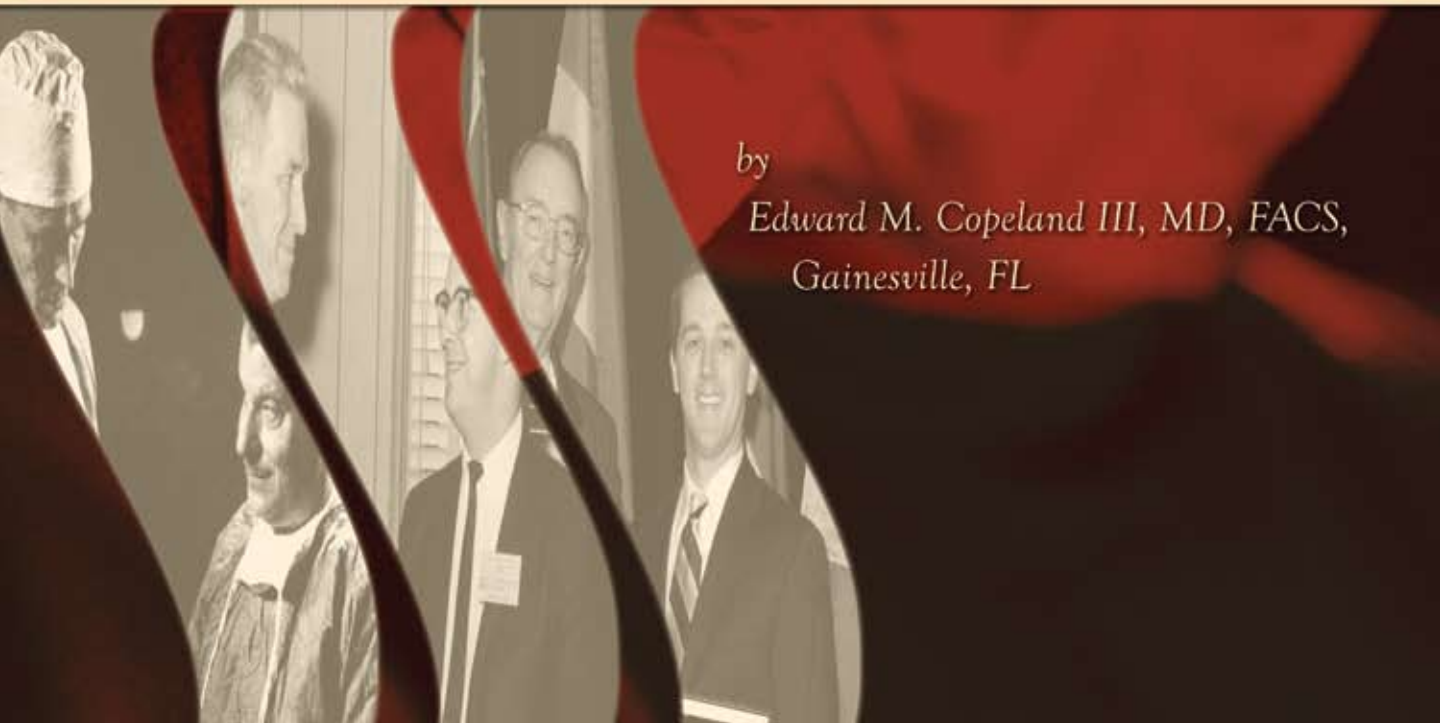
Presidential Address:

The role of a mentor in creating a surgical way of life



by
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Editor's note: *Dr. Copeland delivered this Presidential Address on October 8 at the Convocation in Chicago, IL.*

First of all, let me congratulate each of you on this important achievement in your surgical career. I would like to take this opportunity to describe to you my views of the role of a mentor in creating a surgical way of life. Although this presentation is advertised as being a Presidential Address, it is, in fact, really a Convocation Address to you who are being inducted into the American College of Surgeons in 2006.

