The care of the patient: character, science, and service

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Abstract. Surgery as a profession rests on an age-old foundation based on 3 fundamental pillars: the collective character of our surgeons, their commitment to a practice based on science, and their pledge of service to humanity. The past 2 centuries bear witness to the success of surgical science. Significant improvement in the remaining 2 pillars is less evident. Our profession would be transformed in a positive way if we strengthened our commitment to improving our character while consciously building the character of our young, if we made the scientific method a way of life, and if we truly dedicated ourselves to the service of others.

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It is a great honor to give the Claude H. Organ Jr Memorial Lecture for the Southwestern Surgical Congress. Professionally, I have grown up in this organization, and will always be indebted to the Congress and its members. I wish to thank Dr. Nelson for inviting me to give this address, and Dr. Carey Page for strongly encouraging me, as a young resident, to participate in the Southwestern Surgical Congress. In 1985, I began work on my first surgical manuscript, later presented at the Southwestern Surgical Congress. This was the year of Dr. Organ’s term as President of the Southwestern Surgical Congress. Claude H. Organ Jr, MD, graduated from Xavier University in 1948, then earned his medical degree in 1952 from Creighton University. Sixteen years after graduation, Dr. Organ was chosen as the Chairman of the Department of Surgery at Creighton. During his time in academic surgery, Dr. Organ also led the Departments of Surgery at the University of Oklahoma and the University of California San Francisco East Bay. Dr. Organ achieved international recognition as a leader in American surgery. He was editor-in-chief of the Archives of Surgery from 1989 to 2004. Hundreds of residents and colleagues benefitted from his wise mentorship and friendship. He wrote and edited the 2-volume text of what is widely regarded as the definitive work on the history of African American surgeons of the 20th century.

It is appropriate that this lecture begin with advice from Dr. Organ himself: “Attitude, not aptitude, determines altitude in school and life.” This advice served Dr. Organ well and continues to serve those whom he mentored and encouraged. He reminds us that our approach to the world may well have a greater impact than our ability. By offering us this advice, he directly implies that we can choose our attitude. In line with Dr. Organ’s advice, each of us has the ability to consciously and deliberately shape our uniquely personal vision of the world. Our personal vision then determines our personal attitude. As a group, our collective vision determines our collective attitude. This, in turn, directly impacts our families, our patients, our students, our residents, and our profession.
rism, our collective attitude determines our collective altitude, or, stated more specifically, the health of our profession. Although not often explicitly considered, as surgeons, each of us is the recipient of a great gift; not something we earned, but a true and precious gift. We are the direct beneficiaries of the toil, the dedication, the innovation, and the service of all of those surgeons who came before us. They laid the foundation of our profession; an ages-old foundation that is the direct result of more than 2,000 years of work from our surgical ancestors.

My grandmother was a child at the time of the first J. B. Murphy address at the sixth annual meeting of the American College of Surgeons more than 90 years ago. Consider the words of Sir Berkeley Moynihan, delivering this address: “Our calling, by common consent the noblest of any, dignifies all who join its ranks. The honor of all who both in days gone by and in our own times have worthily and honestly labored in it.” As one contemplates his words, the reverence Sir Moynihan conveys for the profession, “the noblest of any,” and for those who have come previously, is moving. We live and practice surgery in a wonderful time. Sir Moynihan, in his wildest dreams, probably could not have envisioned the fruits of modern surgery. Since the time of his address, surgery has experienced a true revolution in scope, safety, and quality. Entire fields of surgery have been created, and what was once thought impossible is now possible.

We also live in a challenging time, a time when change occurs at a breakneck pace, a time when we are inundated with information and unprecedented informational noise, a time focused on personal fulfillment and personal gratification. In our age, we tend to take for granted the revolution of the past, and our concerns at the beginning of this century are more than subtly different from the concerns of the generation at the beginning of the previous century. Although I share no nostalgia for the suffering or ignorance of the past, we live and practice surgery in a wonderful time. Sir Moynihan, in his wildest dreams, probably could not have envisioned the fruits of modern surgery. Since the time of his address, surgery has experienced a true revolution in scope, safety, and quality. Entire fields of surgery have been created, and what was once thought impossible is now possible.

