The Top-10 Reasons Why

General Surgery is a Great Career

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It is an honor to stand before you with the opportunity to deliver the Presidential Address for the annual meeting of the Western Surgical Association. The Western Surgical Association is a great organization. It typifies so many of the characteristics that make American Surgery great. I have gained more from the Western than I could ever return. To serve as the Secretary for 5 years and the President this year represents the peak of my professional life. It is an honor which I will forever cherish and for which I will be forever grateful.

My first task today is to thank several people who are responsible for my position at the podium. Anyone in the audience who knows me well realizes that I will be unable to accomplish that goal in the manner it deserves without completely dissolving into tears. Regrettably, by necessity, I must limit my remarks simply to saying ‘thank you” to my family, Pat, Margie and David. I would also like introduce and thank the person who has run my surgical practice during my tenure at Virginia Mason, Sandhya Mishra. Finally, I’d like to dedicate this talk to my father, Dr. Richard Leeson Thirlby.

It goes without saying that I have been contemplating the topic and content of my Presidential Address for 364 days. Like most individuals in my position, I reread many of the previous addresses of the Presidents of the Western Surgical Association. It became evident immediately that I could not match the eloquence or insight of my predecessors. I was left to abide by the sage credo that guides much of what I do: “play to your strengths.” I am a very positive person. I believe much of my success results from an ability to ignore frustration and to act on the positives: hence, my topic. All too frequently, I hear tirades of surgical colleagues that could provide the content for another talk entitled “Top 10 reasons why I hate

my job." I will leave that talk for another individual. My objective today is to remind you or convince you that you practice the greatest profession on Earth.

In addition to "playing to your strength," another guiding principle of any good address is to "know your audience." From this principle emerges a potential problem with today's address. My audience today is dominated by several hundred successful, experienced general surgeons. Without sounding pretentious, my hope is that this address will be published and one day be read by young individuals contemplating a career in medicine and, eventually, surgery. This assumption affected my choice of topics you are about to hear. What could I say to convince a high school student, a college student or a medical student that surgery is a great career? I suspect that some elements that you think unimportant may be very important to a college undergraduate. Thus, a potential problem with this talk is the inevitable "constructive feedback" I will receive from my colleagues about my Top 10 choices. They will point out things I forgot! Without doubt, I have omitted things and/or incorrectly ordered or ranked my reasons. I encourage you to let me know the errors of my ways. If I foster an enthusiastic discussion between you and your colleagues, challenging my thoughts with better ideas, I have accomplished my goal today.

So without further ado, with apologies to David Letterman, here we go. The "Top 10 Reasons Why General Surgery is a Great Career."

10. Training is fun (you'll never forget it) & training never stops.

Surgical residency might be considered by some to be a deterrent to making general surgery a great career. I disagree. Is it arduous? Yes. Is it fun? Absolutely. The excitement starts with the first day of internship. Stephen Evans put it nicely in a recently published

editorial.[1] “No other profession comes close in terms of duplicating the level of intensity, fear, or anxiety that comes with the first day of internship.”[1] This intensity continues for the duration of the training. It provides young people with great life experiences and memories. Let me illustrate the latter claim with an observation. If two or more surgeons who trained together are placed in a room together for more than five minutes, the conversation inevitably turns to recollection of experiences of residency. As any spouse of a surgeon can attest, stories of residency dominate conversation during alumni receptions at the American College of Surgeons Clinical Congress. Although the events may have occurred decades ago, they are recalled vividly, as if they occurred just yesterday. When one spends 80-100 hours per week with people in a high stress circumstances, personalities emerge. The experiences are remarkable, life-changing, and the friendships enduring. They cannot by matched by any other career.

Training is fun, and the training never stops. Surgical or medical training does not stop with the end of residency. I can think of few, if any, careers where the necessity of “continuing education” is so relevant. The judicial system has not changed appreciably since 1776; medicine and surgery change weekly. I asked our medical librarian to tally the English-speaking journals relating to General Surgery. Her count totaled 75. Assuming the majority of these journals publish 12 issues annually, there are about 900 issues per year, probably in excess of 9000 manuscripts per year, which advance the understanding of general surgical care. What other career provides so much opportunity for mental advancement? There will be thousands of articles published this year that will be available to stimulate us to improve. Surgery is not unique among medical careers in this regard. However, I cannot think of another career that provides such stimulation, advancement and change for an entire career.

