Our Lives as Surgeons: Finding a Sense of Place and Purpose

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I will say that I am astonished to be standing here now. Who would have thought that more than 3 and a half decades ago, when I started my surgical journey, I would be standing here giving a lecture established in tribute to the first woman surgeon anyone ever spoke of to me.

The year was 1978. I was a young medical student recently smitten by surgery, at a very southern medical school, my University of Virginia (UVA), which I truly love despite the fact that it was many years, if not decades, before a woman surgery faculty member arrived on campus. I certainly could not find one there and then. I did, however, have a wonderful new-found mentor after my defection from pediatric genetics to surgery, named Dr Les Rudolph. Dr Rudolph, like Dr Jonasson, was a pioneer in the field of transplantation surgery, and was one of few surgical faculty at UVA who, despite my place near the top of the class, had embraced my ambition to pursue surgery these 35 years ago. (I might add that several others have now claimed a mysterious role in my decision…somehow I missed that input at the time!). At one of our meetings, he told me that he thought I should know that women—at least somewhere else—had become surgeons and had, in fact, risen to be leaders in my now newly intended future field of practice. He told me in one breath of the 2 he knew—and whom I must meet: Dr Olga Jonasson and Dr Katherine Anderson.

I trust both names are familiar to all in this room, but for those who do not know the name of Dr Katherine Anderson, she is a marvelous pioneering leader in pediatric surgery and just 9 years ago, was the first woman to be president of the American College of Surgeons. With Dr Rudolph's help, I found Dr Anderson, the first woman surgeon I ever met, long before Dr Jonasson, meeting her in my home town of Washington DC, first as a medical student and then as a resident, and she subsequently became a lifelong mentor and friend.

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However, it took me much longer to meet Dr Jonasson—in fact, it was close to 17 years before I personally met her enough to say more than a simple awe-struck "hello" to her. I will never forget the first real conversation I had with Dr Jonasson; it was during one of those days spent in a hotel room examining at times trembling young surgeons. We were, of course, giving the American Board of Surgery (ABS) certifying examination, the "old format exam," a good bit more free form than today's version. I was there as a novice associate examiner and she as the consummate, very experienced director. I was, like virtually all younger surgeons who would have found themselves in my situation with Dr Jonasson that day, shall we say, "concerned" at the prospect of spending the day with her. I can assure you I felt as much on the examinee's seat as our candidates did that morning. At the time, from my youthful perspective, this concern was entirely justifiable for Dr Jonasson was one of the most highly respected leaders in American surgery, and while there were only "rumors," she wasn't known for being warm and fuzzy. I was also mindful of Dr Rudolph's long-ago advice to meet her, and I didn't want to disappoint him.

Dr Jonasson, by then, was even more legendary than when Dr Rudolph had first mentioned her name. In my mind, as a young woman surgeon excessively focused on firsts, she was particularly famous for her recent service as the first woman to chair a medical school department of surgery—at Ohio State University. By the time of this exam, she had moved on from that job.

For those who have not yet served as an ABS examiner, one of the simpler pleasures of this service, other than the thrill of giving oral examinations 8 hours a day for 3 days in a row, is the chance to meet new colleagues from around the country. When you are young, you meet those you have long heard of, but have never known. When you get old, you realize the younger examiners look at you with similar curiosity. If all goes well, one chats, learns of their practices, interests, and often families. As the day began, I wasn't sure if Dr Jonasson thought this came with the process or not. I watched as she began the exam. She did, of course, use the most difficult scenarios from our books, those which I wouldn't have dreamed of asking because I didn't have a clue where to go with them. She was even and clear with the candidates and warm to me as her associate examiner that morning. Evidently, I presume because I did not

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embarrass myself too badly, she asked about my interests and career progress. She expressed what I interpreted as a sense of approval.