The endless cycle of idea and action,
Endless invention, endless experiment,
Brings knowledge of motion, but not of stillness;
Knowledge of speech, but not of silence;
Knowledge of words, and ignorance of the Word.
All our knowledge brings us nearer to our ignorance,
All our ignorance brings us nearer to death,
But nearness to death no nearer to GOD.
Where is the Life we have lost in living?
Where is the wisdom we have lost in knowledge?
Where is the knowledge we have lost in information?
The cycles of Heaven in 20 centuries
Bring us farther from GOD and nearer to the Dust.

The critic and poet Randall Jarrell offers a more direct critique: “Most of us know, now, that Rousseau was wrong: that man, when you knock his chains off, sets up the death camps. Soon we shall know everything the 18th century didn’t know, and nothing it did, and it will be hard to live with us.” There is a characteristically modern negativism in Jarrell’s comment. Although my bias would be that Jarrell is too negative, I am grateful he reminds me science is neither morally good nor evil. Good or bad depends on our application of science. Modern history bears witness to the resultant horrors when science and technology are misused. In less than a generation, the painstaking and brilliant effort required to build the foundation of surgery can be eroded or be misused with resultant harm to our patients and our profession. Eliot, in his opening stanza from choruses from The Rock, alludes to the lack of clarity in our information age. Clear, uncluttered thought, characteristic of surgeons and physicians of the past century, is more difficult to discern today, not because those leaders and thinkers are not there, but rather, because there is more noise. The voices are harder to hear, or alternatively, we are simply not listening. Robert Greenleaf summarizes his theory as to why some ages or places seem rich with great leaders and other times or places seem to be barren of insightful leadership when he states: “prophetic voices of great clarity, and with a quality of insight equal to that of any age, are speaking cogently all the time. Men and women of a stature equal to the greatest of the past are with us now addressing the problems of the day... The variable that marks some periods as barren and some as rich in prophetic vision is in the interest, the level of seeking, the responsiveness of the hearers.” The clutter of the modern information age and its attendant distractions are the greatest threat to our continued professional progress. With this in mind, my address will draw on voices from a less busy, less noisy time, and from a few modern critics (Greenleaf, John Bogle, and Richard Moulton). Much of my address has its roots in the recorded history of the Texas Surgical Society. I am grateful to the founders for beautifully preserving their sources of inspiration in their monograph, The Texas Surgical Society: The First Fifty Years.

The First Fifty Years monologue highlights a few select inspirational quotations, one of which is an excerpt from Sir Moynihan’s address at the 1920 annual meeting of the American College of Surgeons, honoring the recently deceased John Benjamin Murphy. Sir Moynihan identified Dr. Murphy as “the greatest clinical teacher of his day.” In this lecture, he identifies what I believe to be the 3 critical pillars of the foundation of surgery. “Our calling, by common consent the noblest of any, dignifies all who join its ranks. The honour of the profession is the cumulative honor of all who, both in days gone by and in our own time, have worthily and honestly laboured in it. In every generation there are a chosen happy few who shed a special lustre upon it by their character, their scientific attainments, or the great glory of service to their fellow-men (italics mine), for it is, as Ambroise Pare said, 'beautiful and best of all things to work for the relief and cure of suffering.'”
These 3 pillars, as follows: (1) the character of the surgical practitioners, (2) adherence to the scientific method, and (3) as Moynihan states, “the great glory of service” to humanity, are directly responsible for all progress since the dawn of surgery as a profession. Everything else in surgery rests on these broad factors. This includes the care of the patient, medical knowledge, practice-based learning, interpersonal communication skills, professionalism, and system-based practice. These core or general competencies are vitally important. But, without character, an unwavering scientific approach to problem solving, and a deep service commitment to the patient (before self), the competencies are fraudulent.

Because a talk such as this gives considerable latitude with respect to topic, I will focus more on service. From my point of view, the service pillar seems to be suffering, not only from normal weathering but also from direct attacks from mostly well-intended groups outside and inside of surgery. Before we get to service, I will briefly review the status of our collective character and surgical science.

