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Invited Perspective

Sustaining Excellence Over a Career

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Excellence can be defined as the quality of excelling—possessing good qualities to a high degree. It can also be defined as exceeding expectations. I have the good fortune to be enjoying a 40-plus-year academic career as a pediatric orthopaedic and spinal deformity surgeon, researcher, teacher, and orthopaedic leader. In each of these roles, I have always been motivated and sustained by a multitude of interrelated factors. There are many published books or articles on *sustaining excellence* and these publications may unpack these concepts in different and perhaps more articulate ways. The concepts below were developed and driven by mentors and personal perspectives and experiences during a career in pediatric orthopaedics. I have been fortunate to spend the last several months of in-depth personal reflection after being asked to contribute this Invited Perspective to *JPOSNA*®.

My Own Expectations

Vince Lombardi said, "Perfection is not attainable, but if we chase perfection, we can catch excellence."[1] Excellence is a relative condition, achieved by going above and beyond expectations set by institutions, others, or yourself. The fundamental motivating force for me has always been meeting and then exceeding my own very high expectations and keeping that bar moving up and up and up. This requires constant self-assessment after every surgery, every lecture or presentation, every board or committee meeting, and even after my morning run or bike ride. Even after a successful experience, we can almost always come away with opportunities for improvement. Some would find this exhausting, but I've always found it exhilarating.

Dr. Weinstein, Assistant Professor, the University of Iowa, 1976.

Exceeding the Expectations of Others

Working in an academic department at a major university, I wanted to meet and exceed the expectations and metrics set by the department and institution. In that context, one way to frame excellence is to consistently put the needs and expectations of our patients first. We should try to put ourselves in their shoes and ask, "If this were my son or daughter, how would I want them cared for? What treatment options would I consider (or more importantly, not consider) if a loved one was in this situation? What do our patients and their families deserve from us and our teams in the clinic, in the operating room, or on rounds?"

I try to put myself in the position of the patient, the audience in a lecture, or my fellow board and committee members and anticipate what they want, need, and expect from me. As teachers, we should try to envision the learner's perspective to provide them not only with the information we think they need but the information we know they need to be good practitioners. I give

Perthes Study Group, 1983. Back row: George Thompson, Neil Green, George Rab, Timothy Ward, and Stuart Weinstein. Front row: Gail Speck, Hugh Watts, and Tony Herring.

the same series of 10-12 lectures every 2 months to the residents and students on the pediatric orthopaedic service, yet I redo each lecture after every rotation. I am always looking for ways to improve their experience. I modify, take out, or add new material or case examples as it becomes available. I always make sure to cover the topic in an unbiased fashion but also give the topic my perspective and the evidence to support that perspective.

As my career became focused on pediatric hip and spine and the range of surgeries likewise narrowed, I always stayed focused on the moment and the individual patient and how their anatomy, pathology, and other circumstances made them unique. The responsibility of being entrusted by parents with their child requires that we bring our A-game to work every day. Preparation helps us avoid overconfidence and ensures we meet expectations (while avoiding complications and not making the M and M list!). While all of us can and should take pride and get enjoyment out of our successes, self-satisfaction leads to complacency. When I become complacent, it will be time to think about doing something else.

Humility and Managing Complications

In her discussion of humility, Dr. Anna K. Schaffner suggests "…humility is a perfect antidote to the self-fixated spirit of our age."[2] Surgeons are not generally known for humility, but it's exactly what we need. Humility is needed to develop collegial, nurturing relationships that directly or indirectly improve patient care. I try to remember, despite my age and experience, I don't know everything, and I am frequently not the smartest person in the room. I especially try to remember that sometimes the smartest person in the room is my patient or their caregiver. Along with a certain degree of humility is the understanding that nothing we do in our careers should be motivated by self-promotion. It is incumbent for providers to remember that the goal of our careers, in all their dimensions, is to serve our patients, their families, and the organizations that make all our lives better and to guide our actions by those goals.

