Harnessing your passion and connecting to purpose

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I would like to thank Dr. Dennis and Dr. Haut for the invitation to give the Orien's lecture this year and to congratulate Dr. Riojas and Dr. Mallah for their inspiring essays that you will hear following this talk. I have realized in the past few years that as you get older your speaking engagements shift from science to philosophy, and it is an incredible honor to be asked to share with you my thoughts on our profession. I believe the best way to convey philosophy is through stories, and so I am going to tell some stories today.

We are truly blessed to be able to do the work that we do as Acute Care Surgeons, but the road is not easy, and many have succumbed to the stresses we face in caring for patient and families in the midst of sudden, life-threatening, and life-altering events. The hours are long; we take in house call; and much of our work consumes nights and weekends. Yet, I really cannot think of anything that I would rather do. For me, my career has evolved into a vocation. My hope for this talk is that, by sharing a little bit of my story with you, we can think together about how to both advance the care of our patients and support each other along the way.

A few years ago, I was asked by our health care system leadership to give an inspirational, TED-style talk on leadership. Having never given such a talk, I started watching a lot of TED talks and came across this talk by Simon Sinek entitled, "How Great Leaders Inspire Action" (https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action). Forty-seven million other people have seen it, and so maybe you have seen it too. The concept is simple. He makes the case that most organizations do a very good job of describing WHAT they do and HOW they do it but few focus on WHY they do what they do. It is the ability to communicate and connect to this underlying motivation that is the key to success. Now you might say, this should be easy for us. We see the WHY in the faces of the patients and families we care for every day. We start every talk with the statistics (Fig. 1). We make the case that the global burden of injury is a tremendous public health problem. It is the leading cause of death for young people, and it is the most important problem facing our military personnel, but statistics are really not enough. If we are going to effectively convey this message, we need to be willing to tell our stories, and so I am going to share some of my stories with you today.

I started my career as a paramedic in Maryland, and those experiences continue to inspire me to this day. I want to start with the tale of two motorcycle crashes. Once I completed my training, I began working with one of the fire departments in a county outside of Baltimore. I had been on the job for about a week when I encountered my first trauma patient. We had just dropped a patient off at the local hospital with an acute myocardial infarction, and we were very proud of ourselves as the patient was doing well. As we pulled out of the parking lot, within a block of the hospital, we witnessed a motorcycle crash. We jumped into action. The patient was clearly in critical condition. We immobilized him on a backboard with C-collar and given that we were so close to the hospital, we elected to "scoop and run." As we entered the hospital, I realized we had made a really big mistake, because while it was a great community hospital, it was not a trauma center. As we rolled in the door, we were immediately chastised by the nurse for bringing them such a critically injured patient. The resuscitation was chaotic to say the least.

A few months later, we were called for another motorcycle crash. In this case, a helicopter was called for transport. In Maryland, at the time, there was only one medic on each helicopter so for critical patients they often took a medic from the field to help. I flew with this patient to Maryland Shock Trauma where I witnessed a very different resuscitation. Here was a team with clear leadership. They were prepared, organized and efficient, and everyone knew their role. It was that day that I learned that the outcome of a trauma patient depends on the system of care that surrounds them more than the actions of any individual.

Now I want to fast forward 25 years. It is a beautiful sunny day in Seattle, as it always is. I am the trauma surgeon on call and receive a call from our transfer center about a young girl who has sustained a single gunshot wound through the right elbow and into the right lower chest. She was taken to a Level III trauma center for rendezvous with the flight service. She is unstable, being intubated, and blood transfusions have started. It is a 15-minute flight over the water. Well, you all know that one of the great things about a Level 1 trauma center is you can do a lot with 15 minutes. I notified the operating room (OR), and they immediately began to prepare a room. I spoke the pediatric intensivist and the emergency department (ED) team and established a plan to minimize time in the ED, with direct admission to the OR and I made sure the blood bank had the first round of the Massive Transfusion Protocol ready to go. Now, this child

