Ο ΒΙΟΣ ΤΗ ΧΕΙΡΟΥΡΓΙΚΗ ΑΝΑΦΥΕΤΑΙ

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In 1902, at the Congress of Belgian Surgeons with guests from France, Germany, and Switzerland, it was decided to establish an International Surgical Society (ISS), “La Société Internationale de Chirurgie” [1]. The Chair of its first International Congress, held in 1905, was the Swiss Theodore Kocher. He was the first surgeon to ever receive the Nobel Prize “for his work on the physiology, pathology, and surgery of the thyroid gland,” but not the only “endocrine surgeon” to head the society. The Swiss F. de Quervain, known for his work on thyroiditis, managed to keep the Society alive through political turmoil in the 1920s.

But, it was not until 1979 at the International Congress in San Francisco that the International Association of Endocrine Surgeons (IAES) was born, as the first “child,” the first Integrated Society of the ISS. The need for the formation of IAES, based on the vision of Dr. Peter Heilmann, was described as follows: “IAES is a forum for the exchange of views of those who are involved in expanding the frontiers of endocrine surgery, whether by clinical experience, laboratory investigation or in any other way.”

It is that broad “any other way,” which I am most curious about and hope to engage all of you—to help define the future of IAES.

How many of you have looked carefully at the logo of our “mother” Society, designed in 1954 by the then President of ISS/SIC Robert Danis [1]? The engraving shows a young woman rising from the operating table, her knees covered by a surgical cloth, looking toward the sun, with a fountain on the left, an inscription in Greek reads: “Ο ΒΙΟΣ ΤΗ ΧΕΙΡΟΥΡΓΙΚΗ ΑΝΑΦΥΕΤΑΙ.”

ΒΙΟΣ is the first part of our logo, translated into English as LIFE. Βίος captures three distinct but interrelated dimensions, according to the Lexicon of Homeric Dialect [2], the duration of one’s life, the course of life, and the manner of living (including one’s career or profession). It is the root of the English term “biography,” i.e., the record (account) of how we invested (or spent) our physical lives.

The second part of our logo “ΤΗ ΧΕΙΡΟΥΡΓΙΚΗ” derives from the Greek words Cheir (hand) and Ergon (action), meaning the action made by hand, surgery. The meaning of our third Greek word “ΑΝΑΦΥΕΤΑΙ,” according to the Liddell–Scott Lexicon [3], means produce again, grow again. Metaphorically, “recover, make a fresh start.” Putting together the three components of our logo, Ο ΒΙΟΣ/ΤΗ ΧΕΙΡΟΥΡΓΙΚΗ/ΑΝΑΦΥΕΤΑΙ, “the official” translation is: “Life is reborn through surgery.” The question is “Whose life is reborn through surgery?”

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Life is reborn through surgery for our “global” patients

The obvious answer is that surgeons offer new life to their patients. Yet, according to the recently formed Global Alliance for Surgical, Obstetric, Trauma, and Anesthesia

Care (The G4 Alliance), as many as five billion people lack access to basic surgical services worldwide. Less than 6% of all operations are delivered to the world's poorest populations, and even in wealthy countries, access to health care for all, including surgery, is still under debate.

In recent years, more and more individual surgeons and departments of surgery are trying to fill this gap and offer new life to patients living in poor countries around the world. Our own Society, the International Association of Endocrine Surgeons, through the INTEREST program and the personal efforts of Rob Parkyn provides a forum for global surgeries especially for thyroid pathology and opportunities for short-term volunteer work.

"Operation Giving Back" of the American College of Surgeons (ACS) similarly facilitates humanitarian and volunteer work, with an emphasis on both domestic service and international service.

This commitment of surgeons to service is of course not something new. In 1978, surgeons Don and Deyon Stephens, along with friends, bought the retired ocean liner *Victoria* and transformed the passenger vessel into a hospital ship to bring care to the poor, naming it *Anastasis* (the Greek word for resurrection, born again, reborn). Over the years, more Mercy Ships started serving the surgical needs of poor people in 70 different nations around the world to "save lives, improve quality of life and restore hope."

Another example, almost 30 years later, involved transforming a train into a clinic offering medical services to the remote cities of Siberia to the local people that seldom had decent medical care. The train, launched in 2007, is called "Doctor Voino-Yassenetski—Saint Luke," to commemorate the life of a Russian Clinical Surgeon and Professor of Surgery at Tashkent's University, who died in 1961 as Archbishop Luke of Simferopol and Crimea and canonized in the Russian Orthodox Church in 2000.

Professor Yasseneski—Bishop Luke's life is mostly remembered for his repeated persecutions, arrests, tortures, and several exiles in Siberia, because of his devotion to all of his patients independent of their political or religious views. He believed that: "Healing means an essential existential restoration of the person who suffers and a radical amelioration of the quality of life of the patient." He is the example of a surgeon that tried to give life, quality of life, and even spiritual life to his patients.