Hopefully, young surgeons start their careers with some degree of humility as would be commensurate with their clinical experience. Over time, however, contributing to humility is one's life experiences, particularly those which involve dealing with adversity, disappointment,

Dr. Weinstein with Prof. Ignacio Ponseti and past Iowa co-resident Dr. Dennis Wenger, 1993.

and unmet expectations. These challenges to personal development come in many forms and gradations—from patient complications, to not getting an organizational leadership role or committee position, to having your research work rejected from publication, and so on. When you fall short of your motivational goal to "make things better" (patients, organizations, etc.), how you cope with these expectation failures can have a profound effect on your personal quest for excellence and in some cases your self-worth.

Despite bringing your A-game to work every day, patient complications occur in everyone's practice. The magnitude of the complications varies, and the ability to deal with them on a personal level may prove a most difficult challenge. Having a patient die in the operating room, causing a neurological defect during deformity surgery, or having any unexpected intraoperative complication not only causes a life-altering event for a patient and their family but also for the surgeon, the so-called second victim.[3] How one copes with these adverse events is an aspect of a career, albeit unpleasant and often unbelievably stressful, that must be addressed in trying to sustain excellence.

When adverse patient events happen, surgeons naturally feel personally responsible and that they have failed the patient. Depending on the seriousness of the adverse event, many surgeons begin to second guess their clinical skills and knowledge base. Many report difficulty concentrating, declining clinical judgment, loss of confidence, trouble sleeping, and difficulty enjoying daily life.[3,4] Other reactions include frustration, embarrassment, anger, blame, worry about reputation, and reduced job satisfaction. Depending on the seriousness of patient complications and one's ability to cope with the event, a surgeon's response can vary from *getting by* and moving on to dropping out, stopping surgery, or even stopping practice.[3-5]

There are no brilliant solutions to coping with these events, but what is most important is to have institutional and personal support mechanisms (colleagues, mentors, friends, etc.) to help deal with these most difficult situations. Knowing that you did all that you could to acknowledge and inform potential risk, mitigate that risk, and empathetically manage sequelae can help. Thus find the time to have a pre-surgical open and transparent dialogue with the patient and family, go to the operating room totally prepared for the case at hand, and go over each step of the surgery in your mind well before the actual surgery. Having confidence in your preparation and your abilities, maintaining total focus, and avoiding distractions during the procedure are the keys to meeting your and the patient's and family's expectations as well as dealing with untoward outcomes.

Disappointment and not meeting personal expectations are more common issues that one must address. Not getting a committee assignment, an organizational leadership position, a desired position, or having a paper or manuscript rejected are real-life challenges to many motivated individuals. One needs to put these types of *failures* of not meeting expectations in proper perspective. Keeping yourself focused on *what's important* is critical to sustaining excellence. These types of failures to meet personal expectations are less important in the scope of a career. They should never diminish your self-worth. Each of us in our own way is having a positive impact. Keep in mind that you are *making a difference* in the world each and every day you go to work. After a disappointment, it is important to take a step back and realize all the good you are doing as a doctor and a surgeon. You *are making a difference* in your patients' and their families' lives. Keep the motivational aspect in mind that the goal of each of our careers, in all its dimensions, is to serve our patients. That's why you became a doctor and a surgeon.

The Need for Evidence

The foundation of my orthopaedic career was heavily influenced by mentors who valued evidence-based medicine (even before it was a buzzword) and who were not motivated by financial pressures. Our professional careers are about patients, families, and organizations, and how do we make them better?

Dr. Weinstein with recent AAOS President Dr. Kristy Weber, in 1997, at The University of Iowa Residency Graduation.

Striving for excellence in patient care or in organizational work warrants establishing internal and external metrics that expand the evidence base. We don't want to be just doing an activity, but we want to achieve metrics that have meaning. In patient care, it is about tangible metrics—improving outcomes, improving function, alleviating pain, higher levels of decision-making, and more efficient surgery.

In the organizational world of board and committee meetings, expectations start by being respectful of everyone's time and opinions—not meeting just to meet, wasting time by lack of preparation, going over information that could be read independently, not focusing discussion time on important issues and valuing everyone's input.[6] In organizations it's about moving the organization forward and so on. It is humbling to realize that much of what we do is based on low levels of evidence and a lot of so-called expert opinion. There is immense variation in our practices with often little evidence for the effectiveness of different approaches. Requiring evidence pushes me to keep my knowledge base current, to put perspective in the levels of evidence I use in decision-making, in evaluating the literature I read, the lectures I attend, and so on.

