On The Other Side of the Door

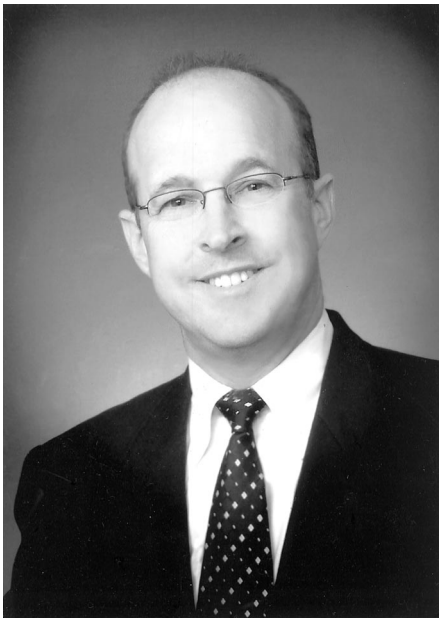
J. Scott Millikan, MD

J Trauma. 2003;55:1007–1013.

My friends, I would like to thank you, the members and guests of the Western Trauma Association (WTA), for the great honor of serving as your president over the past year . This experience has been so very special to me in large part because I believe the WTA is such an outstanding organization. Our group, founded some 33 years ago, has thrived under the principles of collegiality, diversity, fellowship, and scientific endeavor. The WTA has matured from a small fledgling group, with its first Colorado meeting in the early 70's, into the formidable organization that it is today. It has been a great pleasure to witness this transformation over the years.

For me, our meeting has a wonderful aura about it. There is, and I think many of you would agree, something unique here. In many ways it is difficult to define, and yet it is crystal clear in my mind that our meeting, our organization, is special. For some, perhaps it is the western-style relaxation and casualness of our gathering. For others it might be the free-wheeling scientific sessions or perhaps the diversity of our membership. I'm sure we all have our reasons for coming year after year. I can tell you that for me, it's about the friendships and the great relationships that I've made within this organization over the years. For me it's the fact that our meeting is a yearly punctuation point in my life; something I can look forward to, something I can count on. Our meeting is a time when I can be with you, my friends and colleagues, away from our usual lives, to congregate in an incredibly beautiful setting, share some excellent science, catch up on old friendships, and most importantly, develop new ones.

For me, it is also about being in the mountains. I have always loved the mountains; their serenity, their beauty. Perhaps that is why I settled my family in Montana. Being in the mountains allows me to gain perspective on my life. From the top of a mountain I feel appropriately small and at the same time closer to a higher power. In the mountains, I always feel part of something much bigger than myself.



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For me, it is also about our group's emphasis on family. In many ways my kids grew up coming to this meeting, learning to ski, making friends that they continue to keep to this day and I'm sure they will treasure for years to come. My mom likes to say that in the end all you have is your family, your friends, and your memories. Well, many of my fondest memories come from the annals of WTA meetings I've attended over the years. So to be president of an organization that I cherish so much will always be among my greatest honors, and for that I can't thank you enough.

I would also like to take this opportunity to welcome you all to Snowbird. Snowbird has been a very special venue for this organization. We have met here six times now; more than at any other locale. Our group's first Snowbird meeting was in 1980. That year, Dr. Gene Moore gathered a group of aspiring young surgeons to attend. We paid an astonishing $19.00 for one-way airfare on Frontier Airlines from Denver for a week of science and skiing. It was one of my earliest forays to a mountain resort, and for most of us, it was our first scientific meeting. When we arrived here, our enthusiasm was palpable. Excitement was high. To say, however, that we were not welcomed with open arms would certainly not be hyperbole. In fact, the young WTA really did not know what to make or do with residents. Now, attending the WTA's annual meeting in the very same location nearly a quarter

Submitted for publication October 31, 2003.
Accepted for publication October 31, 2003.

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Presidential address presented at the 33rd Annual Meeting of the Western Trauma Association, February 23-28, 2003, Snowbird, Utah.
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DOI: 10.1097/01.TA.0000083339.93868.13

century later, residents occupy a place of high honor at our gathering, and I would like to extend a special WTA welcome to each and every resident physician here today.

