the guiding principle primum non nocere? After observing

**FIGURE 6.** A photo of me and my husband (Joaquim Gama-Rodrigues) at the stairs of the University of São Paulo School of Medicine after the inaugural lecture.

this in a number of patients, I decided to consider what Dr. Norman Nigro did years before with anal cancer: Why not assess response on these patients before doing any surgery?[5] Although it seemed quite logical to me, no one else really fancied the idea. After long and thorough discussions within our department, we agreed that it would be appropriate to at least assess response before definitive surgery in these patients, particularly for those requiring abdominal perineal resections. When we did this, we actually saw patients with completely normal rectums after radiation and chemotherapy. I could not even see where the cancer originally was. So the concept of watch and wait was born.

## SHARING THE CONCEPT

Shortly after introduction of the watch-and-wait strategy, with excellent outcomes, we decided to share our experience with others. We were strongly advised against this! Really? Why? I first presented these data myself to The American Society of Colon and Rectal Surgeons in San Diego. This was not an easy task; it was a big audience, with important and famous people listening, and English is definitely not my native language. Imagine a female surgeon from Latin America having to speak about nonoperative management of rectal cancer after neoadjuvant chemoradiation. The audience seemed certain that I was completely out of my mind! I felt nearly beaten up by the session moderators.[6] They dismissed me from the podium, stating that my presentation was unethical and the data insufficiently sound to allow for any discussion, period.

**FIGURE 7.** Dr. Gerald Marks and me during one of the many scientific encounters to discuss the outcomes of neoadjuvant chemoradiation in rectal cancer.

## REGROUPING

Once again, I persisted and waited. When I revisited the data years later, the idea to compare patients with complete clinical response (managed nonoperatively) and those with complete pathological response (managed by radical surgery) drew the attention of colorectal and surgical oncology surgeons. I presented at the American Surgical Association annual meeting, and everyone seemed to understand the concept. I could not believe it![7] It was the beginning of a new era of organ preservation in rectal cancer management.[8]

## MY (SURGICAL) FAMILY

Many people may have thought that my life was my career and that I had given up completely on family. This was not true. During these exciting years, I had the opportunity to learn and teach. I learned from people who were older than me but also from people younger than me. To tell you the truth, I still learn from them. Many of the people that I have crossed paths with during these years have become

friends. Some of these became permanently attached in many different ways: professionally, surgically, scientifically, and even emotionally. I was granted the opportunity to have a family, including people from different places and countries, different cultures and languages, and different backgrounds. These people constitute a real family to me, and I am happy to be constantly surrounded by them.

I am sure the challenges and hurdles that I faced during my journey may be quite different from the modern challenges that young Latin-American surgeons and young female surgeons face today. However, looking back, the advice I have for you young and not-so-young surgeons and physicians is this: Be headstrong and do not let a "no" defeat or define you; there is so much to learn and do that it will take a lifetime.

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