After a bit, I asked her about how her career had developed, as all young women surgeons do when they happen to encounter another surgeon they perceive to be like themselves; ie, someone with 2 X chromosomes who has run the happy gauntlet of a surgical career before them. Although I had no such ambition of my own at the time, I eagerly asked her about being chair of a department of surgery. Her reply was, "Oh, those deep dark days." She said it not with anger but with a wistful wise smile. I was stunned, and of course silenced. How could this dynamic, surgical icon have ever had a dark day in surgery? She was the epitome of surgical success, a master surgeon revered by her patients and beloved by her residents; ask anyone who trained under her mindful gaze. She was an accomplished scientist and clinical innovator, at the cutting edge of a new surgical discipline, and a potent force in American surgical policy. How could she have had a period of "deep dark days" in her surgical career, particularly in what would have seemed to be a most satisfying time?

I was disappointed, in fact fearful, that my own aspirations for a satisfying career in academic surgery could have been misguided. I was quite dismayed that such a powerful figure could have had such a bad time of it. Fortunately, for Dr Jonasson, the good news is that despite those years—and I have no idea what she really meant and I can assure you I did not explore it any further that day—she clearly regrouped, rebounded, and refocused her mission and once again found bliss in her career. Dr Jonasson resumed her relentless crusade for the cause of all things right that were presently wrong in surgery. She was a magnificent force. For the years after that exam, Dr Jonasson was a wonderful adoptive, available mentor to me in my career. Somehow, she took me on in her "worthy women" crusade.

But, I've thought about this exchange many times over the years, times when I've been happy and fulfilled in my career, and at times when I start to feel that slow burn of dissatisfaction. It happens in all professions no doubt, but for us surgeons, whose careers certainly can be consuming, and for which we have made so many sacrifices, willingly yes, but sacrifices nonetheless, a ripple in the positive energy field of our work is particularly unsettling.

I'm going to talk to you about finding insights into the highs and lows, primarily the emotional elements, of a surgical career. I propose to you that during our decades in this wonderful profession, from training to the waning years, you need a game plan to recognize the misery of spirit, which at times will creep into your career. And, you need a strategy to restore yourself when it does. I hate to tell you, but primary prevention of these downs is not available, so start building your resucistation plan now. I would like to give you some tools that I have often found useful, to help you with those "deep dark" moments. Fortunately, I believe these simplest of tools are available to all of us. I propose to you that keeping a living memory of 2 valuable senses: a sense of purpose, and even better, a sense of place, will serve you well.

Burnout is a well-documented and reasonably hot topic these days in surgery. Analyses derived from surveys a few years ago of some 800 fellows of the American College of Surgeons, performed by Drs Balch and Freischlag and colleagues, have yielded numerous publications about how "burnt out" we are. So burnt out, at times, that we deliver less than compassionate and effective care, unnecessarily place blame on ourselves, and lose the ability to enjoy the essential elements of surgery that called us to surgery in the first place.[1] Burn out and stress make us quit surgery, retire early, behave badly with our colleagues and families, divorce, abuse alcohol and other substances, and even place us in a high risk group for suicide. I know, I lost a dear colleague, a brilliant young surgeon, to suicide just a few months ago. Although burnout can hardly have been the sole cause, the stress of the extraordinary expectations we impose in our highly fueled lives may fail to allow us to seek badly needed help. When it comes to burnout, these are the findings—the facts—of how we view our sense of well-being. I must say, my initial response to these papers was, "Good heavens! How did this happen?"

Contrast this reported reality with the fact that we surgeons often pride ourselves on being members of a magnificent profession, a rare group of physicians who get to do what few others can, apply our knowledge and skills, hard-earned over many, many years of training, to cure people of dreadful diseases; to rescue them from critical injury; and to mend failing parts by using our knowledge coupled with our hands and our tools. Name another profession so privileged in mission. And, given our exceptional preparation, we are a particularly confident group; we do need to be, for many reasons.

First, of course, we ask our patients to allow us to care for them in ways that are unique and that demand absolute trust. We ask them to climb on a table, to go soundly to sleep, surrounded by strangers who will then care for them while we enter their bodies through incisions and portals, with the hope of improving health. We don't get good do-overs; we know our best opportunity is the first. If you are a surgeon, you had best convey a sense of confidence to that patient—in the vast majority of times, well-founded confidence, I believe, for that's what our patients expect and deserve.