9. Job security.

Job security is a good thing. For decades, there has been debate regarding the supply and demand of physicians and surgeons. I have neither the time nor the desire to bore you with the details of the 1910 Flexner report, nor the multiple iterations of the Graduate Medical Education National Advisory Committee (or GMENAC) reports. Suffice it to say, these folks were not good at predicting things. GMENAC predicted that in 1990 there would be about 35,000 general surgeons in a country that needed about 23,000 surgeons, a surplus of about 12,000 surgeons.[2] What happened? In 1990, there were about 29,000 surgeons in a country that needed about 28,000 surgeons.[2] If I do the math correctly, that is about a 12-fold error. If any of us missed our targets by 12-fold on a consistent basis, we would be out of a job. The complexity of the variables involved exceeds the ability of most to make valid predictions. The current consensus is that there will not be enough general surgeons for the foreseeable future. There are several reasons. First, America is aging and general surgeons treat aged patients. At present there are about 35 million Americans over the age of 65 years.[3] By 2020, there will be about 53 million persons over the age of 65 years. Figure 1 shows projected growth or percentage increase by age group of the US population between 2001 and 2020.[3] The aged population, depicted with squares, will increase by about 50%. This aging population will result in huge growth in demand for surgical services. It has been projected that the US population will increase by about 18% in the next 20 years.[4] However, because of the aging population, it has been projected that the workload of general surgeons will increase by about 30%.[3,4] How many general surgeons will there be? As illustrated in Figure 2, reproduced from a recent publication by George Sheldon and co-workers, progressive

specialization within general surgery likely is going to decrease the numbers of general surgeons being produced and add to the complexity of workforce planning.[5] Although about 1,000 persons graduate from residencies in the United States annually, the number of persons graduating and entering traditional general surgery practice in 2004 is only about 250 per year. Furthermore, surgeons are retiring earlier.[6] The number of surgical residents is not increasing significantly. The bottom line is that in the next few years, there will be a significant shortage of general surgeons, roughly 5,000 or a 15% deficit. The Association of American Medical Colleges, the AAMC, recently published a consensus statement on the Physician Workforce.[7] They conclude that there will be a severe shortage of physicians in the next few decades. They suggest, therefore, that entry level positions be increased in both medical schools and residency programs. They calculate that medical school enrollment should be increased by 30%.[7] Similarly, the positions in graduate medical education programs, or residencies, should be increased by the same fraction. In a moment of remarkable insight, they go on further to recommend that "the AAMC should provide students, physicians, programs and hospitals with the best available and timely data on physician workforce needs in order to support informed decisions."[7] That is, the AAMC will give students information suggesting that we need general surgeons. However, I have a level of cynicism for those who try to predict the future. If given the opportunity to counsel young people, I would rather choose to state facts of the present and/or relate empiric observations to illustrate the point. As a Program Director in General Surgery for 14 years, I have never had any trouble getting one of our graduates a good job; most have many great job offers. As a practicing surgeon, I can think of only 1 or 2 examples of good surgeons who left a community or a practice because of politics or lack of income or success of their practices.

The bottom line is that a good general surgeon will be successful and have total job security for the next several decades. Name another desirable profession that can make that claim. You have total job security; and job security is a good thing.

8. The pay is not bad.

I live in Seattle. Not a week passes that does not provide me the opportunity to meet a "Microsoft millionaire." A Microsoft millionaire is usually between the ages of 40 and 50 years, is worth millions, and has not worked for about 5 years. They do serve a purpose. They have the time to coach our children's Little League teams, which, regrettably, busy general surgeons do not. Yet, it does not seem fair. I work harder, am better educated, more skillfully trained and deal with significantly more stress than they. The surgical locker rooms of America are filled with surgeons complaining about inequities of financial compensation. I could relate to you countless examples of corporate greed, of insurance executives collecting obscene compensation packages, but I will not do that. Rather, let us look at the facts. The facts are that the average general surgeon in the United States has an annual salary of $280.000/year (Table 1).[8] This pay scale puts him or her in the top 99.9% of income of employed Americans. The median household income in the United States is $44,000/year.[9] The average salaries of lawyers, computer/information systems, engineers, financial managers, financial advisors and architects are $110,000/yr, $102,000/yr, $66-97,000, $96,000, $82,000/yr and $68,000/yr, respectively.[10]

The Bureau of Labor Statistics also calculates the average hourly wage for all professions in the US.[11] In tabular form, they provide salaries for 427 possible jobs in 2002. The highest hourly wage in the US is airline pilots, $95/hour (Table 2). The catch here is that

pilots only work an average of 23 hours per week. The lowest salary, 427th, is waiters and waitresses, $4 per hour. The second highest hourly wage in the U.S. is physicians, $61/hr. Physicians average 41 hours per week.[11] The data are not broken down into physician specialty groups, but general surgeons are among the highest compensated physicians.

Are there inequities when is comes to compensation of general surgeons? Of course there are. Table 3 compares salaries of a few specialists in medicine and surgery. If you are a general surgeon, you likely have annual earnings that are substantially less than the radiologists or radiation oncologists in your institution; certainly not a fact that is based on common sense or justice. Even the anesthesiologist drinking coffee in the lounge while you are performing a Whipple resection is making more than you are. That is not fair or appropriate. However, the fact remains that general surgeons are paid very, very well. Our salaries afford us a life style that is better than 99.9% of people in Western Civilization. We should be embarrassed if we complain in public about our pay.

