Professional Dissatisfaction: Are Orthopedic Surgeons Spoiled?

Richard H. Gross, MD

Several years ago, I was on the American Academy of Orthopaedic Surgeons leadership fellow committee, reviewing fellowship applications. The committee had been poised to very favorably rule on an application until a new member spoke up, stating that he had been in the applicant's department and that points made in the recommending letter bore little resemblance to the person's performance. Further study confirmed the dishonesty in the letter, and a more fit candidate was selected instead.

I was puzzled. Why would a leader in the field do such a thing? The question led me to a personal investigation into the monumental topic of professionalism and, more specifically, professionalism among orthopedic surgeons.

Physicians, Especially Orthopedists, Are Not Happy

Physicians, in general, are not a happy lot. According to a 2012 survey by the Physicians Foundation,[1] 77.4% of practicing physicians were pessimistic about the future of medicine, and 82% thought they had little ability to change the health care system. Sources of pessimism included "too much regulation/paperwork, loss of clinical autonomy, physicians not compensated for quality, erosion of physician/patient relationship, and money trumps patient care." We are now in the age of "organizational physicians," who, subject to institutional management, are experiencing a distressing loss of autonomy.

What sustains, or does not sustain, surgeons' career satisfaction? Commonly stated positive factors include the ability to provide quality care, time with patients, income, and financial incentives[2]; reported negative factors include threat of malpractice, lack of autonomy, excessive administrative tasks, and high patient volume. Early-career physicians have the lowest career satisfaction, but physicians in mid-career have the highest rate of burnout and likelihood of leaving medical practice.[3] Work–home conflict is most difficult in the early career, when families have young children, and the conflict generally goes unresolved. Burnout and low satisfaction with specialty choice are most common in mid-career.

Despite all the negative factors acting on medical practices, orthopedic surgeons have fared well financially, but not as well in career satisfaction. The *Medscape Physician Compensation Report 2014*[4] places orthopedics compensation first among 25 specialties listed, without a close second, but orthopedists rank 15th in thinking they are fairly compensated, and next to last in indicating they would choose medicine again as a career. A separate study of physician career satisfaction ranked orthopedics 32nd of 42 specialties studied.[5]

What is our problem, and what can we do about it? It's hard to digest this information and not feel that orthopedists are, for lack of a better word, spoiled.

DeBotton[6] wrote about *status anxiety*, which arises over and over again in daily life. Essentially, it is the envy or dissatisfaction one feels when a peer gets a better deal that does not seem just. A remarkable aspect of Medscape's compensation report[4] is that family medicine physicians, whose annual income was well under half that of orthopedic surgeons, were more likely to view themselves as fairly compensated. On this basis, we have to conclude that orthopedic surgeons have status anxiety. But why?

Humanism

Osler, the quintessential physician, counseled medical students: "Nothing will sustain you more potently in your humdrum routine … than the power to recognize the true poetry of life—the poetry of the commonplace, of the ordinary man, of the plain, toilworn woman, with their loves and their joys, their sorrows and their griefs."[7] In short, take the time to know your patients. In a study of physicians who were regarded as clinically excellent, several traits were noted: honest, nonjudgmental, genuinely caring, treating all patients equally, and constantly striving for excellence.[8] A century after Osler, Stellato[9] echoed the sentiment: "Listen to your patients, not just about their illness, but about their life."

Dr. Gross is Research Professor, Department of Bioengineering, Clemson University, Clemson, South Carolina; and Emeritus Professor, Department of Orthopaedics, Medical University of South Carolina, Charleston, South Carolina.

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Address correspondence to: Richard H. Gross, MD, 68 President St, Suite 302, Charleston, SC 29425 (email, grossrh@mac.com).

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Humanism, then, is the trait underlying professionalism.[10,11] Communication skills are essential to humanism.[12] However, a study of specialty physicians in Spain "showed scarce empathic behaviours or behaviours that foster a shared decision making process."[13] In addition, a recent survey placed the communication skills of orthopedists last among 28 specialties.[14] Assessment was based on how often a physician *explains things, listens carefully, gives easy-to-understand instructions, shows respect*, and *spends enough time.*

Could it be that orthopedists are not satisfied with their income because as a group they lack the communication skills and humanistic characteristics of lower-paid physicians?