Second, in regard to confidence, although with good preparation these days, aided by incredible imaging and diagnostics that limit our "surprises" compared to the days of old, we nonetheless occasionally will encounter a truly unexpected finding in the operating room. Or, perhaps even more challenging; we will, on occasion, need to mend an error created by our own hand. When that happens, we need to regroup, to recall out of our experience and knowledge tool-base, the wisdom to make the correct observations and decisions to execute an appropriate new plan right then and there. Outside of that critical environment of the operating room, like all other physicians (those cognitive types!), we would have the luxury of reanalyzing, getting more data, regrouping, and making a new plan; but in the operating room, we have a more limited set of options to progress and we need to make and move on with decisions, often with incomplete datasets that will lead, we hope, to the best result. That takes not only knowledge and skill, it takes confidence. Confidence to make best possible decisions, confidence to call a colleague if needed, and confidence to move forward with the hope of making a decision that will end in a good result for our patient.

And there is one other domain in which confidence matters. Our results, for the most part, show. We lose blood, our operations take variable amounts of time, our patients hurt and sometimes have complications, some preventable, some not. But nonetheless, our results, good and bad, do show. Sometimes our operations simply fail, or errors result in injury or worse, painful not only to our patients but to their families, and of course to us, the personally responsible surgeon, a surgeon who has harmed a patient. If these moments don't hurt you, if you can easily dismiss such events without careful review and self-awareness, I'm worried about you. And I hope we have few in our profession who do not suffer, for the needed period, when bad things happen. But in the end, assuming you really did do your best at the time to remedy the processes that led to that bad result, you need to get back on that horse and ride again. You need to ensure that your confidence to practice your craft is appropriately intact. For after all, a trained surgeon is a valuable resource to our society.

So we are a confident, proud, happy group, right? Well, on balance, yes. But this expectation for satisfaction can betray us. When we get unhappy in our careers, we are in some core manner breaking our covenant with our profession to be confident, proud, and happy. It hurts. I expect a pastor or priest who faces a challenge in faith may feel a similar loneliness and sense of loss. These moments will come to all of us, sometime or another, and we need to be mindful and prepared to address these times. Interestingly, relatively few surgeons in survey data or in personal comments suggest they would have preferred another professional pathway. Our training programs, perhaps the arduous routes we mandate, deliver to us a highly self-selected cohort. We all really want to be surgeons. I believe a primary passion for surgery really does exist in all of us.

We share a group think. We think the same things are funny, we like each other, better than we like, umm, internists. Much of this, of course, is based in shared experience and interest; some, more innately in shared sensibilities and priorities. Many years ago, Gerson Greenberg did a study that evaluated how we choose our residents.[2] He asked the attendings and the residents in the study to place in rank order the qualities that they valued, a list numbering from 1 to 40 qualities. Concordance was remarkable between the 2 groups, with compassion, honesty, and intelligence, and skill ranking at the top. Fascinatingly, when I was entering medical school 40 years ago, those characteristics would never have crossed my mind as being attributes of a surgeon. I will not reveal what my preconceptions were; just suffice to say, they were far less flattering. Of course, I had not yet met one.

Nonetheless, as we choose our successors, it is true we select people that want to be like us and vice versa. For my first 25 years in surgery, that meant that the majority of surgical faculty who were picking their successors as entering residents, had to "stretch" their perspective of "sameness" when faced with young women who chose to enter surgery. Yes, the young women seemed to be strangely like the young men who were applying, smart, compassionate, honest, and ambitious, but they were "different." Did they really know what they were signing up for; did they really want to be us, for a full career? Didn't they know that there were a lot of other options that were less "demanding" and family friendly? For years, until we reached the famous 30% composition rule of gender schema articulated by Virginia Valian,[3] which says we can judge individuals based on their performance rather than our pre-held unconscious biases, surgical faculty making their resident rank lists were required to explain "why" women medical students wanted to be surgeons. Something must be off kilter in these young women; did they really understand what they were signing up for? Now, long past that 30% mark at our entry points, our surgical faculty have learned to embrace and evaluate young women and men equally as future members of our profession. And, I believe, we will eventually get to that equity perspective at the leadership level as well. Perhaps not in my lifetime, but we will get there.