7. Your Mother will be proud of you.

The prestige of physicians and surgeons in the eyes of the American public has declined over the last 4-5 decades. The reasons for this are complex and multiple and time does not permit me to discuss them at length. The condensed version or explanation of this gradual decline in prestige is that we have “what we deserve.” My father practiced urology in Northern Michigan for 40 years. One of his pet peeves was the phenomenon of physicians driving expensive cars with personalized license plates advertising the fact that they are physicians. I recently saw a Porsche with a license plate that said “skin doctor.” How can we,

as a profession, complain that we have lost the respect of the American public when we do things like that?

Thankfully, however, the fact remains that our patients and the residents of the communities we serve respect us a great deal. Surgeons were ranked as the most prestigious occupation in a recent national survey, outranking college presidents, astronauts, big city mayors, lawyers, and all other physicians. Recent data compiled by the National Opinion Research Center concluded that surgeons are the most respected professionals in the US.[12] We are highly respected for our technical skills, the public values our ability to deal with very high on-the-job stress, and they appreciate our work ethic. Surgeons are respected in their communities. At work, surgeons are treated with respect and admiration by all levels of co-workers, from nurses to the maintenance workers in the hospital. Surgeons are revered by their patients. Your family is proud of you. Even the mother-in-law is you. Most importantly, your mother is proud of you.

6. Surgeons have *panache*: the Surgical Personality and the Culture of Surgery.

As described above, surgeons are admired by the public. While you may argue that your life bears little resemblance to that portrayed by the depiction of surgeons in Hollywood and modern television, there must be some justification for the dozens of movies or television shows depicting surgeons in action. The panache of the surgical personality is glorified by Hollywood. Surgeons on the movie screen are portrayed by people like Elliot Gould or Donald Sutherland, on television by the beautiful young men and women of *Grey's Anatomy*. Internists are portrayed by people like Robert Young in *Marcus Welby, M.D.*

The surgical personality is part of the Culture of Surgery. The recently published book, “The Scalpel’s Edge,” was written by a psychologist who had the opportunity to trail a team of academic surgeons.[13] The author, Pearl Katz, very accurately describes the surgical personality and the culture of surgery. Like the writers of MASH, she observed that surgeons have a demeanor of confidence and apparent arrogance. She then attempts to explain why that might be the case. She suggests that “The kind of work that surgeons do influences their demeanor and behavior with others. What other profession makes decisions and takes risks that literally control patients’ lives or deaths on a daily basis? Who but a surgeon routinely and boldly cuts into the most intimate depths of people’s live bodies, penetrates their innermost body cavities …? … Surgeons’ detachment from their patients may be understood as necessary protections from these routine sights, smells, acts and dramatic confrontations with mortality. Their demeanor of confidence and apparent arrogance may be partially explained by the almost superhuman requirements of their work.”[13]

Katz goes on to observe that the surgical personality is characterized by a preference for acting over not acting. This seems like a good trait to me. It has been part of the culture of surgery, since it was distinguished from medicine in the 2nd century. “Surgeons’ reluctance to admit doubt and uncertainty or error was likely to have permitted them to be sufficiently bold to carry out extremely difficult and risky operations.”[13]

How is it that surgeons can deal with the stress of performing life threatening operations on a daily basis? Katz’s hypothesis is interesting. She was fascinated by the rituals of the glove and gown process, of the draping procedure that shielded the face and personality of the patient from the surgical team. She believes that “The rituals that are enacted in the operating room also shield surgeons from the emotions of other patients and from their own

emotions…..In addition to separating the head of the patient from the rest of his body, operating room rituals facilitate a mind-set which focuses [on the technical aspects of the case, not the patient] … they facilitate surgeons' existing penchant for action and to avoid responding to distressing emotions."[13]

"The dominant themes of surgical culture – action, heroism, certainty, and optimism – are not compatible with identification with helpless patients. … The process of repressing normal feelings of empathy is necessary during surgery … the surgeon must protect themselves, otherwise they would be forced to experience intolerable feelings of disgust, horror and death."[13]

For decades, the culture of surgery also was dominated by men. Is the traditional surgical personality by necessity masculine? The answer is no. Will the surgeons of the future have "panache?" I would claim that the answer is "yes." Katz accurately observed that "surgical culture perpetuates itself by the recruitment and training of residents through a long apprenticeship process. The residents are often attracted to surgery by the image of the surgeon, with its prestige, power, and heroic mystique that is shared by most people in North America."[13] There is nothing related to gender in this attraction to surgery and the surgical personality. I would agree with Katz, who believes that women in surgery will make our profession better. "The new surgical heroes may rather be those who can admit doubt and uncertainty when it exists, and can admit limits and be comfortable with palliation. They may communicate sensitively with patients … The new surgical heroes may no longer be those men who make decisions and take risks for their patients, but rather those men and women who make decisions and take risks with their patients."[13] In my view, women in surgery will

only enhance the prestige of our profession, while maintaining the culture and panache of surgery and, more importantly, improving the product.

The culture of surgery is further illustrated by the Western Surgical Association. Name another career that has resulted in organizations like the Western Surgical Association that drives busy professionals to spend thousands of dollars in order to spend time, learn, and socialize with colleagues around the country? There is a bond, cemented by a profession that is greater than any other, which connects us all. In summary, if you choose surgery for a career, you will join a culture like no other.