Many of you residents have participated, or will be participating, in the Earl Young Residents Prize Competition. This event began in 1991 as a tribute to Dr. Young's memory and his spirit of inquiry and love of learning. I think it should be recalled that it was right here at Snowbird in 1989, during our 19th Annual Meeting, that Earl died while skiing. I must confess that I rarely ride the Gad lift, a few hundred yards from here, without thinking of Earl and that particularly sad afternoon. Yet, I believe it is a tribute to this organization and to Dr. Young that we continue to honor him and acknowledge the participation of resident physicians at our yearly gathering through this competition. I'm sure I speak for the entire membership when I say that we hope that you, our resident guests, will continue to attend these meetings as you pursue your careers. I hope that you find participating in the WTA as rewarding an endeavor as I have over the years.

On a personal note, I appreciate the chance to bring our group back to Snowbird because it gives me an opportunity to reminisce about my very first WTA ski run, under the tram on the Peruvian Circ where I lost my hat, goggles, and ski poles back in 1980. I check the lost and found every time we are back here. No luck yet!

Today my remarks will be brief. In many ways they may seem intuitive and perhaps so obvious that one might even question the whole purpose of my talk, yet I am willing to take that chance because I believe that certain concepts, no matter how obvious they may be, remain worthy of emphasis as we go about our professional lives. I believe that what we do and how we act as individual physicians reflects back on all of us as a profession. I also believe that the practice of medicine is at times in danger of losing its tradition as a humanistic art, and I often worry that we are in danger of somehow losing our human touch.

I would like to focus for the next few minutes on this rather famous painting by Sir Luke Fildes entitled "The Doctor" (Fig. 1) This beautiful oil-on-canvas was first exhibited in London in 1891 and is still there on exhibit at the Tate Gallery. To me, the work is timeless. It reflects, in visual dimension, the essence of the interpersonal relationships that have formed and continue to form the very bedrock of medicine.

Before discussing the picture itself, I think it is worthwhile to frame the time when this painting was conceived. To provide perspective, remember that in the late 19th century, the misery caused by disease was so pervasive that serious illness as depicted here was considered a day-to-day part of life. In his discussion of family life in England, historian Lawrence Stone points out that, "The most striking feature that distinguished the early modern family from the family of today, does not concern marriage or birth," it concerned what he calls, "the constant presence of death." Stone points out that in the late 19th century, "Death was at the very center of life just as the cemetery was at the center of the village."[1]

Fig. 1. *'The Doctor,' by Sir Luke Fildes. Copyright Tate Gallery, London 2003. Reprinted with permission.*

In the year of my grandmother's birth, 1888, the infant mortality rate in New York City was nearly 250 out of every 1,000 live births. In 1900 the life expectancy in America was only 50 years. The rate of surgical complications approached 50 percent, with a 10 percent mortality rate even for the simplest of operations.[2] In his autobiography, Claude Welch tells us that at Massachusetts General Hospital—the same year that the six cholecystectomies performed resulted in two deaths—that 109 appendectomies for un-ruptured appendicitis resulted in 10 deaths, and for the 39 appendectomies performed for ruptured appendicitis, there was a mortality rate of 70 percent.[3] So, a scene as depicted here was not at all unusual.

Fortunately, the landscape of American life has changed greatly over the last century. American medicine has come a long way. We are certainly more effective as physicians. Death and suffering do not lurk around every corner, looming omnipresently over our lives. And yet, I worry, as Abraham Flexner worried many years ago, whether we have become so infatuated with our progress in medical knowledge that we've lost our perspective, our historic sense of who we are as physicians.[4]

It is against this backdrop of 19th century everyday life and 19th century medical knowledge that the artist Fildes' eldest son died on Christmas morning in 1877. In the face of this tragedy, the artist was touched by the way the family doctor cared for his young boy. Some years later, Henry Tate commissioned a painting by Fildes but left its subject matter to the discretion of the artist. The result was this masterpiece.