Character

Every surgical leader I know believes that our trainees and surgeons should have strong character. Surgical residencies want the best people as their trainees. Although surgeons of all kinds recognize and advocate for honesty, industry, perseverance, courage, and ethical decision making, I do not believe character development receives the same emphasis in this century as it did in the previous 2 centuries. Indeed, the role of the ruthless and unscrupulous, but technically and scientifically sound, surgeon is probably supported more today than in the past. Our attempts to humanize our educational and training processes probably have unintended consequences with respect to character development of our young people. David Brooks, writing about our undergraduate educational system, describes a great paradox in which, “the great yearning to do good that surges out of most college students” is real; however, “Highly educated young people are tutored, taught and monitored in all aspects of their lives, except the most important, which is character building. When it comes to this, most universities leave them alone.” John Bogle attributes some of these unintended, and perhaps surprising, gaps, in part, to our unprecedented affluence: “The affluent world in which so many young citizens exist today doesn’t easily create the ability to build character. Often character requires failure; it requires adversity; it requires contemplation; it requires determination and steadfastness; it requires introspection—that rarest of human traits—it requires finding one’s own space as an individual. And it surely requires not only courage, but honor.” These sentiments ring true to me. I would confess to some trepidation toward discussing the topic of character in front of a formal audience. I do not suspect that would have been the case at the beginning of the 20th century.

Science

The formal, organized commitment to surgical science in the United States seems unchallenged. This is not to say that our science is ideal, or that it should not and cannot be significantly improved. As one would expect, a modern surgical curriculum is strongly committed to a scientifically derived body of knowledge and a scientific approach to problem solving. In modern Western medical schools and graduate medical education programs, science is king. This emphasis is justified because without science, medicine and surgery are nothing more than superstition and quackery. A serious retreat from this approach would lead a course back to the Dark Ages. Although retreat from surgery as a science is not seriously debated, in a strange twist of modern times, the ready availability of untested information, combined with unscrupulous marketing, has fostered an increase of pseudoscience with dissemination of untested or poorly tested treatments across the globe. Surgery has not been immune from this phenomenon. I would argue that our emphasis on self, specifically the need to constantly increase income, has eroded the development of young surgical scientists. Given the state of surgical science today, compared with a century ago, there is no comparison. Today is better, dramatically better. The past 2 centuries have seen almost miraculous improvements in surgical science, and this science has translated directly into dramatically improved care. This period in time has witnessed the increase of safe anesthesia, antisepsis, blood transfusion, critical care, cardiopulmonary bypass, computer-assisted imaging, minimally invasive video-assisted surgery, and endovascular therapy. Although the progress of science with the resultant improvements in surgical care is unambiguously clear, improvements in our commitment to service are not nearly as striking, and one might seriously argue that our commitment to service today is worse than what it was in the past.

Service

As I turn my attention toward the subject of service, I hope to provide a good working definition, my view of what factors impede our commitment to service, and support for the case that service to the patient is not only important to the patient (the one being served), but it is also critically important to us (surgeons, students, and our institutions).

Definition of service

The dictionary provides 37 definitions for service, of which the first is probably the most widely applicable: “an
act of helpful activity; help; aid: to do someone a service.” Service also refers to a group of industries. From a business perspective, medicine is in the group of service industries that supply aids or services rather than goods or products. For my purposes, the best definition of service comes from the Presidential Address presented by Richard Moulton, MD, at the 1999 Annual Meeting of the Trauma Association of Canada. Dr. Moulton, a neurosurgeon, defines service as “dedicating oneself to the service of humanity and placing the needs of the patient above those of the doctor.” For me, this encapsulation provides the best working definition of service as it pertains to medicine and surgery. With this in mind, I aim to explore the traits of our practitioners and students that have led to our collective success and our collective problems. I will conclude with some suggestions for ways we can provide better service.

**Contrasting views on the practice of medicine**

Before we proceed with this exploration, let us compare statements from 2 surgeons separated by some 150 years. Both surgeons speak to the concerns of surgical practice, but each concludes with very different points of view. The first comes from a 2007 story in The Washington Post regarding specialty coverage, or, more accurately, lack of specialty coverage for emergency departments. Dr. Benson, an orthopedic hand surgeon who provides call coverage every other day to his local emergency department states, “It’s our responsibility to take care of these patients, because that’s what we do. That’s part of our inherent fiber of being an orthopedic surgeon... But there’s no question that as the inconvenience and fatigue and poor compensation and difficulty in having appropriate resources to take care of patients build up, you get this perfect-storm effect where more and more people are thinking, ‘Gee, I don’t know if I want to do that anymore.’” Based on my experience, Dr. Benson is articulating what many surgeons believe. He cites most of the reasons physicians offer for not providing or not wanting to provide service: inconvenience, fatigue, poor compensation, and difficulty with resources. These are real issues, and almost every surgeon I know has raised at least some of these concerns, but to be clear, Dr. Benson is not the problem. He is providing service to his patients. He is the messenger. In a real sense, he is honestly conveying how “we” feel.