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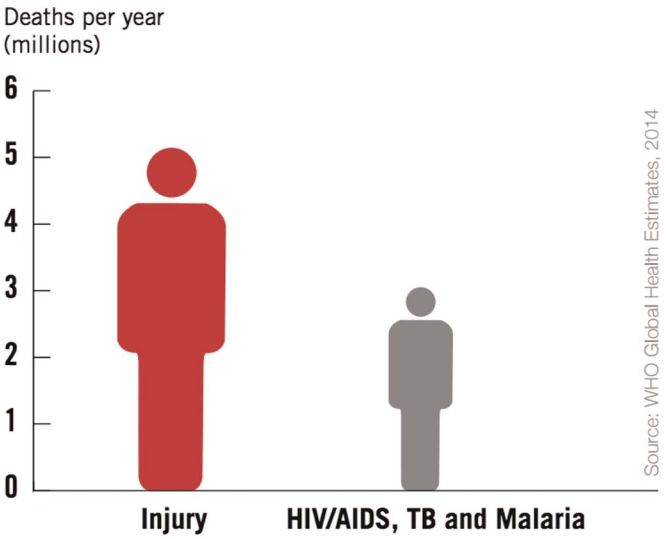

Figure 1. The Global Burden of mortality due to traumatic injury compared with HIV, malaria, and tuberculosis combined. Data from the World Health Organization, Global Burden of Disease 2004. Figure from WHO Injuries and Violence; The Facts 2010 http://whqlibdoc.who.int/publications/2010/9789241599375_eng.pdf.

had a terrible injury. The bullet shattered her elbow, entered the right lower chest, traversed the liver, the duodenum, and the infrarenal inferior vena cava (IVC) before lodging in the paraspinous musculature. I do not have to tell this audience the challenges of managing these injuries, but thanks to the efforts of the entire team, we were able to control the hemorrhage and support her resuscitation.

They say it takes a village to raise a child. Well it also takes a village to save the life of a critically injured child. Table 1 shows my estimate of the individuals that has a critical role in the care of this child in just the first 4 hours. This adds up to 45 people. I cannot say it was an uncomplicated course, but after several operations and over a month in the hospital, she went home with her parents and recently graduated from high school. This is my WHY. This is why I do what I do every single day.

When I think of this case, I think this is an example of exactly how a trauma system is supposed to work. But it did not happen by accident. Years of work have led to this coordinated approach to care, and all of the programs shown in Table 2 have impacted this practice. What do these all have in common? They

TABLE 1. It Takes a Village to Save a Child

Role	#	Role	#
Police officers	2	Blood Bank Team	3
Paramedics	2	Radiologist	1
Fire fighters	4	Laboratory technicians	2
Referring hospital staff and physician	4	Radiology technician	1
ED team	4	PICU nurses	4
Surgical team	4	Pediatric intensivist team	2
Anesthesiology team	3	Social worker	1
OR nursing/staff	4	Environmental services staff	2

Total of 45 people.
PICU, Pediatric Intensive Care Unit.

TABLE 2. COT Programs That Impacted My Patient

Stop the Bleed	Trauma Center Standards
Hartford Consensus Conference	Pediatric Readiness Project
EMS Protocols/Field Triage Guidelines	TQIP Best Practices: Massive Transfusion
Regionalized Trauma System Consultation	Continuous Quality Improvement
Uniform trauma education (ATLS)	Firearm Injury Prevention Activities

TQIP, Trauma Quality Improvement Program; ATLS, Advanced Trauma Life Support.

reflect the work of our community through the Committee on Trauma. And so, for me, I can connect my personal WHY directly to the work we are doing nationally and internationally to improve trauma care. You might wonder how this young girl was shot in the middle of this beautiful, sunny day. Well, it turns out that a young boy in her class was planning to run away after school and took a gun from home for protection and put it in his backpack. When the backpack was dropped on a desk, somehow the gun fired striking his classmate. It is my hope that all of the work we are doing in firearm injury prevention will stop these tragedies before they occur.