Residency and the Academic Medical Center

The education of the orthopedic surgeon starts with the selection process. Simon[15] noted that "the brightest, but not always the best" are selected largely because objective criteria are an excellent measure of cognitive achievement but not of character. Also noting that 10% of examinees pass part I of the board but fail part II, Simon opined that they "lack clinical judgment, communication skills, and, in some instances, ethics." A 1999 team of authors found that 18% of research citations listed by orthopedic residency applicants were misrepresented, and a follow-up study by the same authors in 2007 noted a rate increase, to 20.6%.[16] Both sets of authors wrote of a need for a better selection process and a better evaluative process during residency.

The residency process has been substantially altered by work-hour restrictions. The 20th-century residency, which emphasizes taking responsibility for the patient throughout a hospital stay, has now been dismissed as "nostalgic professionalism." Residents are now advised to avoid such activities as checking laboratory results from home and coming to work when they are not feeling well.[17] However, there has been considerable pushback against diminishing nostalgic professionalism, primarily from surgeons.[18] "Teaching residents that they should go home to rest at the end of their shift without regard for the circumstances of their cases in progress is not an acceptable example for training."[19] Current promulgated restrictions on duty hours move concern for the "circumstances of their cases" to the back burner—the shift ends, the physician leaves. Residents are pulled one way by forces telling them to leave (Accreditation Council for Graduate Medical Education) and the other way by forces telling them to stay (their conscience).

How do residents develop their surgical identities and concepts of humanism and professionalism? There is a substantial body of evidence that the so-called hidden curriculum is the dominant factor: trainees emulate what their faculty say and do.[20] As Gofton and Regehr[21] noted, "It is vital for members of the surgical academic community to recognize [that] the attitudes, beliefs, and values implicit in every action, every word, every inaction, and every silence are not only shaping the attitudes, beliefs, and values of one's protégés, but also are shaping the decisions of students who are considering the possibility of becoming one's protégés." It is not easy being a surgical role model given the conflicts affecting academic surgeons. For example, should a surgeon allot extra time so a trainee can do a case properly, or should the case be finished expeditiously in order to avoid canceling the next case, or to get to a committee meeting or a kid's ballgame on time? Monetary pressures, along with the possibility of losing operative time because the schedule was not full, can influence the decision to operate or not.[22] Trainees absorb what they hear and see.

In 2003, Inui[23] published *A Flag in the Wind: Educating for Professionalism in Medicine*, in which he stated, "There can be little doubt that physicians in general as well as the leadership of the organization of medicine have been preoccupied with finances and the economics of medical care. … The topics and the language of academic leadership [have] shifted in the last twenty years. … Core functions of the academic medical center became 'enterprises.'" He also noted, "The most difficult challenge of all may be the need to understand—and to be explicitly mindful of, and articulate about—medical education as a special form of personal and professional *formation* that is rooted in the daily activities of individuals and groups in academic medical communities."[23] In addition, the "institutional environment we create … [is] a reflection of the values we hold as a professional community."[23] In effect, the academic medical center is part of the hidden curriculum.

Curiously, academic institutions tend not to reward clinical excellence—a self-defeating measure for any institution that recognizes the importance of the hidden curriculum.[24] A peer evaluation of hospitalists revealed that the most highly regarded were highly associated with humanism and a passion for clinical medicine.[25] At a prominent institution, however, it was found that clinical educators were less likely than research faculty to hold a higher rank.[26]

Of the factors affecting physician dissatisfaction, workplace stress is predominant.[27] In this age of organizational physicians, job satisfaction correlates with how a physician feels about his or her ability to function as a *physician*. In a study by Wai and colleagues,[28] "surgical faculty reported low satisfaction with a number of questions about communication in their medical schools and their clinical practice locations." The authors indicated that "medical school and department governance are critical determinants of faculty satisfaction within academic surgical centers." Pololi and colleagues[29] extensively studied the culture of academic medicine and summarized the sources of discontent: "competitive individualism, undervaluing of humanistic qualities, deprecation, and the erosion of trust." In another study,[30] they studied the incidence (~25%) of, and reasons for, considering to leave academic medicine. Reasons included feeling isolated in the department, lack of institutional support, poor communication with administrators, and a perceived difference between the stated culture of the institution and what was observed on a daily basis.[30]

What Can We Do?