Let us turn back the clock about a century and a half and move to the frontier of Texas. Sherman Goodwin (1814–1884), a New Englander by way of Ohio, was a physician and surgeon who practiced in Victoria, TX. At that time, Victoria was a small frontier town of about 2,000 inhabitants. The town sits on the edge of the Texas coastal plain. Dr. Goodwin meticulously kept a personal journal from the time of his arrival in Victoria until the year before his death (1849–1883). “Talking to himself in his journal became Goodwin’s way of rounding out his ideas of life.” In the following text he is writing to himself as to why he practices medicine as a career choice and pondering medicine’s re-
These attributes have led to the construction of a robust, substantial, diverse, and growing profession.

Yet, as with any group or any thing, all is not perfect. Problems start to creep in when, as individuals, we begin to unconditionally believe we have all or even most of the traits in the previous paragraph. Our students are told they have these traits from a very young age, and they readily assimilate these beliefs. They hear it from parents, friends, family, and, to a large degree, from their teachers. The principally bad trait, endemic in our students and ourselves, is entitlement. Although entitlement is easy for the surgical faculty or senior resident to identify among students and junior colleagues, it is a much greater challenge to recognize entitlement in ourselves. Entitlement is intoxicating. It blurs the vision. But do not be mistaken. Without conscious introspection, followed by conscious correction, entitlement is lurking in our background. This belief threatens to crack our professional foundation.

This is not a new problem for physicians and surgeons. Steven Dubovsky’s essay, “Coping with entitlement in medical education,” was published in the New England Journal of Medicine in 1986.14 Dubovsky, writing about medical students, defined entitlement as “a technical term that describes a sense of being entitled to attention, care taking, love, success, income or other benefits without having to give anything in return.” He identified 5 characteristics of the most “blatant form” of entitlement in students of medicine: (1) the notion that knowledge is a right that should be delivered with a minimum of exertion and discomfort on the part of the consumer (student); (2) the expectation that others will provide all the education that will be necessary; (3) problems in learning are caused by the inadequacies of the teacher, the course, or the system, rather than by the student’s own shortcomings; (4) the belief that everyone should receive equal recognition and reward, regardless of individual effort and ability; and (5) the need to relieve discomfort through action, which justifies inappropriate behavior such as addressing grievances through hostile and disrespectful confrontations. Discussion of the student’s behavior on the other hand, is thought to create undue stress. Dubovsky14 was making the point that well-intended attempts to make the educational and training process more humane probably have unwanted and unintended consequences, and the assertion that simply making training more humane will produce more humane practitioners is probably not valid.

Moulton,8 drawing in part on Dubovsky’s essay, summed things up as follows: “Education must above all else be a feel-good process. Student stress, fatigue, or anxiety are to be avoided at all costs.” Moulton goes on to discuss entitlement in a larger societal context, “...such as the demand in society at large for increasing personal gratification with progressively decreasing levels of effort and the avoidance at all costs of any type of personal stress or sacrifice. Coupled with the present cult of political correctness, this tends to create a sense of grievance among even the most privileged people. Old fashioned virtues of selflessness, service to others, patriotism, religious observance, and other values that subordinate self-interest to some higher purpose are all terribly out of style.” Dubovsky14 and Moulton8 were mainly addressing entitlement in students and residents with the implied or explicit argument that these behaviors are problems of a younger generation. Although I agree with both concerning the prevalence and the severity of the problem, my personal observations lead me to conclude that medical students, residents, and practicing surgeons are all quite similar in their attitudes and beliefs. We have a tendency to project negative traits on our young, rather than on ourselves, our peers, or our colleagues.