5. You will have 'Heroes;' you will be a Hero.

The Halstedian teaching model, the apprenticeship model, provides mentors. Mentors become role-models and they become heroes. While many careers potentially foster a "Hero-worship" relationship between the pupil and the teacher, I would contend that the relationship between surgeons and their mentors transcends that of all other careers. Claude Organ incorporated a feature called "Surgical Reminiscences" in Archives of Surgery that illustrated the uniqueness of this bond. Each manuscript describes what I call 'hero-worship" between student and mentor. Western Surgical Association member Byron McGregor talked about his relationship with fellow WSA member and WSA president Chester McVay. McVay quoted the 12-century Chancellor Bernard in his classic anatomy text, saying that "we are like dwarfs seated on the shoulders of giants. If we see more and further than they, it not due to our own clear eyes or tall bodies, but because we are raised on high by their bigness." [14] Byron astutely observed that McVay transformed himself from a humble dwarf into one of the very giants he so admired, "thereby making room up there for the rest of us…..and, the view is fine!"[14]

Doctor Organ wrote about his first interaction with Lester Dragstedt. Claude was a junior resident spending time doing basic science research in a GI physiology laboratory; the legendary Dr. Dragstedt was a visiting professor. During the visit, a young Dr. Organ had the opportunity to discuss his research with Dragstedt during a one-on-one meeting in his lab. Claude then transported Dragstedt to his hotel. As they departed, Dragstedt presented Claude with his card and offered to communicate with him about the research project. It was a moment, Claude observed, "in my surgical training and surgical experience I shall never forget." He observed that "others might possess the card of legendary sports figures, but I had the card of Lester LR. Dragstedt, MD, FACS, Professor of Surgery and Physiology."[15]

My mentors are heroes: I could list dozens of heroes ... many are sitting in this room. I need to acknowledge two, both members of the Western: Bill Fry and Robert McClelland, or "Dr. Mac." I was my privilege to sit on Bill Fry's shoulders for 10 years in Dallas. He is the most talented surgeon I know. Dr. Mac, the originator and Editor of Selected Readings, has done more for surgical education than any surgeon ever. Dr. Mac's knowledge of the surgical literature dwarfs that of any other individual on Earth. A Dr. Mac trained surgeon knows that good surgical care can only be delivered by a surgeon who gets better every day. The best way to accomplish that goal is to read the surgical literature every day. This is a picture taken in the back of my office. (Figure 3) It is my good fortune to be able to look at these two men every day. To quote Dr. McGregor, the view from their shoulders is "just fine."

Every surgeon in this room is somebody's hero. Whether you are in private practice in a small community hospital, or a Department Chair at a major University, there are young surgeons, young medical students or young people thinking of a career in surgery who had the privilege to work with you in a hospital and think of you often. You are somebody's hero. Of

all the letters I've received from graduates of our program thanking me for being part of their training, perhaps the one that affected me most profoundly ended like this. "How does a student thank a mentor?...How do we thank you for those gifts? We emulate you."

What a great career. We have a profession and a culture that fosters heroes, we sit on the shoulders' of giants, and we too can impact others' lives profoundly.

4. There's Spirituality if you want it.

What do I mean by this? I can illustrate what I do *not* mean with a joke you have all heard. Although there are many variations on the joke, the short version goes something like this: "What is the difference between surgeons and God? God knows he is not a surgeon." My circulating nurse of 17 years, Thea Nortness, told me that joke. I don't recall exactly the circumstances that prompted it, but I have encouraged her to retell the joke anytime she feels it is appropriate. We would all probably benefit from having a hospital employee tell us this joke on a frequent basis.

What I do mean is that as surgeons, we are dealing with people on a daily basis that are using their spirituality to navigate through very stressful and/or life-threatening circumstances. A recent poll shows that 59% of the US population considers religion extremely or very important in daily life. However, being a surgical patient is not "daily life."[16] Nearly 100% of our patients use their spirituality during their surgical care.[17] How is that relevant to the career of surgery? If spirituality is important in your life, if spiritual interactions give you strength, give you peace, surgery will make your life better every day.

Surveys of hospital inpatients report that 77% of patients believed their physicians should consider their spiritual needs, 48% wanted their physicians to pray with them, but 68%

said no physician had ever inquired about their spiritual or religious needs….94% thought it appropriate for physicians to inquire about their spiritual beliefs if they became gravely ill.[16-20] How should these data influence my surgical care? I am not sure. I do know that the bond that can form between surgeon and patient is profound. The act of making a skin incision may be a simple technical exercise, but as the tissues open, the patient and the surgeon come together with a bond that may never be broken. From the patient's perspective, undergoing general anesthesia, being put to sleep while lying prone, is cause for thought. Is that spirituality? It usually is.