I titled this talk "Harnessing your Passion and Connecting to Purpose," so I want to spend a few minutes talking about Passion and Purpose, as both are critical to our success. Passion comes from the Latin root: Patior which means suffering or enduring. This may sound pretty negative, but it refers to something you feel so strongly about or have such a strong belief in that you are willing to suffer for it. Purpose comes from the Anglo-French root purposer which means to intend. The analogy I like to use is that of a road trip where Passion gives you the drive, providing fuel for your journey, but purpose gives you the direction.

Let me give you some examples. In the early 1960s, Ralph Nader recognized that large numbers of Americans were dying in Motor Vehicle Collisions. He published a book entitled, *Unsafe at Any Speed*, which at the time was seen as an attack on the automobile manufacturers.[1] He harnessed his passion to testify before congress and that passion, translated into purpose, has resulted in dramatic improvements in automobile safety and significant reductions in fatalities. Today, we have a similar passion. We see far too many people dying from firearm injury and violence. I am hopeful, because we are translating that passion into purpose thanks to the work of the entire medical community, which is coming together on this issue, and the incredible leadership of many in the surgical community.[2–4] This year alone, Dr. Ronald Stewart, our COT Medical Director, has testified before congress three times on the importance of funding research on Firearm Injury Prevention for which congress just appropriated 25 million dollars, an historic step forward.

So why the word Harness? If you search Google images you get lots of pictures of restraining devices, but that is not the definition I am after. I like the analogy of solar power, that is, harnessing the energy from the sun. We need to harness the energy from our passion to sustain us in difficult times and drive our purpose. Whenever I am having a bad day, I think about the little girl I just told you about, and she pushes me to work harder. I encourage each of you to find a story that represents your WHY that you can turn to that will sustain your purpose.

Now we know what we need to do: recognize our passion, define our purpose, and then harness that passion. But, how do we get there and how can we be most effective? I think, in this case, the HOW may be just as important as the WHY. To really make a difference, we need to work together and so you also need to focus on building your network. One of my fundamental philosophy analogies involves the comparison between swimming in a race versus joining a team in a fire truck pull competition. I think we all can agree that we could individually be the best surgeons, and each save a lot of lives, but if we come together, we can have an even greater impact. Working together, both as individuals and as professional societies, I believe we can make a huge difference in improving the trauma system, in advocating for injury prevention, and connecting high-quality research to improve outcomes for our patients.

I recently read a book by David Brooks entitled *The Second Mountain*.[5] In it he talks about how most people approach their career with an individualist mindset. I think we do that in medicine too. We compete to get into medical school, to match in a surgical residency and fellowship, and spend the first several years establishing ourselves to build a practice or get promoted. There is nothing wrong with this, but at some point, we need to shift to a relationist mindset, or the second mountain, where our career becomes our vocation. Sometimes, this is a natural evolution, but other times, something in life happens that knocks us of off the first mountain and forces us to reevaluate our direction. For me, the work of the Committee on Trauma is my second mountain.

Now, networking sometimes gets a bad rap. It can sound self-serving, and if you are an introvert, like me, it sounds painful. I used to think of it as social exercise, and I was not very good at exercise. But what I know now is that networking is just taking some time to really listen; to learn what is important to others; and to share our joys and challenges. There is incredible value in connecting to those who truly understand what is like to face audible bleeding from the inferior vena cava at 2:00 AM or to give bad news to a grieving family. Networking is really just making friends, and one of my favorite quotes from Dr. Stewart is "If you want friends, be friendly." It is that simple.