This image of the quiet heroism of the family doctor was a huge success. The painting drew very large crowds when it was exhibited at the Royal Academy in 1891. The piece was reproduced extensively and later even appeared on two postage stamps. No doubt many of you have seen reproductions

of this remarkable work. Fildes himself said that he wanted to "put on the record the status of the doctor in his time."[5]

On first view, one is immediately drawn to the center of the piece. The haunting image of the very sick child and the contemplative, sensitive physician in the soft light of the night-time oil lamp could not be more compelling. This painting often has been utilized to visually define for us the so called doctor-patient relationship, that defining connection on which we all base our livelihoods. I do not think there can be any doubt that this relationship is the cornerstone of all medicine. Indeed, there have been countless papers, essays, and commentaries on the subject. Recently, many have wondered aloud about the current status of the doctor-patient relationship in today's technologic world. It is a topic worthy of serious thought. I will, however, leave those discussions for another day.

This afternoon, rather, I would like to direct your eyes away from the center of the painting and into its shadows, to the fringes of the art piece, away from the central dynamic between the doctor and his patient, to a place where an entirely different story is being played out.

In his own description of the painting, Sir Luke points out that ". . . at the cottage window the dawn begins to steal in. The dawn that is a critical time of all deadly illnesses. And with it, the parents again take hope into their hearts. The mother hiding her face to escape giving vent to her emotion, the father laying hands on the shoulders of his wife for encouragement, for the first glimmerings of joy which is to follow." You see, Fildes has specifically chosen that. Unlike the sad case of his own son, this painting portrays an event that culminates in a happy ending. This painting portrays a vision of hope.[5] In this painting, a whole other drama unfolds just a few feet away from the main action. It is a dynamic story that occurs every day, in every hospital, in every waiting room, almost with every medical encounter. Fildes, in his art, has depicted not only the doctor-patient relationship but another relationship as well. That is the connection between the physician and those who love and care about his patient: the patient's family.

The patient's family. Who are they? What is their experience? What do they want and need? What are our duties as physicians to them? What can we as physicians do to improve their lives? Where do they fit in today's world of medicine?

To be honest, there were times in my career that I was not always attuned or attentive to these questions. My focus was my patients and the associated clinical decisions that would bring successful outcomes. Then, one day, my perspective completely changed as someone I loved deeply, the mother of my children, fell victim to a life threatening illness. Quite suddenly, and really for the first time in my life and in a serious way, I was instantly transformed from the physician to "the family." Suddenly, I had to view medicine from a completely new vantage point. Over the course of more than two years and many, many operations at multiple institutions, during numerous hospitalizations and emergency room visits, through incredible ups and downs, my children and I spent seemingly countless hours in waiting rooms in our new role. We became the people in the shadows of Fildes' painting. Although Ann eventually slipped through our caring hands, the experience changed me completely and forever. It particularly changed how I view medicine and how I view our roles as physicians. And while my experience was clearly singular in nature, and may or may not translate to your particular professional situation, I suspect that there are strains of commonality that connect families and friends, patients and their doctors the world over.

We live in a much different world than the characters depicted here. Suffering and serious illness are thankfully not a routine part of most people's lives. Yet, we all know that tragedy still occurs. Today I would like to speak to you, my friends, not only as a physician, but also as one of those folks seen here in the shadows, on the periphery of the medical encounter. I would like to share with you some of my reflections about what it means to be on the other side of the waiting room door. What it means to be "the family."

First off, for me, being a family member of someone so ill was a totally foreign and at times surreal experience. Unlike the characters seen here, illness in my family was somehow completely unexpected. Although as a surgeon I was surrounded by serious illness on a daily basis, it seemed that trouble was always visited on other families. The realization that someday my number or somebody in my family's number might be called had always been kept in a closed and dusty closet in the back of my mind. In today's world, that is where I think most people house such thoughts. For while it comes as no surprise to relatives when Uncle Joe who smoked three packs a day for 50 years gets lung cancer, in Montana it is always a terrible shock when major trauma, bringing death or severe injury, strikes any one. In either case, however, it is likely that friends and families eventually will find themselves in hospital waiting rooms, in the shadows of the painting.

We, "the family," inhabit every waiting room of every hospital. Whether it happens to be outside the emergency room, the operating room, or the ICU. Waiting rooms hold a myriad of reactions, relationships, and emotions, as they exhibit collections of people brought together by circumstances that transcend race, education level, or socioeconomic status. Waiting rooms are places where, to me, the light never seems to be as good as it might be, where the coffee staves off sleep that probably would never come anyway, where newspapers, books, puzzles, and the drone of late night TV can never get your mind off why you're really there. They are places where families come together and yet most people, I think, feel somehow alone. Places where privacy might only be found by taking a walk—getting out of there—something you would not dare to do for fear of missing that short window of time when the doctor finally shows up.