All of us acknowledge the value of the recent emphasis in medical care on "patient-centered care" and the paramount importance of health-related quality of life. As John and Maggie Tarpley observe, if the majority of our patients view spirituality to be important in their ability to deal with illness, and "if the patient-centered approach to medicine is the gold standard, then spiritual aspects of each person must be considered."[21] There is abundant evidence that spiritual well-being is a major component of health-related quality of life.[22] However, despite increasing evidence that patients would like their physicians to do so, spiritual issues are rarely addressed by 21st-century Western physicians.[21] Clinicians who ignore the spiritual concerns of patients are, in effect, asking many patients to alienate themselves from beliefs that deeply define them. Astute clinicians pick up clinical clues from patients.[23] The Hindu amulet, a copy of the Qur'an, rosary beads, a Bible or Shabbat candles on the night stand next to the bed may be as much communication to the surgeon as they are spiritual aids to the patient. They are signs of what the patient holds most dearly. All that may be needed is a simple, open-ended question in order to engage the patient on a spiritual level.

Showing respect for such defining features of a patient's life may constitute a healing act and can be integral to the care of the "whole patient."[23]

How many careers can document that 90% of their customers use prayer or spirituality to help them through their relationship the provider of the service? I can only think of a couple: airline pilots and casino dealers. In the former case, commercial airline, there are few atheists in the passenger section. However, the pilot has no personal or emotional contact or spiritual bond with the client. In the latter case, casinos, the dealer is the devil.

The problem for me is that none of the training I received in medical school or residency taught me how to address the spiritual needs of my patients. How should doctors examine and engage religion in the lives of their patients? As a program director in general surgery for the last 14 years, I have supervised the curriculum of about 2100 didactic conferences. Ninety percent of my patients want me to address spirituality, yet I have never put the topic "on the table" for my residents. I have no great expertise or insight into this dilemma, I just know it is important.

Jerome Groopman recently addressed this dilemma in an editorial entitled "God at the Bedside."[24] One of his dying patients told him she was frightened and said "Doctor, I want you to pray for me." Groopman, however, had no training for dealing with this request. He eloquently describes the uncertainty of the boundary between professional and personal relationships. Finally, he drew on the customary practice of his teachers and answered a question with a question. He asked his patient:

> "What is the prayer you want?"
>
> "Pray for god to give my doctors wisdom', the patient said.
>
> To that, he silently echoed, "Amen."

I will summarize my thoughts with a statement that I will boldly call “Thirlby’s Dictum." **There are no atheists lying on operating room tables.** Virtually all of your patients about to undergo major surgical procedures are having conversations with a being that is bigger than you or me. If you wish to do so, you can acknowledge this. You can do it with words, most patients welcome it, or you can do it with a smile, a gentle touch and a few seconds of eye-eye contact that communicates clearly the spirituality of the moment. Few careers involve daily situations where this intense yet peaceful exchange can occur. Name another career that evokes such emotions from the recipient and provider of services.

3. You will change patients’ lives.

On the advice of a colleague a few years ago, I starting saving thank-you letters I receive from patients. They are in a file in my office. All of you have received these. I suggest you save them as well. If you read them again, it will convince you that you are in a great career. It will keep you going. You truly do change patients’ lives.

Shown here is a sampling from my file.

“Thank you for successful efforts. It’s great to have my life back.”

“He was sick for a long time, but thanks to all of you, he has been given a chance to live a normal life again.”

“Thank you all in helping rid me of a condition which gave me no peace. … Love you all for who and what you’ve done.”

"Thanks so very much. … you have freed me from an outer shell of anguish. God bless you."

"I intended to write this note a while ago to thank you for the wonderful care all of you provided during my recent surgical experience. You made such an impact on my life and I feel as if I have been given a second chance after having gone though this "miracle surgery." I am so thankful you have dedicated your lives to help improve the lives of others. I will never forget the incredible impressions all of you have made on my life and in my heart."

"I am doing wonderful! I can't even thank you enough. My appetite is crazy….too good! My system is finally feeling and doing its own natural things once again."

"Thank you so very much for all your kindness and care. I feel better than I have in years

"I don't know how to begin to express my thanks and the thanks of my family."

"It is truly life changing. It's awesome."

"After living with UC for 25 years, for the first time in my memory, I know what "health" feels like."

From another UC patient, *"I count my blessings every day to have had you as my surgeon. I think of my scars as beauty marks that remind me of how much I have to be thankful for. I wear them proudly."*

And another UC patient. *"You have totally changed my life. … I had an absolute blast at the ninth grade dance. My friends … said I looked gorgeous. And I owe it all to you … I will be eternally grateful, you erased the disease that had ravaged my body for three years."*

"I am so thankful you have dedicated your lives to help improve the lives of others."

Many letters will draw on the importance of spirituality that I discussed above.

"I know it was God who placed you in that ER Room that Monday."

"God has given you the best gift of all…the ability to save lives. Thank you for everything."

"We have faith in you and a deep faith in God and He'll watch over both of you."

"I thank God every day….May you continue to be blessed with His healing gift."

"I don't know if you are a spiritual person, but I believe you are an angel."