Dr. Weinstein in his role as AAOS President, 2005-2006.

Having done many long-term follow-up studies of treated and untreated patients of various pediatric hip and spine conditions and having actually seen and examined these patients helps to keep this perspective always front and

center in my thinking. In the surgical field, constant follow-up of your own patients also helps keep this point of view in proper perspective. As one of my learned colleagues said, "Nothing destroys confidence like follow-up." The constant quest for evidence mandates that I continuously review my surgical results and compare them to available benchmarks.

Most of what we do in medicine is neither black nor white but with varying shades of gray. This leads to another motivational factor, especially if one does basic science or clinical research, the quest to try to answer clinical and research questions that bring better treatments or more appropriate treatment options to patients. Even if you don't personally do research, I feel strongly that we all should support research by supporting colleagues who do it and the funding organizations that support research such as OREF, POSNA, and SRS.

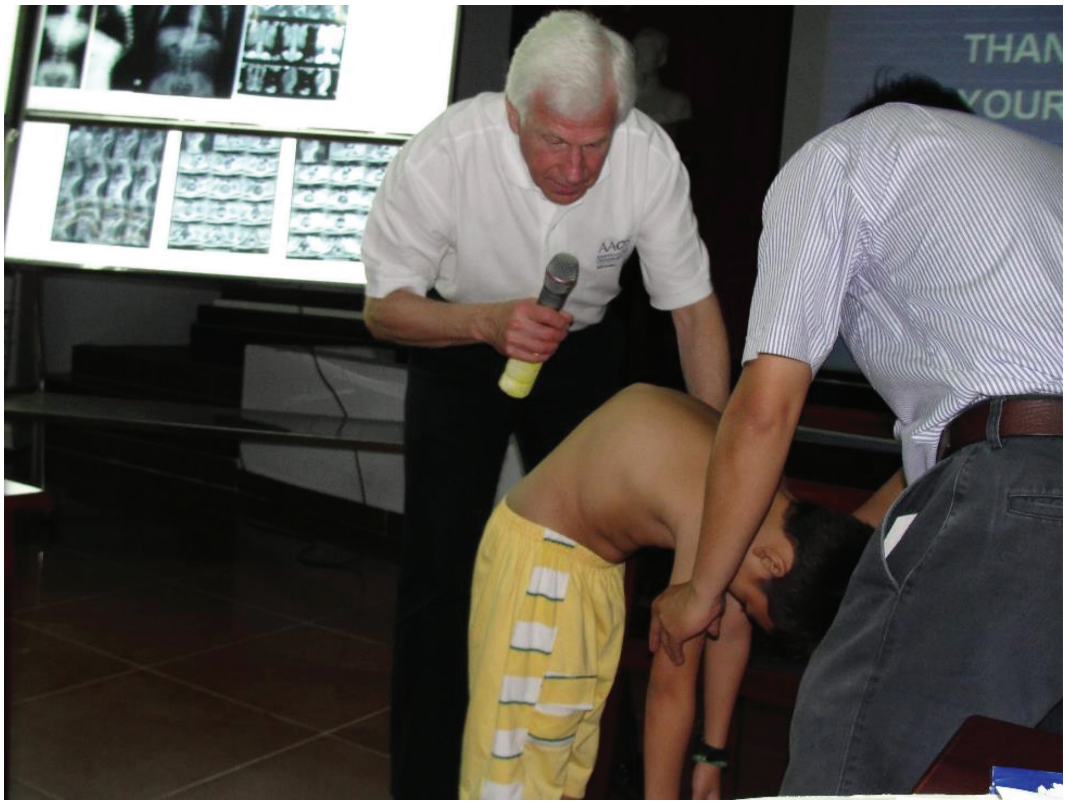
Staying Current

Medicine continually evolves and even those at the top of their game must work to stay current and relevant. I'm constantly reading the orthopaedic and health policy literature and understanding and developing skills for new procedures (even if I don't personally think they are ready for widespread use).