You physicians notice us when you walk by. Sometimes we are in groups, families getting together for the first time in

years or, perhaps, for the first time since yesterday. Maybe we're people meeting each other for the first time, brought together with the only common denominator being kinship with an injured patient. And sometimes we just sit there very alone.

Not much sleep is gotten in the waiting room. I wonder how many of you residents know that patients' families often get less sleep than even you do? If you spend enough time in hospital waiting rooms, you'll see some amazing things. You will get glimpses of the complete spectrum of human emotion. You will see those with their faces in their hands or groups arm-in-arm, usually with the aura of bad news floating in the air. You will witness tears of sadness, and if you're lucky, you also see the occasional tears of joy. We in the waiting room crowd like to take in these particular occasions whenever possible, as we have the chance to share some vicarious joy with a stranger. These joyful times seem to ease the tension of our own situation. I notice that physicians hang around a little bit longer when they get to deliver good news. But why not? That affirms for physicians what they are all about.

If you spend enough time in waiting rooms, you're afforded a lot of time to think. We in the waiting room spend time wondering, sometimes aloud, sometimes in solitary silence. Initially, the obvious questions bubble up from our brain: Is my spouse going to be okay? I wonder what the doctors are doing in there? How long will that damn operation last? I wonder when my kids can get back to school?

But in time—time that is somehow inversely proportional to the seriousness of the situation at hand—we begin to wonder about bigger questions. Why is all this happening? Why is this happening to someone I love? Are they going to be okay? Eventually, the questions become more introspective. What is going to become of my life? We also wonder about the others. What is going to happen to the children, the brothers and sisters, moms, dads, spouses, and best friends, all of those left uninjured, yet hurting nonetheless? There is a lot of anxiety and fear circulating around waiting rooms.

I think the waiting room is the toughest room in the hospital. I would ask you to remember that like ripples from a stone cast into a quiet pool, or like the crack of a branch high on a mountain that precipitates an avalanche, critical illness, trauma, or otherwise perturbs the calm far beyond and long after the moment of your patient's injury. Please remember that illness changes lives. It changes lives far away from the patient's beside. And while this may seem so intuitive and easily understood, I believe it is a worthwhile endeavor to emphasize the connectivity that we all share with others in our lives. Very few of us, fortunately, are in this world alone. We all have relationships to and with others. Please recall that what you do as physicians is not carried out in a vacuum. Your actions have implications far beyond those that affect your patient directly.

I was in the third year of my general surgery residency, and after completing a successful and very routine vagotomy and pyloroplasty for ulcer disease on a newly immigrated fellow from Eastern Europe, I went out to the waiting room to give the good news to the patient's wife. I will never forget the scene. There, with my intern and medical students in tow (no staff man in sight), I told the middle-aged woman, who could barely speak English, that her husband was going to be okay. Upon hearing the good news, the woman broke down in tears, fell to her knees and grabbed me around both of my legs. She proceeded to weep in front of the entire crowded waiting room. She continued to cry and would not let go. Eventually I had to forcibly break from her clutches and sit her down on a chair, where she continued, through the tears, to express her gratitude. As we walked away, she continued to sob. In my haste to get on with the day, to get on with the next task, to be the most efficient resident I could be, I failed to realize the importance of what had just transpired. It wasn't until years later that I would come to know, in a real and true sense, the emotional impact of what that woman was feeling. While her expression of gratitude may have been a little over the top, I have come to think that she personified the incredible relief and overwhelming joy that many in waiting rooms feel when after dreading the worst, they are lucky enough to get good news. It is so important to patient's families when you give us our loved one back. When you give your patient the precious gift of tomorrow, the gift you give the family is just as great.

Now, what about the flip side of the coin? As physicians, we are all called at times to be the bearers of bad news. It is a task that none of us want to do. It is a task that is never easy. This is a time when we must face our own limitations as physicians, our failings as surgeons, and our realizations regarding the limits of human life. I must confess that for many years I carried around some frustration and even anger regarding this issue because, quite honestly, I received little if any training regarding this task. During my residency, these uncomfortable missions often were left to me to perform solo, to learn by experience, to develop my skills completely "on-the job." After a long number of years and some colossal misadventures, I eventually developed some confidence in my ability to break bad news to hurting families.