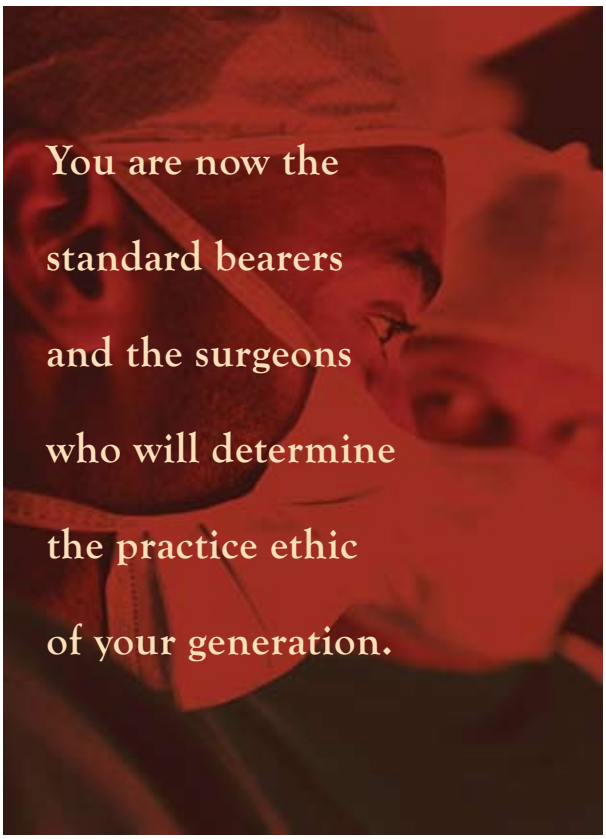
All of you have completed the requirements for initiation into the College and are a somewhat homogeneous group because you are at relatively the same level surgically with your Convocation classmates as you were educationally with your classmates upon graduation from college and medical school. Additionally, you represent a unique group, for you will be among the last individuals to matriculate through a surgical residency in the "old" system—"old" being defined as "prior to the mandated 80-hour workweek" that all of us know has changed the training paradigm, probably for the better. Many of you were in your residency when the changes occurred, so you can draw a direct comparison between the two systems. Much has been written—both pro and con—about the old system versus the new system. You and I have lived under both systems and can draw our own conclusions. Nevertheless, in the near future, surgeons sitting in your seats will only know the new system and any comparisons will only be historical, probably, by all of us referring to the "good old days." Your older partners today relate to your training since they had similar experiences during their residencies. That will not be the case for surgeons who will join you in practice in the future. Likewise, mentoring has become different, if for no other reason than contact time between the potential mentor and the resident has been modified.

Opposite: Top row, left to right: Physicians Joseph Lister, Harvey Cushing, and William Halsted. Bottom row: Dr. Rhoads (left) with his mentor, Dr. Ravdin; Dr. Rhoads with his protégé, Louis C. Bernhardt, MD; and Dr. Copeland (left) with his mentee, Robert Feezor, MD. Background photo courtesy of Punchstock.

Physicians all share the ability to delay short-term goals in order to attain long-term objectives. You have seen your college classmates who entered other fields making money, enjoying free time, and wondering why you would tolerate the grind that is necessary to become physicians. Those, like yourselves, who can delay short-term goals typically introject the personalities of the individuals training them, especially the ones who are revered—in other words, your mentors. In the past, this quality that you possess has made our job as surgical role models easy (if we were any good), since we were with you for long periods of time in the clinic, in the operating room day and/or night, or on patient floors making rounds. We shared the same patients essentially 24 hours per day, seven days a week, and depended on each other to get a block of work done and, therefore, to generate free time for all concerned.

We learned from those who taught us, rejecting the traits that we considered onerous and adopting or introjecting the traits that we felt were important. Many of us then passed this knowledge and behavior on to those we taught. We were proud of our lineage, especially when it came from one of the prestigious training programs with a history of proven excellence over the decades and with an exemplary faculty. Individuals from institutions such as these went on to become chairs of other departments and attempted to establish similar programs to produce surgeons in the image of their mentors and teachers from their parent institutions. This system worked. Will it work in the new training paradigm? Yes, and I will tell you why near the end of the talk. You are now the standard bearers and the surgeons who will determine the practice ethic of your generation.

I should now digress and define what I mean by "mentor" and "surgical way of life." In short, the mentor establishes for the protégé the professional ethics that dictate practice patterns long after the protégé leaves the direct guidance of the mentor. The principles established by the mentor stay with the protégé and often can, and probably should, create a bit of anxiety if such principles are not followed.



The surgical way of life means that the art and practice of surgery stays in your conscious thought continually. You take "pride of ownership" in patients who have put their trust in your expert hands. You look forward to applying the talents that took you so long to acquire to the betterment of mankind. In a sense, surgery should be your hobby. It has been said that 80 percent of people view their jobs as a means of supporting all their activities not related to their job. Many of you should be among the other 20 percent. Certainly, I have always been.

