Annals of Surgical Oncology, **7**(7):477–483
Published by Lippincott Williams & Wilkins

Presidential Address

Values in Leadership - Lessons Learned From Patients, Students, and Colleagues

Glenn Steele, MD

As many of you know, I asked for considerable input into this Presidential Address. And, none of my colleagues were positive when I initially suggested using "Sphincter Preservation" as a unifying theme for describing my personal journey through almost every aspect of surgical practice, research, education, and administration.[1] Even when I suggested that this same theme might be quite appropriate for the latest phase of my experiences in "deaning" and leading academic medicine and biological sciences at Chicago, still no affirmation.

What then began to take shape in my mind was a discussion of leadership. I submit that this theme is most appropriate for a Society of Surgical Oncology (SSO) audience because, as you will see in a bit, leadership is the overall mission and a recurring focus of this society's design and its work. More specifically, what began to intrigue me was the possibility of an interesting set of common leadership traits we learn during our lengthy training, and even more importantly, as we care for patients with cancer. So, rather than Sphincter Preservation, perhaps this Walt Whitman line is a better starting point: "How beggarly appear arguments before a defiant deed!"[2]

Now I must admit that whenever I use this as a lead-in for presenting still another of my strategic plans to various trustee groups at the University of Chicago (always feigning a somewhat self-deprecating caricature of the surgical need to "do something"), I'm aware that in my present administrative venue, argument is greatly valued over anything that smacks of action. In addition, I am quite aware that Whitman is presently considered a literary lightweight by some - not diminished by the fact that a copy of *Leaves of Grass* was among the Lewinsky subpoenaed gift portfolio! But the Whitman line does distill at least one important character trait that is distinctly surgical - a compelling need to accomplish something. This trait is not widely distributed among leaders in academic medicine.

I began this self-analysis by rereading past SSO Presidential Addresses, concentrating on those I have heard during my 23 years in this society. Common themes were apparent and remain pertinent despite details which often become dated. Here are some examples, in no particular order and implying no particular value judgment on my part:

Authors	Themes
Aust	Mentors
	Pedigree
Balch	SSO inclusive or exclusive?
Cady	Leadership
	Learning from patients
	SSO "at a crossroads"
Rush	Leadership
	SSO "at a crossroads"
Gardner	Leadership in education/training
	Leadership in clinical research
Brennan	Leadership
	Training
	Clinical research
Bland	SSO "at a crossroads"
	Leadership in clinical trials
Winchester	Leadership
	Synergism of leadership organizations

Each of these addresses, and others I have not cited, were focused on specific issues or crises of the day. Some of the more prominent examples include:

Received March 17, 2000; accepted April 21, 2000.

From the Department of Surgery, University of Chicago, Chicago, Illinois.

Presented at the 53rd Annual Meeting of the Society of Surgical Oncology, New Orleans, Louisiana, March 16–19, 2000.

Address correspondence to: Glenn Steele, MD, University of Chicago, 5841 S. Maryland Ave., MC 1000, Chicago, IL; Fax: 773-702-1897; E-mail: gsteele@delphi.bsd.uchicago.edu

SPECIFIC ISSUES

Surgical oncology as a subspecialty (formal or informal?)

Special training in surgical oncology (certificate or not?)

Design/implementation of clinical research (surgical technician or trial leader?)

Translating basic science to the patient (surgical technician or trial leader?)

Assuring optimal outcome in surgical cancer care (disseminating best practice or limiting to centers of excellence?)

Evolving definition of surgical oncologist – inclusive or exclusive? (leading or following what's really happening?)

Most of these issues and the social and economic dilemmas underlying them remain as pressing professional problems. Some have been resolved, or at least seem to have become less relevant. But what intrigued me most during my rereading were a number of critical assumptions about shared values that my mentors and all of our past presidents imply but do not necessarily articulate. I believe that it is time we begin to talk about these values - without embarrassment, without apology, and as an antidote to what is the single most important challenge facing us at present - the deprofessionalization of medicine. In this short essay I will postulate the following:

1. Core values derived from our interaction with patients, students, and colleagues can provide "first principles" in addressing most major professional issues.
2. Articulating and espousing our core values must take precedence over adapting or "aping" other value systems.
3. Being willing to step into leadership positions, i.e., applying our core values to a wide variety of "BIG" problems will influence the redefinition of "professional" now underway.