While reading these may seem a bit self-promoting, that is certainly not my intent. All of you have received letters nearly identical to this; all surgeons have. I read these to remind all of you that you are truly changing patients' lives. Save the letters, re-read them when you are down on your luck. It will remind you that you have a great career.

2. Patients will change your life.

JS developed testicular cancer when he was a young man. His treatment included high dose external beam radiotherapy to the pelvis. He presented to the Virginia Mason Medical Center a few years ago in his early 40's with a destructive, high grade sarcoma of the left pubic ramus. The only effective treatment was radical excision. Our orthopedic oncologist, our vascular surgeon and I performed a radical en bloc excision of the pubis and the hip joint. I reflected structures such as the colon and ureter out of harms way, the femoral vessels were divided and reconstructed. The pubis and part of the acetabulum were resected en bloc. My orthopedic colleague assured me that ambulation would be possible despite the loss of the essential bony structures of the left hip, but that it would "hurt a little bit."

During JS's preoperative evaluation and planning, he was always remarkably upbeat. He never expressed any blame on the medical community for this "radiation-induced" tumor. He never seemed the least bit scared, bitter, or sad. He never intimated that he had been dealt an unfair circumstance: he only asked what we and he needed to do to get on with treatment and healing. He did not change after his operation. His pain management used the typical patient-controlled narcotic analgesic techniques. On his second postoperative evening, his care team decided that he needed to mobilize to a bedside chair the next day. I entered JS's room that morning on rounds. He was in the middle of his chair transfer. A nurse was in

attendance but was only watching. Every vein in JS's forehead was popping out, sweat was beading on his brow, he was clearly in great pain, but was determined to transfer to the chair as he had been told to do. As I sized up the situation with my residents, I told JS to "hold on," we could lift him to the chair. JS stopped his agonizing transfer, somehow managed to smile at me, and said "don't worry Doc, I don't need any help." That moment is etched in my brain: I shall never forget it. With tears in my eyes, I thanked him for changing my life.

How many times have you treated a patient with a disabling or lethal disease? Despite pain, despite the prospect of mortality or severe disability, despite potential financial ruin, our patients routinely smile; they routinely exhibit a strength of spirit, mind and body that transcends normal human behavior. Many times, we see the anger. Many times we see the fear. Many times we see difficulty dealing with pain. However, when it is all said and done, what we are privileged to see on a daily basis is a strength of spirit that trivializes our daily worries. How can we, in good conscious, complain about anything in our daily life on the same day that a patient with a lethal cancer in extraordinary pain says "he doesn't need any help." When our patients thank us for all our work on their behalf, our response should be "No, JS, thank you. You did all the work. I did the easy part. Thanks for the privilege of getting to know you."

1. I love to cut.

Rolling the right colon in a thin young patient with ulcerative colitis, putting a suture in the stomach, putting a stitch in Cooper's ligament: I could go on and on. A tough operation is completed with intuitive and clear anatomic dissection, minimal blood loss, a perfect anastomosis. You know the patient is going to do well. My vascular surgical colleagues tell

me it is completing the perfect carotid endarterectomy in the perfect plain with a perfect feather. The patch looks like it was placed with a precise sewing machine. At the completion of a complex operation, you take your gloves off, take a cleansing breath, thank the operating room staff (and, in ingenuous fashion, the anesthesiologist) and find the family to relay the good news: you tell the family that “all is well, your loved one is going to be just fine.” What satisfaction! What other career provides both the rush of operating and the satisfaction of guiding a smooth peri-operative course?

I love to cut. Many a resident has heard me say while rolling the right colon during an ileoanal pull-through, “I can’t believe somebody is paying me to do this.” With the exception of professional baseball, I cannot think of another job where the pay is so good to do something so fun.

The cynics in the audience might respond, “Yes, but what about all of the baggage outside of the operating room?” My response to that is that the prize makes the other stuff worth it. We have a career that affords us the opportunity to be paid to do something that is truly fun. It is why we are all in surgery. Cherish it.

In conclusion, members and guests of the Western Surgical Association: you are all very fortunate indeed (Table 4). You were born with the mental and physical attributes necessary to excel as high school, college, and medical students. You were blessed to be provided with the opportunity to utilize your talents. At some time in your education, you were injected with the addicting drug called “surgery.” You had and/or developed panache. You have become a very successful surgeon which affords you job security, financial comfort, great respect in your community, and daily personal interactions that are profound

and fulfilling. Best of all, when you go to work, you get to cut. Don’t ever complain, you have the greatest job in the world.

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REFERENCES

1. Evans SRT. A Year Like No Other. Arch Surg 2005;140:592.
2. Powell AC, McAneny D, Hirsch EF. Trends in general surgery workforce data. Am J Surg 2004;188:1-8.
3. Etzioni DA, Liu JH, Maggard MA, Ko CY. The aging population and its impact on the surgery workforce. Ann Surg 2003;238:170-177.
4. Liu JH, Etzioni DA, O'Connell JB, Maggard MA, Ko CY. The increasing workload of general surgery. Arch Surg 2004;139:423-428.
5. Stitzenberg KB, Sheldon GF. Progressive specialization within general surgery: adding to the complexity of workforce planning. J Am Coll Surg 2005;201:925-932.
6. Jonasson O, Kwakwa F. Retirement age and the work force in general surgery. Ann Surg. 1996;224:574-82.
7. AAMC Statement on the Physician Workforce. Association of American Medical Colleges, June 2006.
8. US Department of Labor Bureau of Labor Statistics. Occupational Outlook Handbook: Physicians and Surgeons. 2006. http://www.bls.gov/oco/ocos074.htm. Accessed 8/2/06.
9. Fronczek P. American Community Survey Reports: Income Earnings, and Poverty From the 2004 American Community Survey. US Census Bureau 2005;1-20.
10. US Department of Labor Bureau of Labor Statistics. National Occupational Employment and Wage Estimates in the US from the Occupational Employment Statistics. National Occupational Employment and Wage Estimates in the US from the

Occupational Employment Statistics ed. 2006. http://stats.bls.gov/oes/current/oes291067.htm. Accessed 8/2/06.

11. Buckley J. Rankings of full-time occupations by earnings, 2000. Monthly Labor Review 2002;125:46-57.

12. National Opinion Research Center. General Social Survey. Chicago: National Opinion Research Center. 1991.

13. Katz, P. The Scalpel's Edge: The Culture of Surgeons. Allyn & Bacon, Needham Heights, MA, 1999.

14. McGregor, DB. Chester Bidwell McVay, MD: The Practicing Anatomist. Arch Surg 2002;137:226.

15. Organ, CH Jr. Lester is Coming. Arch Surg 2001;136:1087.

16. Maugans TA, Wadland WC. Religion and family medicine: a survey of physicians and patients. J Fam Pract 1991;32:210-213.

17. Hinshaw DB. Spiritual issues in surgical palliative care. Surg Clin North Am 2005;85:257-272.

18. Koenig HG. Religion, spirituality, and medicine: research findings and implications for clinical practice. South Med J 2004;97:1194-1200.

19. King DE, Bushwick B. Beliefs and attitudes of hospital inpatients about faith healing and prayer. J Fam Pract 1994;39:349-352.

20. Ehman JW, Ott BB, Short TH, Ciampa RC, Hansen-Flaschen J. Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? Arch Intern Med 1999;159:1803-1806.

21. Tarpley JL, Tarpley MJ. Spirituality in surgical practice. J Am Coll Surg 2002;194:642-647.

22. Sulmasy DP. Spiritual issues in the care of dying patients: "… it's okay between me and god." JAMA 2006;296:1385-1392.

23. Puchalski C. Spirituality in health: the role of spirituality in critical care. Crit Care Clin 2004;20:487-504, x.

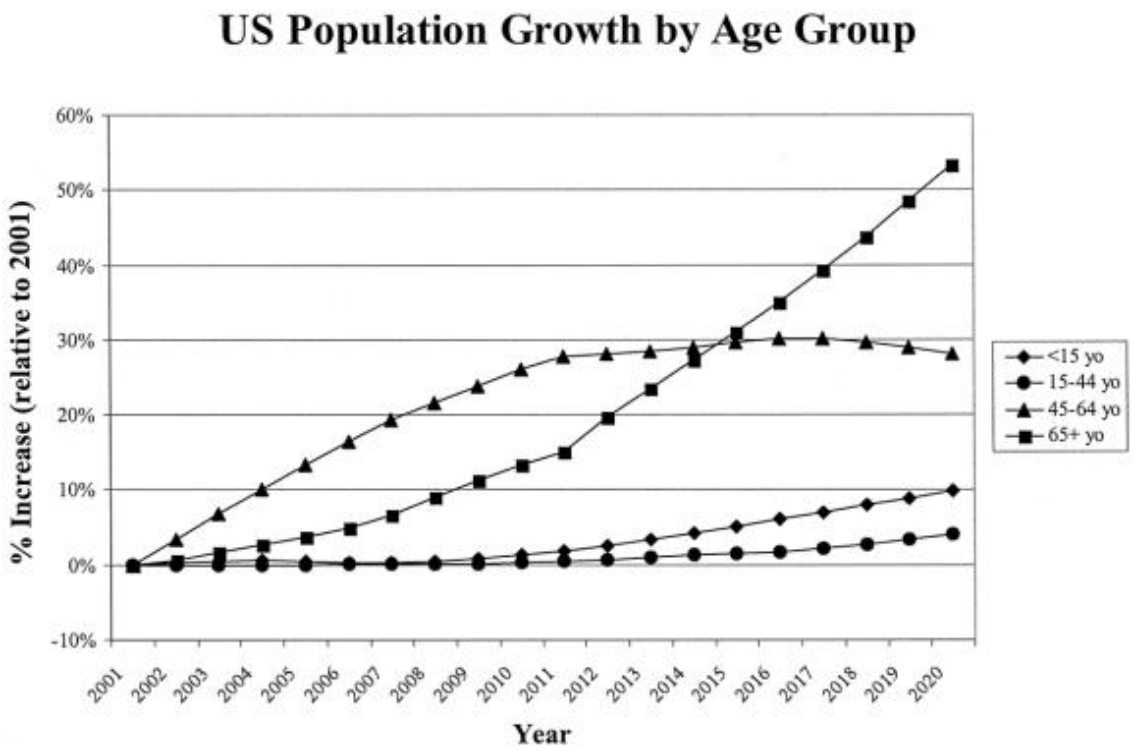
24. Groopman J. God at the bedside. N Engl J Med 2004;350:1176-1178.

