Commentary: The third victim

Thoralf M. Sundt, MD

We often see articles addressing new operative interventions or risk factors for operative outcomes. Less often do we see publications identifying a new disease deserving of our attention. Ungerleider and colleagues present the latter. We likely all have a sense this problem exists, but not its extent given our own personal silos. Their findings are disturbing even if not surprising. To be sure, there are methodological problems with the study; we cannot be sure of the true denominator to determine frequencies or the influence of bias in the response rate. The latter is likely because people are more likely to pen (or post) a complaint than a compliment. But the value of this study is not quantitative as much as qualitative. We have a problem.

Recent attention to the so-called second victim of adverse medical events has inspired interventions to support physicians. But the authors here have identified a third victim—our families and loved ones. This appears in fact a more pervasive problem caused not by occasional adverse outcomes but the constant stress of our profession. Damage to these relationships influence our ability to deliver care, but isn’t it also unfair to our significant others? Sadly, the subgroups most influenced are those early in their careers and those with young children. Apart from the empathy we should feel for them as human beings, these individuals are the future of our specialty. We get worked up over the threat to the specialty posed by progress in interventional cardiology. Perhaps we should reflect a bit more on the threat we pose to ourselves.

It may feel a bit unfair to put the burden on us, but we are surgeons and we are problem solvers. Although economic pressures surround us, in this instance we must ask what can we do that is within our control to ameliorate the situation. This may be a challenge for those of my generation, reared in an ethos of heroic sacrifice: You knew it was going to be demanding when you entered the specialty. We believed this was self-sacrifice, but clearly others pay as well. This study challenges us to change.

This brings me to Keith Naunheim’s Southern Thoracic Surgery Association address, “The Imperative to Change.” Wrapped in the humor for which he is well known, Naunheim acknowledged reluctance to change but identified the existence of hard data as a key to success. Now we have some. He asked us to consider if, given a challenge in the specialty, we were going to be whiners, bystanders, critics, or navigators. Notwithstanding his employ of Jerry Garcia’s quote “Somebody has to do something and it’s just incredibly pathetic that it has to be us,” he challenged us “to improve the health care delivery system for our present patients, our future patients, and those practitioners who will come after us.” In this case, an element of that system is us—and our relationships. It is our responsibility to the next generation to leave cardiothoracic surgery better than we found it.

References