But, returning to how we surgeons self-select, it is fun to examine how this extends even to surgical specialty

styles. We all know that colorectal surgeons are funny and irreverent, plastic and reconstructive surgeons are a bit more intense and refined and always lovely; pediatric surgeons are a pretty serious group although they wear funny neckties and hats; trauma surgeons get bored really quickly if the Injury Severity Score starts to drop; surgical oncologists can be pretty excessively cognitive; transplant surgeons are wacko, but you've got to love them for their passion beyond belief; and cardiac surgeons think they are deities, which is a good thing given the frequency with which they have patients with deadly problems.

Personally, I was destined to become a pediatric geneticist, already considering pediatric residencies, until my last medical school rotation, having put that dreaded surgical requirement off to the end. Then, I met my first surgeons and made my first trips to the operating room. That was the end of genetics. Group think, shared sensibility, like attracts like: done. Gender never crossed my mind, despite the fact I had never met a woman surgeon at the time.

We surgeons have the same core values and principles (with a capital P), in caring for our patients. We believe in patient primacy, we believe in seeing our patients though their entire course of care, from illness until health, and indeed at times until death. We can make decisions. We understand that most bad things happen at night or at some other inopportune moment and that we will unwaveringly respond despite our fatigue and inconvenience. We get a real buzz out of doing our work in the operating room. Thankfully there are still many young people who want to be us, even as each generation refines what that means. We share certain core principles, values, and styles and we all fundamentally relish surgery.

Here's a fun example. At surgical meetings these days, I always stop in at a video session. When I started in this business, the video sessions were full-scale production movies that were shown at night once a year at the annual Clinical Congress. These were amazing movies of heroic cases performed by the masters. It was excellent theater. But now, of course, these sessions are ubiquitous and everyone can create and share their handy work, and they do so beautifully and willingly. When I go to a movie session, however, I go only in part to watch the surgery. I really go to watch the surgeons. Go inside the dark room. These rooms are intensely quiet. Surgeons watching surgery are silent. We barely breathe. No one chatters. No one dozes off. No one answers emails. The entire audience is watching, intently and silently. I really enjoy that total focused silence. It always reminds me that we, we surgeons, all really like this stuff. We hang together with this common passion. That's an up.

For those of us who are surgical educators, and actually all surgeons are educators, I don't mean to dismiss those who educate their patients, families, staff, and colleagues on a daily basis, but those of us who are charged with raising that next generation, we get to see our trainees embrace and develop these same passions. A young surgeon is almost as much fun as a new puppy; everything is exciting, unpredictable, and to be explored. But, raising a surgeon takes a lot more work than raising a puppy. But what a reward to see them mature into responsible, ethical, ready-to-be-delivered-to-our-communities surgeons and ready to join the ranks of our profession as life-long members. That is fun. For you educators, take note, even though it may seem daunting at times, that's another up. So why is it that a surgical career is not always full of bliss? I suppose we could make a long list of irritants. There are many reasons, the most obvious being that in addition to providing a valued and essential professional service to our patients, surgery is also a job, a means to support ourselves and our families. We get paid to do this stuff.

The current business of being a surgeon is personally taxing, often capricious, frequently infuriating. What are we supposed to do about that? I suppose we could all buy hospitals and make sure we kept them full of our patients, but I doubt that would add to our fundamental satisfaction, even though it could fatten our wallets. As much as we would all love to say that we can restore the old times, the glory days of (dare I say excessive) reimbursement and privileged practice, a return to that time is not in our stars. Our professional societies, no matter how large the political action committee war chests, are not going to be able to deliver us, unmodified, from this current transformation now upon us in health care. I simply don't think surgeons are going to make more money, regardless of how much harder we work. However, with any luck, and the abundant hard work of many volunteer surgeons and our organizations, I believe we will be able to craft a new order that will be fair and tolerable in supporting both our purpose as surgeons and offering a return on investment of our energies that is equitable and satisfying. This one is a down we need to turn into an up. If your bliss is in trying to influence new systems and policies, get involved to the extent you wish; influence as you can, choose the deliverables that will add value to your patients and your career, but remember, this is a long and winding road with no clear common destination. This is not a job for every one of us, but I am grateful to those who choose it.

