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EDITORIAL

# Taking Stock of Surgeons' Integrity and Vitality: Why the "Three A's" No Longer Tell the Whole Story

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In her commentary "A Fire In Our Hearts: Passion and the Art of Surgery," Dr. Eva Singletary calls on faculty surgeons to share our inspiration as surgeons with residents and students. Her review of the surgical trainee recruitment and retention literature discloses an attrition rate in surgery that exceeds other specialties. What deters students from choosing a career in surgery, and why do many students who have chosen surgery change their mind, rejecting not just a particular program but the specialty as a whole? Long work hours and lack of balanced lifestyle are often cited factors, but surprisingly the 80-h workweek restriction has failed to improve retention. Dr. Singletary found reports of only two interventions that helped improve surgery resident experience, and both were targeted at better management of workload. Adding physician extenders to the surgical team has been helpful in some institutions. One program described success decreasing residents' rounding time as a result of hands-on faculty instruction to improve efficiency.

Most of us, whether or not we are teachers, are passionate about surgery, but most of us would also readily admit that the hopes and expectations we held for our careers have been challenged—and sometimes pummeled—by the realities of practice. These challenges can range from the anguish of failing a patient to more mundane problems such as the perennially incorrect preference card. We weather our own disappointments, small and large, as we make our way through our own 80-h or longer weeks. We have our issues, and all too often we either have little insight into them or just ignore them. By disposition, we are a group inclined more toward action than passive contemplation. This quality is adaptive in many aspects of our profession, but it can be a liability when a good dose of introspection might serve our psyche and our relationships better. The motto in my residency was the Nike athletic wear admonition "Just do it!" This helped power through a scut list but did little to bridge the conceptual divide with our colleagues in the ER. It did not help us find a spouse or know what do with the feelings of inadequacy or helplessness in the face of the 7-year-old whose younger sister shot him in the chest, the depressed 80-year-old who tried to take his life jumping off a 100-ft bridge and inexplicably survived, or the conscientious, pleasant anesthesia resident who was a bit of a loner and was found dead from an overdose in his call room one morning.

The prospect of a surgeon articulating passion for our work other than a little chest-thumping ("Gee it's great to be alive!" and "Nothing beats doing a great case!") is frankly a little hard to imagine for many people. If surgeons are expressive, it is much more common to overhear complaints about lousy reimbursements, lengthy operating room turnaround times, the indecipherable computerized medical record, the surgical horror story that pits the surgeon's wits and will over patient's poor protoplasm and bad luck, or the perceived threat to our very well-being posed first by Hillary Clinton and now by Barack Obama. How often does anyone walk in on a surgery lounge conversation in which surgeons are sharing what we value about our work or extolling our good fortune? We share our trials and tribulations, but how many times in the last 5 years has any one of us had an informal, heartfelt conversation with another surgeon that included sharing thoughts about the intrinsic rewards of our work?

What does our work mean to us? How did we mature through our training to be prepared to shoulder tremendous responsibility for our patients, to be decisive and technically proficient in a crisis? How did we learn to be good listeners even for difficult patients and colleagues? When as a senior resident I had my turn to present at grand rounds


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on a topic of my choice, I took a chance and discussed an idea I had been mulling over: how do we reconcile ourselves to hurting people in order to make them better; in other words how do we make a healing wound?[1] [Medical anthropologist Joan Cassell's work helped galvanize some of these ideas.] It struck me that this was a largely unconscious but essential developmental task, and it seemed possible that a lot of the strategies surgeons employ to manage ambivalence about this central conflict partly define, for better or worse, the surgical personality. Although I anticipated being ostracized for choosing such a psychological topic, I was astonished by the warm reception my talk engendered and how much interest there was, especially from the faculty. I realized how little opportunity there is at all levels for this kind of conversation.