With this in mind, consider the words of Sir William Osler from 1897, “No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egotism of a most intense kind, to which there is no antidote. The few setbacks are forgotten, the mistakes are often buried, and then years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered.”15 It is not a stretch to conclude, although he does not use the word, that Osler is addressing entitlement as common among the physicians of his day; so despite some deeply held beliefs that entitlement in physicians is a new phenomenon, it would appear that it has been with our profession for at least the past century and a half. Those with “egotism of the most intense kind” truly believe they are entitled to attention, care taking, love, success, income, and many other benefits. Without conscious effort, this tends to lead the doctor to a shift of focus from patient to self.

I believe Dr. Moulton’s remarks get to the heart of the issue, as he poignantly describes the dangers of shifting focus from the patient to the doctor. I believe entitlement arises in individuals and social groups that are intensely focused on themselves as opposed to focused on serving other people or other larger ideals. Thus, entitlement is not unique to the poor or the rich, nor is the middle-class immune. It is not unique to our own time. It is a behavior that arises when a person is intensely focused and sincerely committed to him or herself. In other lines of work, this might simply be an annoying behavioral tic, but, unfortunately, for us it is more serious. Because our profession is based on the premise that our patients’ interests come before our own, such behaviors are destructive to the root of the profession, and threaten to undermine our tremendous collective progress. Failure to recognize or address entitlement leads to behavior that is not conducive to good patient care, and, ironically, leads to a less happy physician. These are the natural consequences of an obsessive focus on one’s self, and, unfortunately, in my opinion, a pervasive mindset in our culture. As a pampered subset of the most affluent society ever to inhabit the earth, we are unquestionably not immune. I understand that my use of the word pampered risks offending my truly hard-working surgical friends, but
if you do not believe me, try working in the oil fields of West Texas in triple-digit temperatures. Your frame of reference will promptly be adjusted as to what is, and is not, pampering.

The importance of service to education and the profession

The residency training system that evolved from the dawn of the 20th century closely resembled an organized apprentice system. The system, almost by definition, had a strong focus on service. In many communities, there was an implied pact linking residency training to the much-needed provision of care for the poor. Although not perfect, in its time, this implicit pact was supported by the physicians-in-training and the communities they and their institutions served. To be fair and complete, not all residency programs were structured in such a fashion, but this implied arrangement was exceedingly common during most of the 20th century. It has become clear to me that the implicit social pact of service-for-education is no longer valid, having lost the support of the physician trainees and the patients being served, specifically, the poor and those without health insurance. Consequently, we are in the process of forging new models for residency training and access to care for the poor. As of today, however, there is not a clear view, or consensus, for how each of these new systems will function, or how we are to pay for them.

The old system of residency education has been criticized for being inhumane, excessively punitive, and damaging to its trainees. I know my mother shared this view. Critics, however, often fail to acknowledge the benefits of the old system, and, of greater concern, they fail to come up with solutions that ensure the new system will be better at producing excellent surgeons than the old. As Dr. Moulton describes, the time-tested system was a “relentless and producing excellent surgeons than the old. As Dr. Moulton’s partners was apparently fond of saying, “you do not learn to become a concert pianist by reading a book.”

Service, however, is not only necessary for the education of our students and residents, it is the moral reason our profession exists. With respect to professionalism, we should consider what professionalism really means. Service is what we are professing to the outside world. We profess the patients’ needs come before our own needs. This concept is at the heart of professionalism. Rakesh Kurana, Professor of Leadership Development at the Harvard Business School, sums this notion up well when he provides his definition of professionalism: “I will create value for society, rather than extract it.” As surgeons, we are professing that we are here to serve the patient first, before ourselves. We do not profess that we are here to educate ourselves using patients. If we did, we would not have a profession. Service is not an unwanted or damaging activity; it is rather, the reason we exist.

Along these lines, I will add my personal critique to the old system. The major critique of an apprentice system should not be that it entails a large amount of service. The principal problem with such a system is that it entails a large amount of forced service. And, in its worst form, the service was forced by those not wishing or willing to provide the service themselves. This is and was a travesty. It not only led to the trainees disliking service, but it also provided a virtual treasure trove of ammunition against the old system. I believe service must be integral to our educational process, but it should not be forced. Service should be modeled, taught, and encouraged. If service must be forced, the student has made an incorrect career choice. Other more lucrative, albeit less important, occupations are available for those not wishing to serve the patient or their colleagues.