Next problem, our careers are long, 30, 40, 50 years; I've even seen 70-year careers by notable surgeons in Texas! What we need to know and do is changing so rapidly that our heads can spin. How do we keep up, much less at the top of our game? Do we throw in the

towel and just keep doing things the way we always have? This is a looming, constant, threatening down, but we can turn this into an up, I think.

We surgeons are the ones who have 1-shot opportunities in patient care. We are the group who will need to define the new infrastructure needed to ensure a surgeon can safely retool in new technologies and procedures in non-patient–based learning and training environments. We can't repeat the sins, the patient harms, of our recent modern history as we prematurely disseminated laparoscopy, endovascular surgery, and more recently, robotics, allowing our learning curves to be fully born by our patients. We need new infrastructure: effective, efficient training environments for hands-on learning to proficiency, policies that support this training in the financial cost of delivering high quality surgical care borne by all the stakeholders of surgical care delivery: the surgeons, the hospitals where we practice, our payers, and industry. We need to build the educational and training infrastructure to support all of us for our 40 years in practice, to continue to improve.

I've had the marvelous opportunity to formulate a prototype facility for this infrastructure at my home institution in Houston; we call the place MITIE — the Methodist Institute for Technology Innovation and Education, a 35,000 square foot, spectacularly beautiful, magnificently staffed, high efficiency procedural training facility coupled to a technology and procedural research and development program. I believe MITIE can serve as an experimental platform to start to build and evaluate how best to develop a retooling infrastructure.

More than 30,000 health care providers in practice, mostly surgeons, in virtually all surgical disciplines, have come through MITIE's doors during these first 5 years of operation. I pinch myself each time I am there. Now that's an up. And for those who come to learn, a surgeon coming for a retooling experience in a new technology or procedure in a safe environment, the experience is nearly universally a most satisfying and professionally resuscitating event. That's another up. Never stop learning and retooling. As a profession, our job is to ensure we keep all boats afloat and indeed rising with the tide of quality and safety. Although MITIE has supported many health care providers in practice, the challenge to stay current remains a source of stress and challenge for many surgeons with uninterruptable busy practices. Lots of work to do here.

Another problem, particularly for that 10% to 15% of the surgical workforce who live in administrative and other leadership roles in their health care communities, is that these jobs we take on are not clearly jobs about surgery. They are jobs about managing people, working with other disciplines, business, and delivery of health care and systems of care. Where is the surgical purpose in these roles? It is there. It is essential work, but it is not for everyone. Only those who relish this dialog and have the capacity to take these missions on for the greater good should take these jobs. These jobs are about service, not empowerment, and they are tough jobs and are getting tougher all the time in these challenging times. These are potential areas of bliss for some, and real downs for others. Make sure you know where you belong before taking on one of these. And of course we all know that having the job of a surgeon can be personally consuming, with long hours, unpredictable schedules, broken promises to family and friends, and no time for personal interest and relaxation. Simply put, surgery as a job has the potential to be miserable.

So, I contend, the key is to figure out how to keep surgery from becoming a job. I don't care if you are a baby boomer, generation X, Y, or millennial, you need to figure out how you are going to keep your surgical career from becoming a job.

There is great emphasis these days on personal wellness; life balance, personal time, and individual sense of purpose. Many counselors, coaches, and others propose these as strategies to improve your sense of success and happiness. Those may be laudable goals; however, I do not believe that these individual purposes can solely sustain you in a career as demanding or essential as surgery. These things cannot routinely make you happy in your career. They cannot correct a practice partner who fundamentally differs from you. They cannot remedy a fundamentally flawed work environment or other sore point. They cannot offer you control of the uncontrollable aspects of your job, nor can they create more hours in a day. These things cannot remedy your gnawing discontent when you recognize that financial reward has become a driver of your practice as a metric of success, to meet your own expanding needs or the standards expected by your family or peers of success. This individual sense of purpose cannot remind you why, the essence of why, you really became a surgeon. What drew you to this passionate field of medicine?