I would like now to take you through a personal journey that led me into medicine and established my surgical folkways and mores. Possibly you can relate my journey to the evolution of your own professional core values. Along the way, I plan to discuss lifestyle so that you do not think me too narrow or one of those people who think that the practice of surgery should be all-consuming.

Throughout all of my undergraduate schooling, my real aptitude was for science. All of the science courses were taught to me in high school by my favorite schoolteacher, my mother, so having an aptitude for science helps. Had I been destined for a career that required any literary skill, I would have been in trouble.

Enter my uncle, Dr. Murray M. Copeland, a surgeon during his career at both Georgetown University in Washington, DC, and M.D. Anderson Hospital and Tumor Institute in Houston, TX (see photo, page 12). He was president of the American Cancer Society, trained at Johns Hopkins Medical School in Baltimore, MD, and is still known to some of the surgeons on this stage. As a youngster, I would visit him while he and my aunt were living in Washington, DC. He came home from work late most evenings and then continued to work on patient-related activities. I remember once hearing my aunt say—and very appropriately so in my mind—that she wished he would leave his patient concerns at the office like many of their physician friends appeared to do. He remarked that he worried about his patients 24 hours per day, and I vividly remember thinking that I would hope that my doctor would do the same for me. They had no children, however, and the practice of medicine was all-consuming.

My uncle was fond of quoting Sir William Osler, the Canadian physician who is credited as being the father of the medical residency in the U.S. At the turn of the 20th century, Dr. Osler was professor of medicine at the University of Pennsylvania, then at Johns Hopkins Hospital and, finally, at Oxford University in the United Kingdom. His quotes are many but my uncle's favorites were, "Medicine is a jealous mistress" and "Live neither in the past nor in the future, but let each day's work absorb your entire energies, and satisfy your widest ambition." But these were the thoughts of a previous generation of physicians.

In my day, qualifications for medical school included not only good grades but also the stamina to survive a strenuous residency system. Not being one to miss a night of sleep—it takes me a week to recover, and I have many outside interests, mainly in sports—I proceeded

cautiously into medical school and then, at the suggestion of my uncle, to the University of Pennsylvania for a surgical residency. I came under the tutelage of Drs. I. S. Ravdin and Jonathan E. Rhoads (see photo, page 12). Dr. Ravdin was Dr. Rhoads' mentor and both were previous Chairs of the Board of Regents and Presidents of the American College of Surgeons. In fact, counting me, there now have been six presidents of the College from the University of Pennsylvania, two of whom share the stage with me tonight, Drs. James C. Thompson of Galveston, TX, and R. Scott Jones of Charlottesville, VA. The fifth University of Pennsylvania alumnus is Dr. James D. Hardy of Jackson, MS, who died in February 2003.

At the University of Pennsylvania, I learned what I consider to be my surgical core values: honesty; respect for patients, colleagues, and trainees; education of the next generation; adding to the clinical and scientific knowledge base; not having surgical decisions be income driven; and respect for tradition. Near the end of Dr. Rhoads' life in October 2001, some 32 years after I left the University of Pennsylvania, I received a letter from him that I think reflects the intense bond between mentor and protégé, especially when one realizes that Dr. Rhoads was not an effusive man. He wrote, "…it is with great satisfaction to see you join the Board of Regents of the College and to feel that you would be there reflecting your values and those of your uncle and perhaps, to some extent, those of us whom you knew during your residency."

He went on to address the issue of patient safety prior to it becoming the cornerstone of every medical organization today. He said "My experience on the Board of Regents was surely one of the great highlights of my life and I continue to hope that the College will continue to enjoy a reputation as the advocate of the patient rather than the advocate of the surgical member."

Have I always put patient safety first and foremost? You bet—I was taught to do so! I will share a portion of the letter of response that I wrote to Dr. Rhoads: "Take great pride in all of us whom you trained. The professional folkways and mores that we learned under your tutelage at the University of Pennsylvania have now been passed on to multiple other surgeons through each of us."

From whom did we learn the Accreditation Council for Graduate Medical Education's core competencies of professionalism, patient care, medical knowledge, practice-based learning and improvement, systems-based practice, and interpersonal skills, all of which must be documented as being taught during residency training today? The answer is that we learned them through concentrated contact with our faculty mentors.