FIGURE LEGENDS

Figure 1. US population growth by age group. Reproduced with permission, ref. 3.

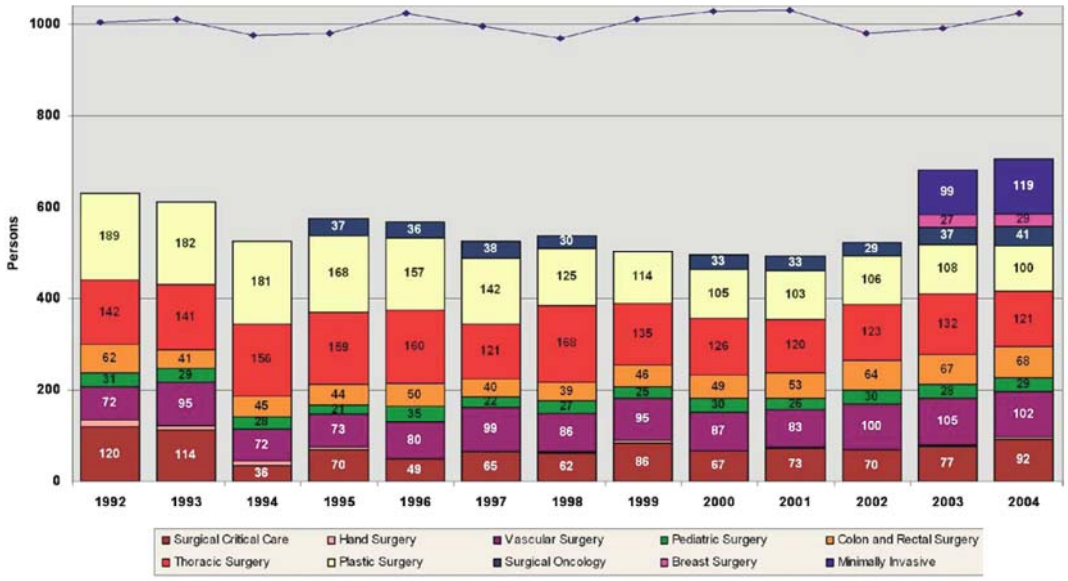
Figure 2. Number of general surgeons pursuing fellowship training and number staying in General Surgery, 1992-2004. Top line is number of trainees certified in surgery by the American Board of Surgery each year. Reproduced with permission, ref. 5.

Figure 3. The author's "Surgical Heroes." The view from their shoulders is just fine.


US Population Growth by Age Group
% Increase (relative to 2001)
60%
50%
40%
30%
20%
10%
0%
-10%
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Year
<15 yo
15-44 yo
45-64 yo
65+ yo

1

CAREER CHOICES OF GRADUATING SURGICAL RESIDENTS IN THE U.S.




D-T
FILE
LETTERS
PARKLAND SURGICAL SOCIETY
certifies that
Richard Coller Thirlby, M.D.
is a
MEMBER
of the society established June 1, 1982
to foster camaraderie among its graduates
and to pursue excellence in surgical education.
200
June 1, 1984
D-T
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Table 1

Median Annual Income: General Surgery

Years Practice	Median Income ($)
1-2	228,800
3-7	279,300
8-17	299,800
> 18	284,000
All	282,504

1

1

Table 2			
Rank		**Hourly Earnings ($/hr)**	**Mean Hours/Wk**
1.	Airline Pilots	95.8	23
2.	Physicians	61.2	42
3.	Economics Teachers	54.5	43
14.	Lawyers	38.8	40
34.	Financial Managers	33.9	41
427.	Waiter/Waitress	3.99	37

1

Table 3

Specialty	*Annual Income (2004)
General Surgery	299,800
Radiation Oncology	447,100
Radiology	448,800
Anesthesia	337,800
Internal Medicine	175,800
Orthopedics	415,900

*8-17 years of practice

2

Table 4

Top 10 Reasons Why General Surgery is a Great Career

1. I love to cut.
2. Patients will change your life.
3. You will change patients' lives.
4. There's Spirituality if you want it.
5. You will have 'Heroes;' you will be a Hero.
6. Surgeons have *panache*: the Surgical Personality and the Culture of Surgery.
7. Your Mother will be proud of you.
8. The pay is not bad.
9. Job security.
10. Training is fun (you'll never forget it) & training never stops.