I propose that whenever you approach one of those doldrums or dispassionate or aggravating moments that you pause and seriously try to recall what drew you to this practice. Remember the patients you first touched, remember your valued teachers, recall those moments in training and the fun and formative experiences you have had. There are 2 years of my life for which I have no recollection of life outside of the hospital. Shocking, I suppose, and no doubt a miserable time for my husband. But, for me as I recall, these were wonderful times. We residents of all sorts were together, learning, taking care of patients and each other, laughing, living. We were a vital community,

a group with a real sense of place and purpose. We certainly knew why we were there: to become surgeons. And we shared a place to do this.

A sense of place describes the essence of an environment that defines your relationship to it. Your sense of place is dictated by the experiences you have had within it, the thoughts and memories that you have generated in it. It defines your human experience in a building, a landscape, a community. A sense of place evolves with experience, with memories, with reunions; the people in it; the intensely personal moments you have had there; and your linkage to the purpose, activity, and values of a place.

In those years, my group of residents (as I expect did yours) shared vital and intense experiences, often filled with life's greatest mysteries; unanticipated recovery, death, unimaginable grief, and wonderful joy. I can still feel the ICU reclining chair where I occasionally dozed for a minute or 2 in the early hours of the morning by the bed of a patient near death, or the trauma bays where we tried to snatch the injured from death, and of course, our operating rooms. I can recall the shape and setting of each and have distinct memories of times with my surgeon mentors in so many. I can remember "accidently" transecting the esophagus rather than the proximal stomach as Dr Tsangaris, in his very deep, gentle slow voice said, "Barb that was a little higher than we needed… not to worry." I can remember turning off the ventilator of the young blind woman who worked in our hospital as a transcriptionist and came every day to work with her beautiful German shepherd guide dog, until the day she stumbled off the subway platform and sustained lethal head injuries. Dr William Knaus, the intensivist who was creating the APACHE score at the time, comforted me while I sobbed, perhaps the only time I really cried with overwhelming sadness during my training. I remember rounding with Dr Kathy Anderson at Children's Hospital in DC, in the neonatal ICU, for weeks, with a baby who would not allow her beautiful little mouth to be used for any useful purpose, having missed the chance to learn how to suck due to her many operations for gastroschisis. These memories are precious. They form my sense of place and purpose.

And over the many years I have been in practice, I have developed an equal familiarity and comfort in the same environments in the several hospitals I have called my professional homes. There is not an operating room in any city around the world that I have ever entered that I did not find in a very funny way to be a very familiar place.

I guarantee that all the senior surgeons in this room can describe to you the sense of place that nurtured them as they grew into surgeons during their training and, no doubt, in an ongoing way in their subsequent hospitals. As physicians, and especially surgeons, these are our special places where only we can float comfortably and do our most valued and special work. This is one of those great shared experiences, this sense of place that hospitals and operating rooms provide, that binds surgeons together. They remind us of our real purpose as a profession. Remember this very valuable tool to restore your ups.

It took a special experience to allow me to articulate the value of this sense of place for me. It dawned during one of many trips to Europe, to my dear France in particular. I was in Beaune, in the heart of the Burgundy region of France, during a crisp beautiful fall; the smell of burning vines was in the air. I stopped in one of the notable tourist destinations in the region, the Hospice de Beaune, also known as the Hotel-Dieu de Beaune. Beaune is very famous for its beautiful medieval buildings with geometrically ornate colored tiled roofs. I love to travel and marvel at the world's most beautiful and meaningful creations; cathedrals, masterpieces of creative works, and the special meanings they convey, and I expected one more beautiful creation this day. Before I go much further, let me tell you the story of this place. A story I did not know as I entered.

In 1435, the Hundred Years War between France and England was nearing its end. One of the victors of this war was the great Duke of Burgundy, Phillip the Good. It turns out his chief chancellor was a certain Nicolas Rolin, an exceedingly powerful and efficient minister. He acquired great wealth and privilege in his ministerial duties and was known as a most effective, but at times, less than generous administrator. After losing his first 2 wives to disease, his third wife, Guigonne de Salins, requested that he use his wealth to demonstrate his good will toward the people of the region of Beaune. Together they founded the Hospice de Beaune in 1442. Their foundation was established to serve the needs of the destitute peasants who had been ravaged by years of war. During the 10 years after the founding of the foundation, they built a state-of-the-art facility, L'Hotel-Dieu de Beaune, to provide health care to the poor, elderly, sick, and disabled people of Beaune and its region. Mind you, this was at a time when health care, such as it was, was best provided at home with the services of a physician, for the wealthy few, who would come to visit. The poor simply fared on their own. To assemble such patients into hospital structures was a radical construct.