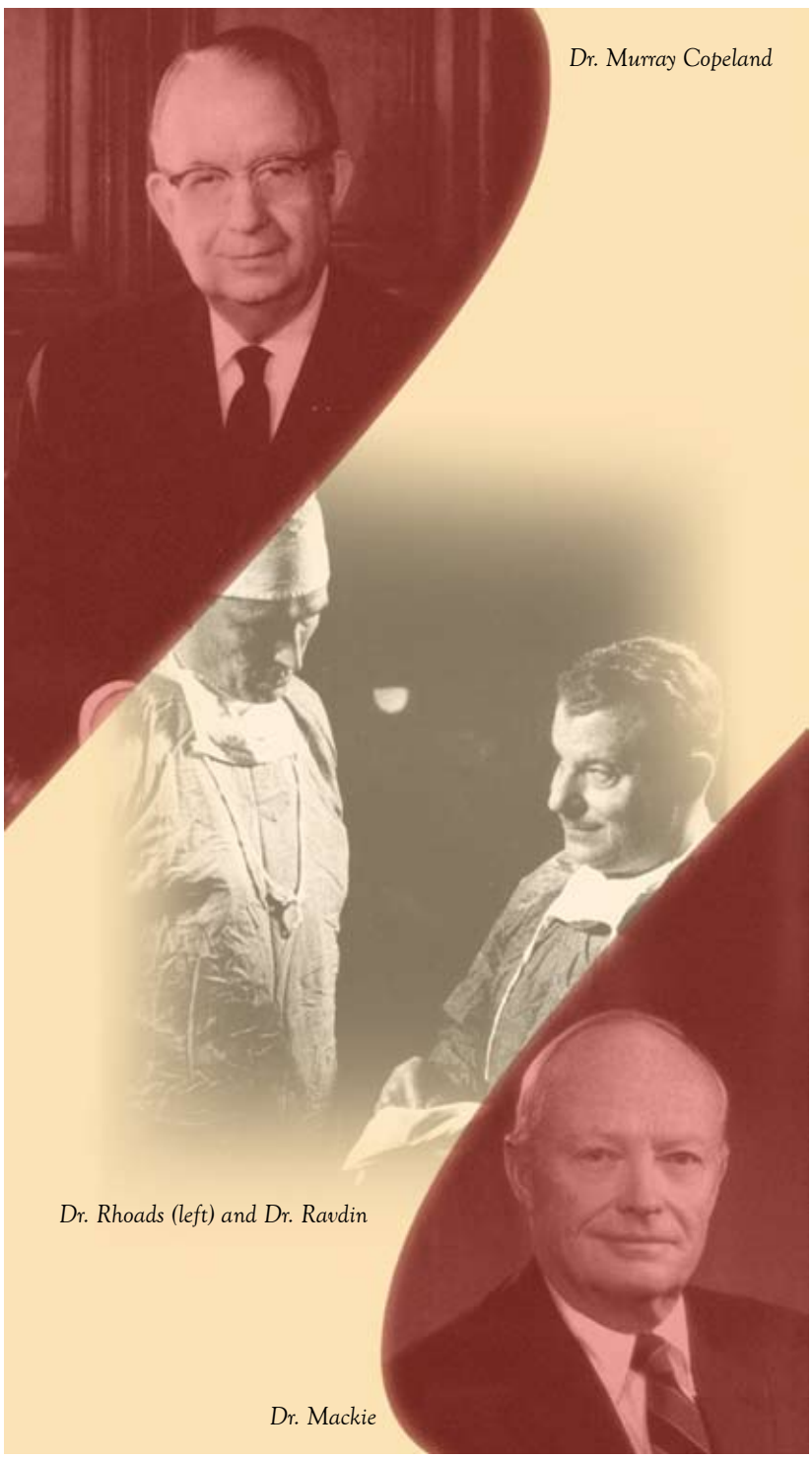
Enter Dr. Julius A. Mackie, the man behind the scenes at the University of Pennsylvania (see photo, page 12). He is well known to only a few of you, but he was my most significant faculty mentor. From him, I learned core values for patient safety: If a test is ordered, know the result. If a tube is inserted, be sure it works. Talk to the patient—it is amazing what they know. When practical, check on inpatients at least twice a day. Instill teamwork among health care professionals—ensure that the physician who assumes the care of your patient is well informed. When in the operating room, be prepared for the unexpected.

Even today, when I violate one of these principles, I become anxious. Many times I have told myself, especially on weekends, that there is no need to make rounds when coverage should be adequate. Almost always, I have found something that has made me glad that I decided to visit my patients—for example, something as mundane as finding a drain not working that would have resulted in a seroma. The patient would then have to experience the discomfort of drainage of the seroma and I would be the one to spend time draining it. Every complication costs the patient pain and the physician additional time. Patient safety is both time- and cost-efficient.

To this day, I have seldom been without sleep for 36 hours in a row, including a tour of duty in Viet Nam in 1970. Prevention of complications, interaction with colleagues both in organization and collegiality, and selection of the entire specialty of surgical oncology to practice has made surgery a "lifestyle-friendly" profession for me. In fact, I am not sure I would have the stamina to survive a surgical residency today in which "hand-offs," night float, and cross-coverage often result in a resident on call being up all night to leave at noon the next day.

The face of medicine is changing. In my graduating class at Cornell Medical School in Ithaca, NY, in 1963, there was one woman. I was the other attempt at diversity: I was from the South! In the class of 2009, 51 of the 101 students are women and the members of the class were born in 16 different countries. And here is the reason I answered "Yes" to the question I posed to you earlier. I bet if you read these students' personal statements, you will find that they are entering medicine as a career for the same reasons that we did, and the training in most disciplines is just as long, if not longer. The thirst for appropriate role models and mentoring is just as strong as ever because the motivations to become a physician have not changed, in my opinion, over the years. Neither gender, nor race, nor religion affects the ability to become a competent, compassionate, and committed physician.

This is where you, the members of the Convocation class of 2006, become important. Your partners of the future may not have had the luxury of close communication with potential mentors and may not have introjected the personality traits that you expect of young physicians. Their folkways and mores of medical practice may not be as fully developed as you anticipate. They may not have adapted to or accepted the surgical way of life, and, if not, a conflict may arise in your practice. You may find yourself in the role of mentor or wishing to be in such a role.



Dr. Murray Copeland

Dr. Rhoads (left) and Dr. Ravdin

Dr. Mackie

In fact, it may be your responsibility to become a mentor.

In the past, it has been hard to change the behavior of physicians who have completed a residency program. The best way to accomplish that goal has been to persuade by example rather than by any didactic means. The new training paradigm, however, may produce a different kind of surgeon, one who is eager to continue the training process while in practice. If so, you will find yourself in the potential role of both partner and mentor. Mentorship implies a hierarchal relationship between mentor and protégé. Partnership implies an equal relationship between parties. These two roles may be incongruous and how you integrate them will determine the outcome of your relationships. In the past, partners were selected because their training indicated that they could be independent from the outset. Possibly now you should select partners who are as well trained as possible but who remain receptive to additional education. There is a trend toward becoming highly specialized in a narrow field of surgery, for example, breast surgery. No doubt this trend is somewhat lifestyle related, but it may also reflect a feeling of inadequacy that some surgeons experience when faced with the prospect of a broader-based surgical practice. Likewise, a new specialty of emergency and acute care surgery is emerging to fill the void left by those surgeons who do not wish to participate or feel insecure in these areas. There will remain, however, the need for the broad-based surgeon in all disciplines for some time to come. For the surgical specialties, the disappearance of this broad-based surgeon may not be a pressing problem, but for general surgery, the problem is rapidly approaching.

I welcome you, the members of the Convocation Class of 2006, to the important and challenging world of mentorship. Remember, gaining the friendship and respect of your peers at a young age cannot be overemphasized, for a career lasts a long time. Be collegial with your associates and they will be your supporters for a lifetime. Err on the side of being inclusive, not exclusive, and create no second-class citizens in your practice. Everyone needs to have a positive identity. Maximize your potential without hurting others. Strive to make those around you successful and your successes will be potentiated, more appreciated, and better recognized. Mentally change places with your colleagues and evaluate how your decisions will affect them.

Good judgment needs to be combined with influence and patience. Good judgment alone can be a curse. Remember, it is not what you say that determines a person's behavior toward you but what that person hears you say—so be succinct and pleasant, but do not leave room for misinterpretation. Explore both your colleagues' and your patients' personalities well enough to know what makes them smile—that smile will mean more to you than it does to them. Look within yourselves for your core values that have taken so many years of personal sacrifice to develop and do not compromise them.

I will leave you with one thought that has pervaded throughout my career: it is a privilege to have the life of another person placed in your hands. It is a unique privilege to serve as a role model for those who assume the responsibility for the lives of others. Ω

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