Clin Orthop Relat Res (2017) 475:1929–1931 / DOI 10.1007/s11999-017-5391-9

Clinical Orthopaedics and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

Published online: 31 May 2017


Editorial

# Editorial: Giving at the Office

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The first law of thermodynamics holds that energy cannot be created nor destroyed, but that it can change forms. I sometimes wonder whether this also applies to symptoms. Surgeons alleviate discomfort in patients, but over a span of years, many physicians develop symptoms of their own.

I'm certainly not suggesting that orthopaedic surgeons develop arthritis from treating arthritis, and I'm not talking about bloodborne viral illnesses and needlesticks. Rather, I wonder what we "give at the office." What does caring for others under stressful circumstances take out of surgeons, and are the feelings we experience as we prepare for surgery universal among surgeons or are they particular to each of us? Although I favor evidence-based approaches for solving clinical problems, and certainly those can guide the care of surgeons who have work-related emotional distress, I wonder whether each of our stories in this regard is just too personal for big data to be the solution here. Perhaps we should look to one another for inspiration, openness, and maybe even some sharing.

This much seems clear: We pay to play. Alcohol abuse among surgeons appears common [5]. Physician burnout and depression are on the rise, and although the rates of suicide among physicians remain stable [4], doctors are more likely to bring a suicide attempt to a fatal conclusion than are laypeople [6].

There are so many trials on interventions seeking to mitigate burnout that scientists can meta-analyze their results [8]. Dozens of studies, thousands of physician-patients. And yet the problem continues to grow.

Last year in *CORR*®, an accomplished and successful trauma surgeon announced his retirement in a commentary he wrote for us—about an article on physician burnout [9]. Following that, we asked him to host a debate for publication here [10]. While *CORR*® columnist and self-efficacy expert John D. Kelly MD felt strongly that mindfulness and resiliency training can help providers thrive in challenging environments (and he has covered these topics with great eloquence elsewhere [3]), the other participant in that dialogue was deeply skeptical. That other participant (Michael J. Goldberg MD) suggested that efforts seeking mainly to stiffen the upper lips of providers may inappropriately focus the attention on the physician, when the real problems lie at least as much in the organizational structures in which doctors practice. Another observer has suggested, colorfully, that focusing on the individual rather than the system simply creates a "stronger canary" to send into the same toxic coal mine [1].

I can't disagree; system-driven externalities should be addressed, since unquestionably some stresses that surgeons face—perhaps many of them—originate in the complex systems in which we practice. But insofar as these systems are difficult and slow to change, at this point I would

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delightfully content myself with becoming a better-adapted canary. I am fortunate not to have depression or alcoholism, but looking back, I certainly have experienced symptoms related to my earlier inefficiencies in acknowledging work-related stress. I took some guidance from individuals who had been to these places before, and in time, my symptoms—at one point, relentless nausea; at another, severely disrupted sleep—abated.

To say that I am glad to have those miseries behind me understates the feeling. I swapped those symptoms for this small bit of self-awareness: For me, at least, the main problem is not the hospital, the practice group, or the paperwork. The main problem is not the lawyers or the threat of litigation for mistakes I inevitably will make. For me, at least, it's not about the coal mine. The problem is indeed in the canary. The night before I operate, and the whole time I am on call—despite my surgical practice being fairly straightforward, and despite having trauma-center colleagues as a strong safety net during call shifts—I am uneasy. I don't feel social on those days and nights. The job no longer causes symptoms, and I can name the emotions behind my unease. Having said that, I had hoped that by now that these feelings would go away. After 20 years in practice, I don't believe they will.

One solution might be to walk away, a luxury option not shared by healthcare providers in all settings [7]. The alternative, of course, is to stay in the game. How best to do so? Perhaps perspectives from individuals whose challenges are far greater than our own can inspire us, and perhaps a little more sharing among surgeons who have such feelings can lighten the load.

Edward Farrar MD, a spine surgeon who experienced a devastating spinal trauma resulting in paraplegia, recently offered his perspective in a deeply moving essay [2]. Perhaps the most-poignant vignette he shared involved Dr. Farrar becoming a caregiver to his partner, who previously had been his nurse during his own recovery; in a cruel turn, she developed disseminated glioblastoma, resulting in thoracic paraplegia. "It was hard to believe that life could become more difficult," Dr. Farrar wrote. "And yet, for the first time since my own injury, I did not have time to think about myself. As we cared for her in the last months of her life, another change occurred. Making another person's life more important than my own led to even more of my own healing and recovery" [2].

Although stories like those of Dr. Farrar can lift us up, each time we visit with a patient in the office, step into the operating room, or begin a shift on trauma call, we are left with our own feelings. But we need not be alone with them.

I've offered up some of mine. What are yours? Share them in a letter to the editor (EIC@clinorthop.org).

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