First the "BIG" problems. Certainly, one of the basic things we learn as clinicians is to differentiate symptom from disease. This differentiation is critical to the framing of any problem. And, you would probably agree, how we frame or design a question influences what answers

"Symptom"	"Disease"
Big Problem I—Resources	
Lower reimbursement for services rendered	Increasing demand for care Increasing demand for access Increasing ability to "heal" No political consensus on how to pay or whether to ration
Big Problem II—Education	
No time or money to teach students, residents, fellows, or ourselves	Teaching and learning are no longer defined as a *privilege* by either us or our students Nobody is prepared to pay for teaching
Big Problem III—Leadership	
Loss of decision-making autonomy	Are we responsible only to the patient or to a larger community? Deprofessionalization
Big Problem IV—Information	
Patient confidence eroded by uncertainty of:	How do patients distinguish between junk (PR) and good information?
Treatment alternatives Treatment outcomes	How do we convey assurance and comfort at the same time admitting that nothing in medicine and surgery is optimal?
Competing caregivers (In and outside profession)	
Big Problem V—What is best for the patient?	
Fewer surgeons can do fewer things well as knowledge and technical expertise becomes more focused through a career. Fragmentation is inevitable	How to assess competence? How to maintain competence? What mix of general competence and narrow specialization is best for the patient?

we arrive at in dealing with either a difficult diagnosis or research problem. So let me list a series of my own personal selection of BIG problems and distinguish between what I would characterize as "the presenting symptom" and what I suspect to be the underlying disease. I submit that responding only to the symptom will not solve the problem and most often moves us into a "low road" position, easily viewed or misconstrued as self-serving, reactionary, and anti-professional.

So, specifically, what shared experiences have honed our core values that might help us deal with these big issues (not solve them necessarily) and deal with them in a way that can easily be recognized as putting us on the high road of "first principles" to the benefit of our patients, our profession, and society.

First, the privilege of patient contact. Physicians, and cancer surgeons in particular, are forced to understand that problems in patient care are most often complex, must be addressed in partnership with the patient and always in the context of the patient's family setting, must be dealt with honestly, and at the end of the day, might not be solvable. For a cancer surgeon, the reality that short term technical success in individual patients with liver or lung metastasis or T_3 pancreatic or N_2 gastric adenocarcinoma is most often followed by recurrence should in no way diminish the gratification of accomplishing a significant but temporary good outcome. Equally important is the gratification that comes from caring for that patient and his or her family throughout the entire natural history of the disease. The combination of technical challenge well met plus the long-term relationship with patient and family is what provides us our peculiar privilege and creates the "magic" in the doctor-patient relationship described by many authors. Here, Anatole Broyard reflects while dying of prostate cancer: "To get to my body, my doctor has to get to my character. He has to go through my soul. He doesn't only have to go through my anus." ". . . The doctor can keep his technical posture and still move into the human arena. The doctor can use his science as a kind of poetic vocabulary instead of using it as a piece of machinery. . . "[3]

The eminent physician, Francis Peabody, said it most succinctly in 1927: "The secret of the care of the patient is in caring for the patient."[4]

Our grounding as surgeons is *caring* for the sick. The concept of preventing illness is worthy, but, of course, can never completely be achieved. We should not allow politicians to put prevention into competition with healing. Most of us with some reality testing and a touch of residual Calvinism understand that no matter how "well" we live, no matter how much "good advice" we take, we will at some point be sick or deal with major illness in our family. And when we or our loved ones are *sick*, no amount of technological advance, "optimization" in health care delivery, or political demagoguery about one or another aspect of the health care industry can replace the "magical" power of the individual bond between patient and physician that is the core component of our professional identity.

Why is it important to talk about what many here would hold as self-evident? First of all, the matter may not be so self-evident to our surgical and medical progeny. Second, we tend to be somewhat more open minded than people give us credit for and we often try and adopt other role models.

Present popular options include:

The business executive
The medical entrepreneur
The "faux-CEO"
The technical genius
The research maven
The hourly worker
The dinosaur
The trade unionist
Even. . . the investment banker

Although we can learn from at least some of these models, I would submit that none has the power to justify society's designation of us as "professional." The essence of "professional" in our modern social contract was described first by one of the University of Chicago's founding sociologists, Everett C. