

Bulletin



AMERICAN COLLEGE OF SURGEONS

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♦
Presidential Address:
**The
joy and privilege
of a
surgical career**
♦





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by
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Editor's note: The following is an edited version of the Presidential Address that Dr. Bass delivered at the Convocation Ceremony at the American College of Surgeons (ACS) Clinical Congress 2017 in San Diego, CA. The presentation has been modified to conform with *Bulletin* style.

At risk of being too personal, I want to ask each of you to ponder some fundamentals on this occasion of being inducted as a Fellow in our American College of Surgeons (ACS).

Have you at this moment of accomplishment, or perhaps at some other time fogged by fatigue in years past, considered how hard you have worked to have come to this accomplishment? Sleepless nights, thousands of hours in the hospital, endless hours of study and practice? What price have you paid for the privilege of becoming a surgeon? Have you missed dinners, parent-teacher conferences, dates, soccer games, anniversaries, quiet moments, workouts?

And, for you family members here with your loved one this evening, have you missed this person at times over these last 5, 10, 15 years? Times when you really wanted her or him to be with you—maybe even needed this person to be present? I hope you know he or she missed you, too, and suffered that missed moment like you—a moment often laced with the pain of guilt, of having chosen a career that at times holds the prevailing vote.

Why, young surgeons, would you have let these things happen?

The joys and hardships of surgical training

Let's consider, from some perspectives, why those unthinkable missed moments may have happened. What were you doing during those years of training and practice that asked so much of you, far more than many careers?

Actually, any of us on this stage and, indeed, each of you could answer that question. You were learning—a lot! You were doing remarkable things with your hands and minds. You were developing fundamental and then advanced surgical and professional skills. You were witnessing life's simple miseries, life's greatest

tragedies. You were learning about human kindness, anger, frustration, and joy.

You were building that remarkable portfolio of skills that we call surgery. Learning when and why to operate, developing technical skills to combat a surgical disease, to repair the human body.

Over this last decade or two, you often worked under the watchful eye of trusted mentors who brought you along all those years. Keep in touch with them, by the way, and pass on what they gave to you.

During those, at times, missed years, you were busy becoming knowledgeable, skilled, and emotionally prepared to care for a patient that was yours. I suppose someone else could have been there instead; you could have made a different career choice. But, no—surgery chose you, and you dove in. So in those away times, you were doing important work—deep experiential learning and intensely personal immersive patient care.

I hope during those, at times, challenging years, you found a brother- and sisterhood of shared experience with your colleagues, a net in which to share both challenges and joys. It may not have always felt that you were making good progress, or even that you made the correct choice on some days, but recall day one of your training—day one after graduation from medical school and then day 1,500, 2,000, or 3,500—whatever day it was when you “finished” your training. An astonishing transformation, yes? Yes! Not good enough to last you a lifetime in this business, but a fabulous foundation for the next 30, 40, maybe 50 years.

No matter where in the world you experienced this pathway to becoming a Fellow—and we have surgeons from 68 nations from around the globe joining our College as Fellows tonight—this transformation from student to surgeon is a magnificent, if at times arduous, shared experience for all of us.

The surgeon-patient bond

But, remember please, please, the lives you have touched during these “lost” times: Injured people, previously unknown neighbors with deadly diseases, or simply those needing a little “repair.” People who are afflicted with a surgical disease, who are our special



and often routine joyful opportunity, are experiencing a rare life event—an operation.

In fact, most of us will have only a few of these in our lifetimes. So what for us, who have done many thousands of operations, seems ordinary, to each of our patients is often a major life moment. And while we all know we can't do what we do without our incredible teams, always remember that individual, that patient, came to you—you personally—to help them.

And never forget to pause and recognize that our often fearful but brave patients allow us this trusting moment while they sleep in a room surrounded by strangers.

So, what I hope you and your loved ones who did the most waiting and missing, like those family members in our waiting rooms, can understand is that those years of training, those years as you begin your practice, those times going forward when you are honoring that commitment to your patient, are not only part of an important and critical mission but also a rare, rare privilege. What we get to do for the people who need us is a joy and a privilege for us!

The greatest reward in our profession is the gift of trust we receive from our patients when we are allowed to help them. It's priceless.

So with all of this, I can't absolve you of those missed personal moments past and future, and perhaps there were fewer than my own. I'll have to ask my Wes, Wyatt, and Richard but never trust their answers; each graced or cursed with the affinage of life years. But in my mind, your choice to become a surgical servant is a most noble calling. As I've said many times to my residents, we aren't surgeons because we want to be, we are surgeons because the citizens of our communities need us to be.

The challenges of a surgical career

So when you get in the doldrums, as I promise you will or have been, remember this calling, this privilege, and this joy. I trust it will pull you through.

Except when it doesn't.

This bond between a surgeon and a patient can get lost in our busy, burdened lives. It can get lost in

fatigue, in regulatory hoops, in the frustrations of our electronic medical records. Lost in demands fueled by wRVU (work relative value unit)-driven contracts and our compensation expectations, by a sense of a loss of control in our health care delivery machine.

It can get lost in nights on call, when we should be having resuscitating moments with those we love the most, and in skipped periods of caring for ourselves, our minds, and our bodies.

I get it. Where is the privilege and joy in this? We have to dig deep on many days.

And, if we are heading down a foxhole of negative disruptors in our careers, let's add a few others that will be real challenges in the years ahead. You will face various forms of threatened obsolescence in knowledge, skills, technologies. On a very personal level, you will age. You will suffer personal tragedy and loss. You will become ill, sometime or the other. These facts will challenge your will and resilience.

That you may stumble when facing such challenges during your career is not a sign of weakness. It's life. And while you will do your best to maintain your personal resilience tool kit, it is also our profession's responsibility to craft solutions for our members, or at least bumpers, to soften the impact and to enhance personal performance and wellness as we face these challenges.

I believe there is a bit of light ahead as our health care industry begins to recognize that this thing we call burnout is not a personal failing, but rather a function of our flawed work environments. Yoga and mindfulness or grit can get you only so far.

Our health care systems are beginning to acknowledge systematic repair is in order as the real costs of surgeon and other health care provider burnout is recognized as a threat not only to the individual within the system, but also to our bottom lines of patient safety, quality of care, and financial stability.

An active voice and action in this essential domain of working environment restructuring is mission critical for our profession and most assuredly one that is being pursued on many fronts by individuals and programs in our College. Jump in, help craft some solutions.



Dr. Jonasson



Dr. Anderson



Dr. Numann

Our communities need surgeons

Let's tackle a few other challenges. To frame this, be aware of just how valuable each of us is to our community as an asset. First, getting you to this skilled and knowledgeable point reflects an investment of well more than \$1 million: medical school, graduate medical education, and time and effort calculations. Your money, our society's investment—a lost opportunity for another.

Second, the dire anticipated shortage of surgeons of many stripes—general surgeons, orthopaedists, urologists—appears to be real. Fueled by us aging baby boomers, with our failing bones, bellies, genes, and hearts, we can anticipate that surgeons will remain in high demand in the years ahead. We need every one of you.

The gender gaps

Let's take a look at our incoming cohort. In this entering class of 1,857 Initiates, 448 are women. Now, that's progress! However, knowing that medical schools around the globe are reaching gender parity, if we are to keep our surgical pipeline full, we need to offer careers that are equally attractive to men and women.

While the U.S. general surgery pathway has entering classes of 40 percent women, the other surgical disciplines have not so far attracted women to their ranks in sufficient numbers: neurosurgery, orthopaedics, cardiothoracic—very important and high-demand specialties of the future. Work to do for our College, our profession, and indeed, each of us.

While much has changed for women in surgery since surgery claimed me, there are still differences in the lives of many women surgeons compared to their male colleagues: differences in marital status, child-bearing age, partner employment, and other factors that may seem at first blush to be personal matters, but differences that actually have substantial impact on our professional lives as well.

Women still hold primary responsibility for much of making a home in most families: meals, shopping,

child and aging parent care, health care, gatherings. In all honesty, many of us will not give up those roles—they are a chosen responsibility, a gift to make a home for one's family. We may not make home the way our mothers did, and we will gladly share these roles with our willing partners in new ways, but we will not give them up.

But let's separate home for a bit from the reality of women surgeons' professional lives. A sharp look shows that women surgeons are still compensated 10–17 percent less for equal work than their male colleagues. Poor negotiation skills, diminished personal expectations, implicit bias from prospective partners and health care organizations, or overt residual inequity?

The answers are not clear, but the data speak clearly. Women, as we have seen for the last 20 years, are less likely to rise to leadership roles in their group practices, hospital structures, and professional organizations or through the academic ranks. The ripple effect of this is passed on to our medical students who don't see women surgeons in leadership roles, but rather as entry-level, stretched young surgeons starting their careers at perhaps the busiest times of their lives, as long-deferred children begin to arrive.

But, the changing face of surgery is astonishing when we look back over the last three decades. And we can thank our founding mothers for their resilience, remarkable surgical talents, and commitment for the fact that women continue to grow in the surgical ranks, with satisfaction in our careers equal to that of our male colleagues.

Each of that primary cohort, a few most important to me and to many others—Olga M. Jonasson, MD, FACS; Kathryn D. Anderson, MD, FACS; and Patricia J. Numann, MD, FACS—found their way independently, carving and crafting a pathway; each and every one, adopted and guided and challenged by the men, and an occasional woman surgeon, just as I was, who formed them into the surgeons, leaders, and contributors they became.

Mentorship is not gender-specific. Visible role models, however, may be. One wants a glimpse of



what one's life might be like as a surgeon, not only as a professional but as a wife or partner, a mother, or friend.

We surgeons, of course, are not the only cohort of working women and families who suffer for the failure of our American society to embrace pregnancy, parenting, and child care as a common good. Our College, with the guidance of the Women in Surgery Committee and the Association of Women Surgeons (join it, by the way), has endorsed a statement that acknowledges the need for appropriate pregnancy and parental leave and clearly articulates that the choice to become a parent in no way diminishes a woman surgeon's commitment to her career.

Our profession must commit to forging meaningful maternity and child care policies and practices so that this issue will not be a factor that may defer prospective students from choosing our disciplines or restrict the career aspirations of women surgeons—more work for our College.

Staying at the top of your surgical game: Retooling reimaged

Let's ponder another challenge. It took each of you between four and 10 years of formal training to get to your current level of proficiency and knowledge. You're actually getting even better during these early years in independent practice.

But then five, 10, 15 years from now, you are going to realize that while your foundational training is durable, you need to add a piece to your repertoire, a new potentially transformative skill. You are in a busy practice doing the best you can every day, and then something new must be added.

In my lifetime, I've seen numerous transformative technologies rock our surgical world: laparoscopic surgery, endovascular surgery, robotic computer-aided surgery. Theoretically and in reality, each has brought incremental and sometimes transformative improvements in how we treat our patients.

Thematically, these advances have introduced new technologies, interfaces between our hands and our patients' bodies: image guidance, computer-aided

procedures, augmented visualization, and minimal access sites—fundamentally delivering us to “precision surgery.”

But, how do we safely retool? We all recognize the potential harm that comes with a surgeon's learning curve, which in our past and present is largely borne by our trusting patients. You can't keep doing the old stuff if the new stuff is better. But premature adoption without proper training and supervised practice is unfair to our patients and can, we know, come with harm.

Twenty years ago, in the flawed early adoption of laparoscopic surgery, which left harmed patients in its wake, the ACS Committee on Emerging Surgical Technology and Education articulated the principles of new skills acquisition. And no, it is not see one, do one, teach one. Rather, the cycle of didactic learning, coupled with simulation-based training, and then proctored early experience leading to independent practice and assessment of outcomes, was framed. We know the principles. But when it comes right down to it, we still have a long way to go in implementing this pedagogic model for surgeons in practice.

In this matter, we've had visionary leadership in the College with the establishment of the Accredited Education Institutes (AEI) program. The premise was to develop a network of centers leveraging emerging simulation technologies to enhance surgical training. Now numbering 96 national and international sites, the AEIs have served as both educational and research centers to teach surgical skills—technical and nontechnical skills—to surgeons and others in our surgical pipeline.

A prototype facility: MITIE

At my hospital home, the Houston Methodist Hospital, we have built a center known as MITIE—Methodist Institute for Technology Innovation and Education—a beautiful, comprehensive center with a sharp focus on retooling surgeons in practice. We have hosted more than 12,000 surgeons in practice for retooling hands-on courses in all disciplines of surgery. We built MITIE as a prototype facility to determine how best to craft an efficient educational

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center for busy surgeons in practice and to study how best to deliver the retooling mission.

To begin to address this need, our College has gathered the stakeholders with vital interests in maintaining a skilled surgical workforce. The parties include our payors and consumers, liability carriers, surgical technology industries, the executive leadership of the hospitals where we deliver care, and of course, us surgeons. This group has started to define the infrastructure components—facilities, faculty, curricula, assessment tools—and, importantly, to consider financial models to incorporate retooling and training into our health care budget.