Anecdotal discussions I have had with many of my academic colleagues lead me to believe that, unfortunately, not much has changed. These difficult family discussions often fall to junior members of the surgical team who often lack skills and experience in this area. I believe this is simply wrong. When things go awry, when outcomes are not good, the patient's family wants, and has the right, to hear the news from the senior person on the team. They need to know who is in charge. Importantly, they need to know everything that could have been done was done. They deserve to have their questions answered. Is this the staff man's job? This is something we each must decide as individuals. In these situations it may be wise to bring your residents along to mentor them and teach them these valuable skills. We are not all great communicators, but these are skills that can be learned.

Robert Buckman, a medical oncologist from the University of Toronto, has developed a protocol for breaking bad

news to patients.[6,7] Although this protocol was developed for doctor-patient communications, I believe the principles apply with equal force for physicians in their dealings with families. These principles were reviewed in the November 1998 Bulletin of the American College of Surgeons.[8] I would highly recommend this article and its associated bibliography for all physicians, and I advise it as mandatory reading for any physician in training. The protocol is as follows:

THE SPIKES PROTOCOL

Setting

These conversations should occur in a setting that allows good communication by ensuring privacy and family comfort. Some have advocated a private, special room with a telephone, comfortable decor, hand basin, mirror, and coffee.[9] The physician needs to use proper body language by sitting and facing the family directly so that direct eye contact can be made. You must give the impression that you are not hurried and have time to talk and answer questions. I always bring an experienced nurse with me who can be supportive and help the family after I leave.

Perception

The physician needs to ascertain what the family already knows and access the family's level of comprehension and degree of denial.

Invitation

A family will not understand serious and complicated medical facts unless they are prepared. The physician should ask them if they are willing to accept the information that is about to be delivered.

Knowledge

Look directly at the family, be honest and to the point. Avoid technical language. Emphasize the major points. If death has occurred or is likely to occur, say so directly. After breaking bad news, allow some silent time for family comprehension.

Empathy

The physician does not need to sympathize or feel the same feelings the family does, but the physician does need to acknowledge and respect the reactions and feelings the families express. The physician needs to expect a wide range of emotional expression. Allow and encourage reaction such as crying. Although it can be upsetting, relatives appreciate the truth. They appreciate your empathy. One should avoid platitudes, false sympathy, and euphemisms.[9]

Summary

The physician should emphasize all the important points and be prepared to answer questions. Again, let the family know that everything that could have been done was done. I believe it is important that the family understands that you are always available to answer questions that may come up at a later date. If death has occurred, I always call the closest family member a few weeks later to check on any unresolved questions and express my ongoing concern for them. This phone call is always appreciated.

In an important paper presented at the 1999 American Association for the Surgery of Trauma, our former president, Dr. Jerry Jurkovich, showed us that, as judged by nearly 75 percent of the families interviewed, the attitude of the news giver is the most important feature of the encounter when someone receives bad news. Clarity of message, privacy, and competency in answering questions also are highly valued. "The behavior that families perceive as most comforting and helpful can be summarized as follows: Families want a caring attitude of a well-informed sympathetic care giver who gives families a clear message and is able to answer their questions.'[10] It is so true, as Dr. Jurkovich reminds us, that the physician can have a remarkable impact on how people reflect on this major life experience. How you, the physician, interacts with the family, during this conversation is of the utmost significance. There is no shortage of literature on the critical nature of this discussion.

What about families who find themselves camped out in the waiting room day after day, sometimes week after week? What do they want? What do they need? What are their concerns?

We families want to interact with the physician. We want some of your time. We want to be updated. We want our questions answered. We want some sense of reassurance and comfort. We want hope. Although the ethics of physician-family interaction may not in the very strictest sense be well-defined in major textbooks on medical ethics, I believe that paying attention to the families needs and emotions is without question the right thing to do.