One advantage we have is that our community is a manageable size. We have lots of overlap in our professional societies, and it does not take long before you start to realize you are running into the same people several times a year, and so, there are many opportunities to build connections. There is much being written about burn-out in medicine and all of the systemic pressures which tend to isolate us, and as a result, we are at risk of losing that sense of community. I think the solution to that is our professional organizations. In Figure 2, I have illustrated my perspective on the Natural Lifecycle of progression in our societies. We are usually introduced to the group by a mentor who brings us along as a student or resident. We are uncomfortable, as we do not know anyone, but we stick by our mentor and make it through. Our next introduction may be as a fellow when we are looking for our first job. Now we talk to a few more people who might hire us, but still feel pretty out of the loop. As junior faculty, we tend to cluster with those from our home institution and over time, if we get involved in committee work, our circle starts to widen but it still may be 10 years to 15 years before we really start to feel at home. I think we need to do better. The good news is that there are lots of initiatives underway to support earlier engagement (Table 3), and Eastern Association for the Surgery of Trauma (EAST) has clearly been a leader in this approach, but I still worry that we lose some people (penguins) along the way.

From my perspective, we must make is a priority to strengthen our community, so I am going to tell you another story. Just a little over 10 years ago now, I was sitting in my office when I received a panicked call from my mother. She has gone in for a routine upper endoscopy to check the status of her ulcer and has just received a call from the gastroenterologist telling her that the biopsy showed some cancerous cells, and she should find an oncologist. She had no idea where to start. My family lived in Rhode Island so I thought I would try reaching out to Dr. Cioffi who was the Chair of the Department of Surgery at Brown. I did not know him very well, but hoped he could recommend a good oncologist to sort it out. I sent him an email, and he responded almost immediately offering to see her himself and coordinate her care. I will be forever grateful to him for the kindness he showed to my parents in helping them navigate the system. Unfortunately, despite two attempts at surgical resection and two challenging courses of chemotherapy, the cancer won this battle. Eighteen months later, as we sat by her bedside in our local community hospital, where she was admitted with septic shock, my father and I wrestled with the decision to transition to comfort care. We called Dr. Cioffi to get his opinion, and he talked us through that difficult time. I found out later that he had stepped out of the banquet at the American Surgical to take my call. The support I received not only from Dr. Cioffi but also from my friends around the country made this time bearable. This is an example of the value of building a strong community.

So how can we do it? First, we need to make it a focus, we need to have a communal story. As a group, we need to articulate our passion and our purpose, we need to connect to our WHY. We need to embrace both maximal inclusion and radical hospitality. How can we ensure that everyone feels welcome? How can we ensure that everyone has the opportunity to be engaged? How can we create opportunities to network that are not stressful and do not feel like social exercise? I think we need to work both as professional societies, and as individuals to consciously build our community. As individuals, we need to be approachable and take the time to really listen. We need to say thank you and recognize the contributions of others and most importantly, we need to have a GIVER mindset.

I promise this is the last book I am going to recommend today, but it is the most important. If you read only one book this year, it should be *Give and Take* by Adam Grant.[6] Adam Grant is a Professor at the Wharton School of Business, and he describes three general preferences for reciprocity that are seen in the workplace, Givers, Takers, and Matchers. Takers tend to self-promote, are cautious, and self-protective in their interactions. They will only help others if it benefits them. Matchers seek fairness and an equal balance of giving and taking. Most people are Matchers. Givers, however, are other-focused and generous in sharing their time, skills, ideas, and connections without expecting anything in return. There are both advantages and disadvantages to being a giver. Givers tend to have stronger relationships. They have wider, richer networks, and they bring out the best in other people, and so they are very good at leading teams. Givers may suffer from pronoia, the irrepressible fear that