The obvious starting point is the selection process—focusing more on finding the "best," not necessarily the "brightest."[15] This is not easy. Recommendation letters are often based on limited contact and may or may not reflect applicants' true

character. Numerous websites advise resident applicants on what questions to expect and how to prepare and practice for them. I have found questions of current events very illuminating, as they can probe how applicants view the world. Given the high income of orthopedic surgeons, some applicants likely are attracted to that aspect of the specialty. These applicants are not the "best."

Residents who exhibit questionable ethical reasoning or behavior must be identified and not be allowed to finish their program. It is the responsibility of the program, not the board, to ensure that those entering practice exhibit a high degree of professionalism. Faculty must seriously recognize, every day, that everything they do is part of the hidden curriculum.

As noted, the academic medical environment can be inimical. Faculty who experience dissonance must be able to effectively confront administrative leadership to express their concerns, and they need to feel their concerns are recognized. Leaders of academic medical centers must guide their institutions in such a way that the day-to-day functions are compatible with the stated mission and values.[31]

Chervenak and colleagues[32] forcefully stated that "appropriate ethical values" are the core component that academic leadership needs in order to respond to the opposing forces of increasing pressures of patient satisfaction, compliance, liability, and other administrative demands on one hand and diminishing resources on the other hand. They listed 4 "professional virtues" that characterize responsible professional leadership: *self-effacement*, which obligates physician leaders to be unbiased; *self-sacrifice*, the willingness to risk individual and organizational self-interest, especially in the economic domain; *compassion*, or "What can I do to help?"; and *integrity*. The principles of effective leadership are not that complicated, but implementing them requires conviction and courage.[33]

Physicians increasingly are practicing in the organization setting. They need to increase their involvement in the organization in order to promulgate the needs of physicians. Organizational executive leadership is primarily driven by budgetary and capital planning processes; physician input is essential to ensure resources are directed toward better patient care. A feeling of loss of control over one's practice is a primary cause of physician dissatisfaction. The schism between physicians and administrators traditionally has been characterized by a lack of trust; a more trusting relationship, reinforced by frequent constructive dialogue, will result in more physician control of the practice.[34] This will be difficult, but it is necessary for improving professional satisfaction.

For practicing physicians, Wynia[35] made the compelling case that professionalism demands self-regulation, which involves identifying and reporting impaired or incompetent physicians—another task that requires conviction and courage.

But the core issue is how an orthopedist regards the day-to-day aspects of his or her practice. Shanafelt and colleagues[36] concluded that surgeons are not very good at assessing their own well-being and stress levels. Certainly high stress can affect well-being, which in turn can affect professionalism. West and Shanafelt[37] uniquely described this relationship: "The effect of distress on professionalism in medicine has become clear in recent years. The well-documented decline of crucial elements of professionalism, including empathy and humanism, during medical training appears to be related in part to personal distress experienced during medical school and residency. Unfortunately, this decline continues as physicians move into practice, where distress also is associated with decreased compassion and empathy." This description sounds completely synchronized with the current career dissatisfaction of orthopedic surgeons.

Improving orthopedists' status requires ethical and involved leadership, both in academia and in our professional organizations, which too often seem mired in the (not so effective) status quo. Recognizing that the resident selection process is fallible is the first step in taking action—engaging in scrupulous role modeling and insisting that residents demonstrate professionalism and communication skills in their daily work. Becoming involved in organizational management is preferable to becoming angry and dissatisfied. Getting to know one's patients is its own reward in terms of career satisfaction. Orthopedic surgeons have a well-earned macho image—that image can be enhanced with a dose of humanism. The result would be a true professional who enjoys his or her practice and has a satisfying career.

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