COMPASSION

All of this requires a sense of compassion. Compassion is a virtue, as editor and commentator Bill Bennet points out ". . . that takes seriously the reality of other persons, their inner lives, their emotions, as well as external circumstances. It is an act of disposition towards fellowship and sharing, towards supportive companionship in distress." He goes on to point out that, "the seeds of compassion are sewn in our very nature as human beings."[11] Compassion is a bedrock attribute of an effective physician. I cannot imagine a good doctor who does not have a large dose of it flowing through their veins. We just need to remember to put it to work as often and where ever we can.

Would any of us drive by the scene of an accident without offering to help? Of course not! This is because, as the 18th century philosopher Jean-Jacques Rousseau put it, "Compassion is a natural feeling that contributes to the preservation of the whole species. It is this compassion that hurries us, without reflection, to the relief of those who are in distress."[11] Please remember that in the world of serious

illness, plenty of distress extends out into the waiting rooms. I am asking you to remember to extend your compassionate selves to those families there.

HOPE

And now a word about hope. Hope is the currency of the waiting room. As a waiting room veteran, I can tell you we all want it. We instinctively know its value. We crave it. We even measure it. It's a part of the waiting room vernacular: "Is there much hope?" "The doctor says things are very hopeful," "I hope tomorrow things will be better." It is clear to me that when it comes to serious illness, hope is precious. Hope sustains. Serious illness is a terrifying experience for both the patient and family. Hope gives us a way out. It provides a road map for redemption.

I can tell you from personal experience that hope—even when hoping for a long shot, even when hoping for a miracle, even when hoping against hope—keeps one going. During my time as one of "the family," hope allowed me to get up in the morning. Hope allowed me to get through the day. Hope allowed me to sleep at night. Believe me, ladies and gentleman, hope is very real.

As physicians, you play a critical role in this regard. Physicians are the primary dispensers of this precious commodity. On a daily basis you have an opportunity to keep hope alive, not only in your patients but also in those on the other side of the waiting room door. We in the waiting room look to you for guidance. We hang on every word you say. Often, what you say is, in reality, all we have to go on. There is a sign in my hospital that reads, "Never take away anyone's hope. It might be the only thing they have left." I believe that is good advice.

Psychologist Charles R. Snyder and his colleagues at the University of Kansas have focused much of their research on hope. According to their studies, hope consists of two components: (1) a determination to meet goals; and (2) the ability to create plans to meet them. Snyder has even developed a questionnaire that measures hope.[12] In several studies he and his colleagues have shown that hope is linked to successful outcomes in various domains of life, such as work and school performance and also in health. It has been well documented that hopeful patients do better both emotionally and physically than those who are more pessimistic. For example, psychologist Timothy Elliott has found that patients paralyzed from a spinal cord injuries who scored high on Snyder's measure of hope fared better than those who scored low. Even if their levels of injury were comparable by objective measures, the more hopeful patients became more mobile than those who were relatively hopeless.[12] Significant data is accumulating that supports the proposition that hope and its cousin optimism reflect crucial attitudes than play a role in our physical well-being and our ability to recover from illness.

I also believe that a hopeful and optimistic attitude among patient's families might actually have a positive impact on the patients as well. There is a wealth of evidence supporting a link between social support and physical well-being. Certainly anecdotally, I have noticed over the years that cardiac surgical patients who have a strong social network with lots of supportive friends and family seem to recover more quickly, get out of the hospital earlier, and generally do better than those who are isolated and lack family or friends.

This is not to say that one should promote hope when there is none or optimism when there is no reason to be optimistic. Physicians' dealings with patient's families need to be tempered by reality. We in the waiting room want to have a realistic assessment of our loved one's condition. False optimism can be destructive. When things are going badly, an unrealistic brand of optimism serves no one.

When there is no hope left for a loved one, we the family want to know. We need to know. We need to get ready for our new reality. As a physician, however, I believe that it is helpful to leave shattered families with some hope for the future. Letting them know that things will get better or that time will ease the pain gives families at least some hope for improvement in a very dark situation.

TIME

All of this takes time. Carving out a segment of time in an already very busy day to actually seek out your patient's families, spend time with them, and care for them takes a special effort. To do this in a health care environment where physicians are busier, work harder for less, and are being tugged from all directions, to do this in an environment where such activity will extend the length of an already long day and cut into time with your own family is, to say the least, difficult. But difficult is not an unknown adjective in the physician's lexicon. Physicians have always been called on to perform difficult tasks. This extra effort requires only resolve, determination, and of course, time—mostly time.