As the reader may have noted, I refer to the old system in the past tense. That system is not dead, but we are clearly at a turning point in our graduate medical education system. The changes are significant, not simply cosmetic. We do not
know exactly what our new system will look like. Furthermore, we do not know a new system will be better at producing outstanding surgeons, but I am optimistic. I remain optimistic, because our students and residents possess the previously described traits of intelligence, curiosity, innovativeness, discipline, integrity, industry, honesty, a willingness to forego immediate gratification in exchange for long-term benefit, passion, compassion, and most of all, a desire and a willingness to help people. And, they want to be great surgeons.

Although I do not know exactly what the system will look like 10 years from now, I know that it must rest on the character of its practitioners, the scientific method, and service to humanity. We, as the heirs of modern surgery, must ensure that the fundamental pillars are not only maintained, but also reinforced during our short time as caretakers. It gives me some pause to consider that we will be judged as to how diligently we cared for these fundamentals of surgery and medicine. This critical time requires our attention and our professional reflection as to what is really important.

The importance of service to the business of medicine

“Customer expectations of service organizations are loud and clear: look good, be responsive, be reassuring through courtesy and competence, be empathetic, but most of all be reliable. Do what you said you would do. Keep the service promise,” says Leonard Barry, from the Texas A&M University School of Business.19 Substitute the word patient for customer, and I would bet that most attending surgeons would strongly agree that this is a concise and clear statement as to how they want their residents and students to act. Medicine exists in the service sector of the economy. Service is the reason we exist, but it is also the way we make a living. High-quality service is critical to the current and future practice of medicine, and it is a distinguisher in the market place. Some years ago, Drs. Trunkey and Mabry participated in a debate published in the American College of Surgeons Bulletin: “Point/Counterpoint: At What Price Commitment?”20,21 Dr. Trunkey argued that Medicine has a strong ethical heritage and requires a strong commitment to the profession. He argued that an overemphasis on business hurts the profession. Dr. Mabry agreed that ethics and professional commitment are critical for surgery. He believes that business is critical for our collective success. I believe both are correct. To me, it depends on how one defines “business.” I do not believe business as a process or a profession is to blame for our woes. High-quality service is developed most effectively in modern, capitalistic businesses. Reliability, responsiveness, and even empathy are strong points of all successful service businesses. In medicine, the priorities of the physician are really the root issue. If we are deeply committed to service, we have no need to worry about the profession or the business because both will be wildly successful; however, if we are committed to greed, money, and self, both our business and our profession are in serious trouble. Similarly, if we are not really concerned with our business, but instead, lost in busyness, we are doomed to the status quo or much worse. If we cannot clearly see what got us here and what will ultimately get us there, our profession and our business are in danger of drifting dangerously off course. From a business point of view, service is the goose that lays the golden eggs. Self-centered greed kills the goose.

Importance of service to the provider

I have tried to offer coherent arguments that service is critically important to the patient, the profession, and the business. It has been my observation that dedicating oneself to the service of humanity and placing the needs of the patient above those of the surgeon are probably most beneficial to the surgeon, not from a business or professional perspective, but from a personal perspective. Albert Schweitzer (1875–1965) the theologian, physician, and Alsatian missionary, believed the key to happiness was found in the service itself: “The only ones among you who will be really happy are those who will have sought and found how to serve.”

Two years ago, Dr. Mary L. Brandt,22 in her Claude Organ address, “The Practice of Surgery: Surgery as Practice,” discussed the concept of compassion fatigue, defining it as “emotional and/or physical exhaustion involving the development of negative work attitudes and perceptions, poor professional self-concept, and loss of empathy for the patient.” It is characterized by “emotional exhaustion, depersonalization and loss of personal accomplishment.”22 Compassion fatigue to some degree is almost universal among acute health care workers, which certainly includes surgeons. In its most blatant form, this presents as an unhappy, negative person, maybe even hostile to students and colleagues. The person is tired, often angry, and it seems almost impossible to get him or her to see a patient in consultation. Often, they are asking a variant of the question, “Why are you making me do this?”

Dr. Brandt22 proposed a plan to “modulate the negative.” She outlined a proactive program to reduce, eliminate, or manage compassion fatigue, describing 8 specific steps: regular exercise, interests outside of medicine, good nutrition, managing sleep deficit, time with family and friends, humor, prayer and meditation, and the use of support structures. Schweitzer expressed a common sentiment with respect to family, friends, and support structures: “In everyone’s life, at some time, our inner fire goes out.”23 It is then burst into flame by an encounter with another human being. We should all be thankful for those people who rekindle the inner spirit.” I would suggest, in this 2011 Claude Organ Memorial Lecture, that we should add one more strategy to the prevention of compassion fatigue.