The Hotel-Dieu de Beaune, with its exquisite tiled roof, received its first patient in 1452, and unbelievably, remained in continuous operation until 1971, when a new modern hospital was built outside of town. The Hotel-Dieu de Beaune of 1452 had remarkable structural

features. It was built over a small river that runs through the town to facilitate use of fresh clear water from upstream. It was staffed by the Sisters of the Hospitalier, a new order founded to care for the sick. A state-of-the-art pharmacy, surgical instrumentation, learned physicians, and all other remarkable modern amenities of the late Middle Ages were provided for the welfare of the poor. It was an unprecedented concept in health care—a facility treating poor patients with dignity and compassion using sophisticated care of the age.

Not only was it a magnificent functional structure, it was also adorned with glorious commissioned works of art, the art I had intended to see that day; art that was installed in 1452 to inspire the souls of the patients and to support their emotional and spiritual needs. To heal patients was more than to provide remedies, it was to provide hope. After the 500-year-old hospital moved to a new site in 1971, the old Hospice de Beaune was completely restored over the next 25 years to the original structure of 1452. This is where my recognition of a sense of place comes in.

On that fall day, before I knew any of this story of the Hotel-Dieu, I walked into the grand hall of the building looking for art. Immediately, I was overwhelmed almost to the point of breathlessness with a sense of familiarity. A sense that this was "a place of my profession." The soaring arched wooden ceiling with gargoyled timbers looked down on 2 long rows of beautifully draped hospital chambers, some 40 or more, each with a small bed, table, and basin with rich crimson curtains placed around for privacy, with a large open central space for the work of the sisters. This, to me, was immediately not an artistic historical masterpiece, although it certainly was that, with exceedingly valuable and rare paintings and statues adorning the walls. This place was a hospital! It was a place that served the purpose of us doctors and nurses and, of course, our patients. I knew what had happened here, I understood the people who worked here and the patients who lived and died here. Though more than 500 years old, this place cried out that it was a place of healing. To me, this recognition was so powerful, so unexpected that I was startled. I looked at my husband and younger son and others in the room who were marveling at the art and statues and magnificent architecture, while I was overwhelmed with the sense of the physicians and patients who had been treated for so many years in this very place. I was stunned, silenced, and comforted.

This experience catapulted me to the present and made me mindful of all the places and shared experiences that our houses of healing have created. It reminded me of the sense I had when I stepped into the grand foyer of the old Charity Hospital in New Orleans, of Grady Hospital in Atlanta, of every VA hospital lobby I have ever had the pleasure of entering, of my now so comfortable Houston Methodist Hospital, and of oh so many operating rooms. We, collectively, have built hospitals and clinics and used them, but actually they become vital living structures that allow us to serve our purpose unlike any other places. These are not just structures with people in them doing work, they are special environments for us and our patients where our healing is done, our compassion is shared, patients' lives are lived and lost, and the next generation of doctors come of age. They convey the most powerful sense of place. Please, you must all go to Beaune someday. I want you to feel this place.

For those of you still in training, when you get back to your teaching hospitals, clinics, and operating rooms, I want you to consciously look around your environment. Breathe it in; feel that sense of place. It will sustain you when times get tough. And when you start feeling flustered, disillusioned, and angry, think back, find your roots, and use them as resuscitating events. Remembering these things may well help remind you of the purpose of your life as a surgeon. It will remind you not of your individual purpose but of our professional purpose, which, by virtue of your choice of surgery as a career, you have taken on as your own. Remember, we exist as surgeons not because we want to be a surgeon, but because the people of our society need us to know how to take care of them with our surgical skills when they are ill.

Remember, resuscitate, breathe deeply. Look around at the places where you practice your profession. Reflect on shared purposes with your colleagues. Recall valuable places and the important purpose you serve. It will keep you fresh and vital, and reassure you that you truly did make many important, very correct, choices in selecting your surgical career. Thank you again for the honor of this opportunity. I am truly humbled to be here with you.

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