One last story. My mother-in-law was recently in the intensive care unit of a major academic center. She was critically ill, intubated, and comatose with a serum sodium of 106 meg/L. As a worried son, I managed, with some difficultly to get in touch, long distance, with the senior medical resident on call. After a collegial and professional discussion regarding her condition and differential diagnosis, along with plans for further studies, I asked my young colleague if he would mind giving me a call if my mother-in-law's condition worsened over the night. After all, I was on call as well and would really appreciate the update. His response was, "Hey, I understand. But listen, I have got five sick people here in the ICU tonight. I'm not sure I'll have time to give you a call." His response left me stunned and saddened. Clearly, my young colleague had a long way to go. Maybe today's medicine has a long way to go.

Many medical students today define career in terms of "lifestyle choice." They go on to define "lifestyle" in terms of time. One student recently wrote in the *Archives of Surgery*

about the reasons students were opting out of careers in surgery. She stated, "With a finite amount of time in the day, more time at work necessarily means less time with family or friends."[13] Well, we can all do that calculus. But I believe it is a privilege to do what we do. Since when did the privilege of practicing medicine come without any element of sacrifice? Clearly, added attention to patients' families requires added time. And those not willing to give it, should perhaps, stay out of the area of critical illness.

Unquestionably, career sacrifice is a lot easier when your career is a calling, not just a job or a lifestyle choice, when it is clear to you that your life's work matters. Believe me, physicians spending time on the other side of the waiting room door really matters to those folks out there.

We have come a long way in medicine since the seventeenth century initiation of the scientific revolution. As noted, we live in a completely different world than did Sir Luke Fildes' doctor. By the middle of the twentieth century, science had become as some say, "our secular religion, a faith that has become an unquestioned assumption in most of the industrialized society."[14] But as our technologic breakthroughs continue, will we as physicians continue to distance ourselves from our patients and their families? Will we get farther and farther away from the ideals depicted in this painting?

It is sobering to realize, that by 1990, 1 in 3 Americans had practiced relaxation therapy, herbal medicine, acupuncture, chiropractic medicine, spiritual healing, and other medical approaches in addition to standard medical care. An estimated 425 million visits were made to alternative practitioners, in contrast to the 388 million visits that were made to family doctors and other primary care physicians. In terms of money, $13.7 billion was spent on these unconventional therapies, of which $10.3 billion was out-of-pocket. With the amount of time, money, and hope that is spent on alternative approaches to healthcare, it is clear that traditional medicine is not giving a significant number people everything they want.[14] In one modern survey, 85 percent of patients responded that they either had changed physicians over the last five years or were considering changing physicians. Why? Not for reasons of competence. Instead, they are troubled by modern medicine's (1) insensitivity to their needs; (2) poor communication techniques; (3) overemphasis on technology; or (4) lack of respect for their viewpoints.[15] Edward Golub points out that in our lifetime, "curing has replaced caring as the dominant ideology of our new technology-driven medicine." I agree with Dr. Golub that, "most people want both. Patients as well as families want to be cared about as well as cared for."[14]

As I finish, I would like to take this opportunity to thank my own family, Ryan, Amy, and Dana and my incredible wife, Tamra, for all the support they have given me on my life's journey. Should my journey take me into the world of injury or serious illness as a patient at your hospital, I know that you will treat me well. But if that happens, I also want you to remember them. I ask you to take care of them, too. I ask that you find some time to spend with them. Encourage them. Show them your compassion. Give them hope. Care about them. They will be right there, just a few feet away, on the other side of the waiting room door.

Finally, Rabbi Harold Kushner reminds us that, "to know that we matter to God makes a lot of our doubts and fears disappear." He says, "We do not have to find a cure for cancer to make a difference in the world. We only have to share our lives with other people."[16] He continues, quoting Mother Teresa who tells us that, "Few of us can do great things, but all of us can do small things with great love."[16]

I believe we as physicians are so privileged to give great meaning to our own lives with the ability to touch our patients' lives in such profound ways. We also have a great opportunity to touch the lives of our patients' families in an equally profound manner. What we do as physicians matters so much to folks on both sides of the waiting room door.

It has been my privilege and honor to address you today. Thank you for your attention. God bless you all.

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