We've got great medical schools and teaching hospitals in this nation. How about the infrastructure for those next 40 years in practice?

16] This retooling reimaged initiative is driven by a need, a need we surgeons identified. It is our duty as members of an essential profession to craft a solution. This is but one example of how we can shape our professional futures.

Creating solutions: Individuals matter

I have often been amazed, and somewhat concerned, at how well we surgeons can express our frustrations, or even fury, on bad days. Can't we transform that energy into a positive? Well, if College history has relevance, which, of course, I believe it does, then on a good day, I can see what happens when a surgeon or a group of surgeons begins to craft a solution based on real needs in the work environment.

Remember, the ACS was founded 104 years ago by a group of surgeons with the explicit goal of improving the care of the surgical patient. This is still our mission today.

So when faced with, at times, aggravating moments at work, I insist on recalling that individual surgeons, banding together within our College, have created some of the most effective systems in the world to improve surgical care.

In 1922, surgeons dismayed by unnecessary deaths from injury formed the Committee on Fractures, which

later blossomed into the Committee on Trauma, producing the Advanced Trauma Life Support program, trauma system verification programs, and military partnerships to translate lessons learned in war zones to the care of the civilian injured, programs that time and again prove invaluable in saving lives when the unthinkable happens in our communities.

The Commission on Cancer, originally the Committee on Cancer, also formed in 1922—whose programs now guide the delivery of integrated cancer care and research throughout our nation—was founded based on a need identified by surgeons caring for patients with dread diseases without solutions.

The ACS National Surgical Quality Improvement Program was born in the Veterans Affairs (VA) health care system with the vision of a single surgeon, Shukri Khuri, MD, FACS, who when tasked with a perceived problem in surgical care in the VA health care system launched a research study to measure quality. Soon thereafter, he led a collaborative army of surgeons to improve surgical care in their own hospitals—the founding of a nationwide movement that now flourishes in thousands of hospitals as the world's most effective surgical quality measurement and improvement system.

These College programs and systems have saved hundreds of thousands of lives.

We can go on and on—a surgeon identifies a gap and with a good idea and abundant College focus and the engagement of our Fellows, a valuable new program is made: the Surgical Education and Self-Assessment Program, Fundamentals of Surgery, the *Journal of the American College of Surgeons*, and, most recently, the newly released manual on defining the *Optimal Resources for Surgical Quality and Safety*. I believe it will soon be our guiding manual for all aspects of surgical care delivery in our ever-changing health care system.

The point? These programs were not delivered from on high. They were created by regular surgeons, like you and me, who saw gaps in their professional worlds and took steps to effect a meaningful change.

So, be engaged. Participate in those initiatives in your home institutions so that you too will have an

impact beyond yourself. Look to the College and other professional organizations to help you. Don't just talk—engage.

Caring for each other

In closing, I have one more request, and it is a hard one. I want you to be aware of your colleagues. I want you to watch them for signs of stress, disturbances in their forces. And, if you see something, please, offer a chat—a supportive question, an offer of possibly needed assistance. We need to start the dialogue with someone who may be in trouble. We need to be proactive.

Be aware of help that is available in your institution; know how to move a concern up the chain with sensitivity but also with compassionate concern for your colleague.

These are not easy discussions and may prove fruitless, but it is worth the effort that we try, for we, regrettably, are a high-risk group for depression, substance abuse, and suicide—yes, all of these—and for failing to seek assistance. This situation must change.

We must remove the stigma of mental illness and personal struggle from our profession. We can't allow our colleagues to suffer, and indeed to lose them, to their own hand or to violence or oppression at the hand of an intimate partner, without having tried to help.

Yes, these things happen to us, we professional women and men, and we need to start a discussion together to create new more effective methods to extract those in harm's way, without judgment, without stigma: another vital mission for our College and for each of us.

Looking forward

But, for now, on this happy evening when we celebrate your induction into our College, I hope you are excited and most satisfied in your near future. I hope you enjoy the love and warmth of family, friends, and community in the decades ahead. I urge you to be kind and generous, humble and wise.

I hope you are proud of your new fellowship in the American College of Surgeons. I hope you will draw endless support and friendship from those around you and that you will contribute more than you receive.

And I hope that you will forever treasure your opportunity to practice as a surgeon, an exceptional joy and privilege. ♦

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