Throughout my career, I have always budgeted time to try to visit and spend time with individuals I considered *thought leaders*—seeing patients in the clinic with them to learn their thought processes or watching them do newer surgical techniques while deciding if I could or more importantly *should* incorporate these procedures into my practice. As an example, having started my spinal surgery career during the Harrington rod era, I had to learn all of the subsequent techniques and approaches on my own (open anterior spinal surgery with Dwyer or Zielke instrumentation), Cotrel-Dubousset (CD) and other posterior instrumentation systems, pedicle screw techniques, vertebral column resections, spinal tumor removal, trauma care, pedicle subtraction osteotomy, etc.). Early In my career, I spent a month with John Hall at Boston Children's to learn his approach to spinal deformity treatment. I also spent time with Drs. Bob Winter, John Lonstein, and David Bradford at the Twin Cities Scoliosis Center to gain their perspective on the various spine deformity approaches. After studying CD instrumentation in 1984, I invited Prof. Jean Dubousset and Dr. Harry Shufflebarger to come and critically review my cases.

Over the years, I employed this same approach to pediatric hip disorders. I spent a month with Dr. Bob Salter learning his approach to hip dysplasia and with Dr. Wood Lovell at the Atlanta Scottish Rite Hospital on his general approach to various pediatric hip conditions. When I felt that the Pemberton Osteotomy might offer my patients more options than the Salter Innominate Osteotomy; I spent a week with Sherman Coleman in Salt Lake City learning to do a proper Pemberton osteotomy from the master. After researching PAOs in early 2000, I practiced on cadavers during evening hours until I felt comfortable operating on patients. I never felt the need to be at the *cutting edge* but always wanted to offer my patients options that had been well thought out and researched. I was always comfortable with the approach that I might be "one fad behind." I have never been willing to *experiment* on patients. I would only offer new treatments if they were well reasoned and if the patient or the family were informed participants in a clinical trial.

Staying current also helps us provide up-to-date information to help our patients and their families negotiate the often-treacherous waters of internet misinformation and physician self-promoting advertising. Excellence in patient care mandates the use of shared decision-making and evidence-based practice. We need to know the levels of evidence supporting what we are suggesting. We need to understand our patients' and families' expectations and bring to bear our own personal experiences, which increase each and every year to help our patients and their families make important healthcare decisions. These concepts are so critical to demonstrate to residents and fellows who will hopefully carry the same approach forward to families with children not yet born.



Dr. Weinstein teaches in Hanoi Vietnam, 2015.

Saying "No" to Oneself and Others

We need to develop an understanding of our own personal bandwidth for the tasks and responsibilities we all have. No activity is worth doing unless it is worth doing well, from surgery to research, to leading a professional organization. We need an unbiased and accurate assessment of the capacity to do each activity, developing the self-awareness to only take on what we have the capacity to do at the highest level. Effort matters and if we are not prepared to give an initiative/task our full attention, perhaps we should reconsider taking it on.

Participating in the larger orthopaedic community was always important to me. It was an expected part of the academic culture in which I was raised. I was always passionate about the mission and vision of the various organizations in which I participated (POSNA, SRS, AOA, ABOS, AAOS, Bone and Joint Decade, the Orthopaedic PAC, OREF). Participating at any level in organizations in whose mission we invest can be a very satisfying use of our non-practice time. Carrying out assigned responsibility at the highest level can provide a sense of contribution to a larger community. I am a believer that hard work and excellence in performance are rewarded by other organizational opportunities *if you want them*. Participating in the greater orthopaedic community motivated by personal gain is a disservice to the larger community and poor use of non-practice time.[7,8]

Personal Wellness

I also cannot underestimate the importance of maintaining personal wellness. I have always operated under the rule that I must take care of myself before I can take care of others. I have always exercised before the workday begins (regardless of where I am). For me, this is daily jogging and weekend road cycling. Once I have taken care of myself, I can devote the rest of the day to taking care of my patients, my research, and my other activities. This has been a constant my entire life.

Dr. Weinstein with a resident.

Maintaining excellence in a professional career requires constant nurturing.[9] It is made somewhat easier when you love what you do and when you view each day as an opportunity to do something positive. When your job is not work, it becomes your passion. As Charles Dickens wrote, "My meaning simply is, that whatever I have tried to do in life, I have tried with all my heart to do well; that whatever I have devoted myself to, I have devoted myself completely; that in great aims and in small, I have always been thoroughly in earnest."[10]

Disclaimer

The author has no conflicts of interest to report related to this manuscript.

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