In my experience, not everyone is equally susceptible to compassion fatigue. Some are clearly more resilient than others in the face of environments that produce compassion.
fatigue. I believe those who have a clear, uplifting, and personally meaningful vision are significantly more resilient. For the practice of medicine and surgery, a vision based on service to others is not only most aligned with our professional goal, but such a vision is also the most personally uplifting. Helen Keller provided a glimpse of her vision in her 1933 essay, “A happy life consists not in the absence, but in the mastery of hardships... To be happy we must do those things which produce happiness... It all comes to this: the simplest way to be happy is to do good.”

A meaningful, hopeful, and personal vision is a powerful immunization against compassion fatigue or situational depression. Physician-author Jerry Groopman sums it up best for me when he provides his definition of hope: “Hope unlike optimism is rooted in unalloyed reality... Hope is the elevated feeling we experience when we see—in the minds eye—a path to a better future... Hope acknowledges the significant obstacles and deep pitfalls along that path. True hope has no room for delusion.”

Hope in this context goes beyond our usual, superficial use of the word, rather it is a profound form of personal vision. It is this type of hope that allowed Dr. Viktor Frankl to survive the horrors of a Nazi death camp in Auschwitz; hope that for Admiral Jim Stockdale to survive 7 brutal years in a North Vietnam prisoner-of-war camp; hope that motivated Mahatma Gandhi to lead an entire nation to freedom, inspiring movements for civil rights around the world; hope that motivated Thomas Jefferson to draft the “Declaration of Independence,” laying the principles of Democracy for all to see and follow; hope that motivated Rosa Parks to remain at the front of the bus on that cool December day in Montgomery, changing the course of history; and hope that may have allowed each of us to do things that we did not really think we could do. If each of us were more clearly and profoundly focused on service to others, we would be personally and professionally happier, healthier, and more resilient. In these ways, service is vitally important to the provider.

Conclusions

Dedicating oneself to the service of humanity and placing the needs of the patient above those of the doctor is essential for the patient, our profession, our business, and our surgeons. So, if you believe as I do that we could do better, where is the enemy, where is the obstacle to improvement? Writing in 1969, the sage Robert Greenleaf provided guidance as to the nature of the enemy. He was not writing specifically about surgeons, so I paraphrase and adapt Greenleaf’s thoughts to our present condition: it is not evil accrediting organizations. It is not the system. Not lazy people. Not evil people. Not unmotivated young people. Not paperwork. Not bureaucracy. If completely eliminated, these things would re-emerge within a generation.

We live in an imperfect world. So, who or what is the enemy impeding dramatic improvement to service that, if accomplished, would benefit all aspects of our professional lives? The real enemy is fuzzy thinking from the mass of good surgeons, vital people who care, but who are distracted or focused on the wrong issue. Most of us settle for being critics and experts. We choose intellectual wheel-spinning. We choose to blame our young while we retreat, failing to prepare for the difficult and hard task of building a better profession, better institutions, and better organizations in an imperfect world. We have too little disposition to see the problem as residing within us rather than out there. In summary, the enemy is us: strong, well-educated, well-trained surgeons with an inherent, natural predisposition to serve. Where does the problem rest? It sits in front of us, at the feet of surgeons who have the potential to lead but do not lead, or surgeons who choose to follow those who are clearly not servant leaders themselves. We suffer. Our patients suffer. Our profession suffers. Society suffers. And, so it shall be in the future until we, one at a time, decide to make our problem better.

How, then, should we proceed? First, we should recognize that without active corrective effort, our vision is clouded. To see through the external fog requires a clear, uplifting, and personally meaningful vision. Second, we need to be conscious of the insidious psychology of entitlement and its destructive nature. None in our profession is immune.

Improvement does not require us to achieve heroic, unobtainable goals. Our profession would be positively transformed if we strengthened our commitment to improving our character while consciously building the character of our young, if we truly made the scientific method a way of life, and if we truly dedicated ourselves to the service of others, because it really is something to have labored for the betterment of life.

Thank you.

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