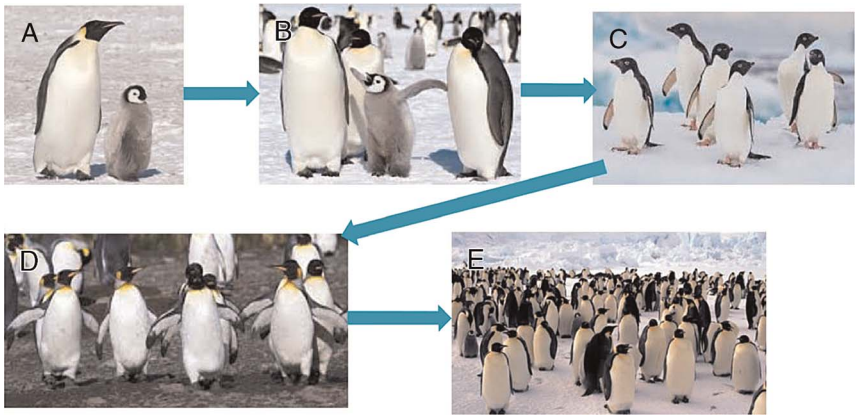

Figure 2. The natural lifecycle of engagement in professional organizations. (A) Introduction to the society by a mentor, (B) American College of Surgeons (ACS) Fellow looking for his/her first job, (C) Junior faculty clustering with partners from home institution, (D) First Committee assignment, (E) Know enough people to be comfortable mingling at social events (10–15 years later).

others are out to help you, that is, the opposite of paranoia. The disadvantages are that you are at risk of being taken advantage of, particularly by a Taker, and you might sacrifice your own success to benefit others and pay a price in productivity. This may increase your risk for burnout. Adam Grant outlines how to be an "Otherish Giver" which avoids some of these risks, and I encourage you to read the book for the details. I am blessed to know several Givers in our community, and the more we can emulate that approach the stronger our community will be.

How do we build resilience, as a community, that is, avoid burnout? I think, if we always connect back to our passion and purpose, have a strong network that supports us, are not afraid to ask for help, serve as Givers, and take every opportunity to say thank you, that we will build resilience and a strong community to support each other.

Last year, I was attending a panel session at a multidisciplinary surgical meeting which was focused on the challenges of mentoring in the "Me Too" error. One of the men on the panel spoke about the concern that some had expressed to him about the risks of mentoring women in this environment. I was so troubled that I stood up and made a comment, as nearly all of my mentors have been men and I know that without their support I would never have made it to where I am today. When I sat down, a woman sitting nearby, who was also a trauma surgeon leaned over and said, "Trauma surgery is special, we have got each other's backs, we have to…."

I hope that is true for all of you, as I believe the secret to combatting burnout is a resilient community where we have each other's back. I am grateful to those who have looked out for me. I am grateful for the opportunity to stand on the shoulders of giants as the 20th Chair of the Committee on Trauma and work with an incredible team, both the surgeons on the COT and the staff at the American College of Surgeons, who operationalize all of our programs. I am grateful for my many friends in our Acute Care Surgery family, for whom there are too many to fit on any one slide.

My hope for each of you is that:

- You will take some time to identify and embrace your passion.
- You will harness that passion to define your purpose.
- You will find home in our Acute Care Surgery Community.
- You will engage in our professional societies, be energized to contribute, and execute your purpose with the support of our community.
- You will be a Giver and help build and enhance our community.
- You will support each other, have each other's backs, and avoid burnout.

If you do these things, you will make lasting friendships that will enrich your lives. Thank you again for the honor of sharing these thoughts with you. Thanks to all of you for the work you do every day for those suffering from critical illness

TABLE 3. Programs to Support Early Engagement in Our Professional Societies

Eastern Association for the Surgery of Trauma	American Association for the Surgery of Trauma (AAST)
• Leadership Development workshop	• Associate member council
• Resident & Fellow workshops	• Junior faculty research scholarships
• Mentorship Teams	• Associate members on committees
• Junior Faculty Research Scholarships	• Networking breakfast
• Practice Management Guideline development	• Scholarships to attend AAST meeting (students, residents, and in-training fellows)
• Networking breakfast	
• Oriens Essay Contest	**ACS Committee on Trauma**
Resident paper competition	• Future Trauma Leaders Program
INVEST-C Research Hackathon	• COT Regional Representation (vice chairs)
• Committee Leadership opportunities	• Resident Associate Society Liaison
	• Resident Paper Competition
Western Trauma Association	• Young Fellows Association Liaison
• Networking reception for trainees	• Scholarships to attend Leadership and Advocacy Summit
• Ski with an Officer	
• Earl Young Paper Competition	

or injury. Please never hesitate to reach out to me if I can help you along your journey.

DISCLOSURE

The author declares no conflicts of interest.

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