The question, "What are you doing when you're doing what you're doing?" asks that a moment in time be put in the context of an inner and outer world and possibly taken as a microcosm of a whole life. If we are to understand and share our passion, we need to ask questions like this at least some of the time. Balch and colleagues allude to the difficulties surgeons have with this, arguing that we "share an unwritten but understood code of rules, norms, and expectations… [that] includes coming in early and staying late, working nights and weekends, performing a high volume of procedures, meeting multiple simultaneous deadlines, never complaining, and keeping emotions or personal problems from interfering with work."[2] He argues that stress and burnout result from overwork. The risks of work addiction among surgeons and lack of lifestyle balance were also eloquently addressed by William Orrom in his presidential address to the North Pacific Surgical Association.[3] Results of The National Lifestyles In Surgery Today survey were recently reported by Troppmann et al. who also found dissatisfaction with work/life balance. Even though only 15% of nearly 900 surgeons responding were completely dissatisfied with their careers, a whopping 40% would not recommend a career in surgery to their children.[4] How well will we inspire trainees to do work we would not choose for our children?

When sociologist Charles Bosk did fieldwork observing surgeons at two urban hospitals in the 1970s, he discerned an unspoken, professional code for the management of surgical errors. He also understood that these inchoate rules distinguished who was "in" and who was "out" and thereby helped define membership in the guild of surgery. His monograph, *Forgive and Remember: Managing Medical Failure* is still apropos today.[5] Time and again, he saw that normative (or moral) errors were punished while technical errors or errors in judgment were more likely to be forgiven provided the errant surgeon acknowledged the lapse and was contrite. He argued that surgeons believe that "honest errors exist and that all physicians make them" and that good surgeons will learn from their own and from other's mistakes. In contrast, "deficiencies in moral performance say more about an individual's capacity to improve and become a reliable colleague." He noted that surgical "subordinates" (including residents) signal their moral worth to their superiors "in a variety of manners: by their degree of attentiveness as they hold retractors, by their affect as they discuss clinical problems, by their rapport with patients, and by their resourcefulness in getting things done. Superiors take all these as indicators of a person's moral performance." Bosk maintained that the three A's (availability, affability, and ability) were cited in the order of their rank importance to surgeons. Availability—being present in body, mind and spirit—is paramount.

Because both kinds of errors (normative and technical/judgment) can gravely harm patients, Bosk wondered why controls over moral performance would take precedence over controls of technical performance. He thought that surgeons' reluctance to pass judgment on technical errors and the difficulty determining a range of acceptable technical performance left normative errors as the default criteria for creating professional boundaries (see[5], pp 174–175). I would argue that we have an unconscious but deep-rooted understanding of the profound potential for violation of the patient, both figurative and literal. We know that if we are not operating for absolutely the right reason and with the proper mindset, the trust patients have in us will dissolve and we risk becoming something grotesque. Even the most elegant technique executed for the wrong reason is shameful.

Surgical residents and attendings face a more serious dilemma in the era of the 80-h workweek than improving efficiency or easing the workload. A much greater challenge is the adjustment faculty must make to new signals of moral worth by trainees seeking to be inducted in the guild. Older surgeons complain about lack of dedication by younger surgeons. We can no longer use personal sacrifice measured hour-for-hour as a yardstick of character. "Availability" means something else now. Work-hour restrictions had been implemented during my 5-year term in solo practice between graduating from residency and returning to academic practice in 2004. In my new faculty role, I gathered it was common knowledge that residents felt compelled to lie about their hours both to allow themselves time to complete work and to protect the program out of loyalty and pragmatism since closure of the program would interrupt their training. I thought they lost on all counts. Not only were they criticized for being inefficient, leaving too early, and exceeding their hours limits, but they also were regarded as having weaker moral fiber and less commitment than their predecessors. Their ethics were questioned by the same staff they were protecting. Finally, they were deprived of the opportunity to

discover the inner resources, the endurance, and the desire to be in the service of our profession that we all need to know and which traditionally came from total immersion in training. This knowledge gives us the strength and confidence to carry on when we are tired and discouraged. Most importantly—even if the formula is wrong—we all take comfort regardless of our level of experience in the idea that we did the best we could. This is never more important than when the outcome of an operation is poor. This is vital for the young surgeon who has yet to acquire the backlog of successes and the confidence that comes with experience and helps put treatment failures in perspective. Having a clear conscience partly assuages guilt about failure and fortifies us see our next patient.

Dr. Singletary has provided us an excellent occasion to think about our students and ourselves. I hope every reader finds a moment to ask himself or herself and perhaps a surgical colleague: What is the nature of our passion for surgery, and how can we share the fire in our hearts?

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