Life is reborn through surgery for our colleagues (surgeons)

While no one in this room will disagree that the role of a surgeon is to restore life to our patients, and in that sense that "life (ΒΙΟΣ) is reborn through surgery," it is equally important to acknowledge that it is not only the patient's

Bios, but also the surgeon's Bios that is on the line. By the nature of our profession, adverse events (complications and errors) during surgery are expected to happen to all surgeons, independent on how good they are or how carefully they follow all the safety measures.

The World Health Organization (WHO) describes as adverse event an incident that results in non-intentional harm to a patient, as unexpected clinical result of health care, but which may or may not be related to a clinical error [4]. Whether or not the harm to the patient is based on an unexpected complication at no fault of the doctor, or actually due to medical error, the surgeon suffers. Yet, we rarely talk about this serious toll that these adverse events have on the life, the Bios, of the surgeon. This significant emotional stressor for the surgeon remains "under the rug."

In a recent study from the Massachusetts General Hospital, the emotional toll of intraoperative adverse events was significant with 84% of responding surgeons reporting a combination of anxiety (66%), guilt (60%), sadness (52%), shame/embarrassment (42%), and anger (29%). Interestingly, colleagues constituted the most helpful support system (42%), rather than friends and family [5].

Another study from the Mayo Clinic and Johns Hopkins University showed that of 7905 participating surgeons, 700 reported concern they made a major medical error in the last 3 months. This had a large, statistically significant adverse relationship with mental quality of life, all three domains of burnout (emotional exhaustion, depersonalization, and personal accomplishment) and symptoms of depression [6]. Suicidal ideation was found in a much higher than expected frequency in the same group [7].

A similarly significant emotional stressor for surgeons is medical litigation. A New England Medical Journal research paper has revealed that by the age of 65 years, 75% of physicians in low-risk specialty (i.e., pediatrics, general medicine) have faced a malpractice claim. This figure is much higher, estimated at 99% of physicians in high-risk specialties, including surgeons [8].

A study of 7164 members of the American College of Surgeons showed that medical litigation is common and has potentially profound personal consequences for them. Recent malpractice suits were strongly related to burnout, depression, and recent thoughts of suicide. Surgeons who had experienced a recent malpractice suit reported less career satisfaction and were less likely to recommend a surgical or medical career to their children [9].

And of course, the negative psychological impacts do not only harm the individual surgeon.

A JAMA study from the Harvard Medical School and School of Public Health as well as the Columbia Law School, entitled "Defensive Medicine among High Risk

Specialty Physician's in a Volatile Malpractice Environment," brings forward the truth about the usual behavior of surgeons toward their next patients after having experienced the psychological personal consequences of a surgical complication or a malpractice suit. Among several other reactions, 42% reported that had taken steps to restrict their practice, eliminating procedures prone to complications, and avoiding patients who had complex medical problems [10].

Psychologically devastated, burnt-out surgeons can cause harm not only to themselves but also to their next patients as well. A supported surgeon is a better surgeon for the next patient. What is surprising, though, with very few exceptions [4, 11–13], is the lack of support which exists for the surgeon after being involved in an intraoperative adverse event or in a medical litigation. No surgical society, national or international, has yet taken specific measures to support their members during the difficult period following such events.

Today, I want to propose that our Society, the International Association of Endocrine Surgeons, initiates a Peer Support Program for our member surgeons around the world involved in a surgical complication or medical litigation. This Peer Support Program would provide immediate "first aid" psychological support to our colleagues going through these emotionally stressful events.

The Program could consist of a group of distinguished endocrine surgeons from around the world that would either volunteer or, even better, be elected by our members for this particular job. All supporters must have themselves experienced the psychological shock associated with adverse events or malpractice litigation. Only passionate supporters who have been there themselves can comfort their peers. Peer supporters will need to be trained. For example, while the usual tendency of many surgeons is to minimize the adverse event or downplay its impact, in a peer support system, this does not help.

The practical steps necessary for the success of the Program are to provide a one-to-one peer support to individuals following a stressful event. We can learn from existing initiatives. The RISE (Resilience in Stressful Events) peer support program at Johns Hopkins Hospital developed a two-tiered call system, whereby two peer responders were on call at any given time. The first peer responder responds to the RISE pager, while the second one provides backup for the first if additional support is necessary [13]. Others [11, 14] believe that since most physicians will hesitate to proactively seek support, a system that allows peers to reach out to the surgeon in need might be better. Special care should be instituted to match supporters according to their age, rank, and specific injury. In addition to empathetic listening and sharing experiences,

peer supporters must avoid judging the details of the case, but rather help put things in perspective.

Above all, as Dr. Jo Shapiro, Director of the Center for Professionalism and Peer Support at Brigham and Women's Hospital, has argued: "creating a peer support program is one way forward, away from a culture of invulnerability, isolation and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety" [11]. Once we can accept, as surgeons, that adverse events will happen, no matter how prepared we are, we will be able to fully support one another and improve the long-term quality of life, the Bios, of our patients and our colleagues.

As we look to the future, I believe we must embrace our logo Ο ΒΙΟΣ ΤΗ ΧΕΙΡΟΥΡΓΙΚΗ ΑΝΑΦΥΕΤΑΙ as: "Life is reborn through surgery for both our patients and our colleagues." This is the "other way" I propose to help expand the future of our Association.

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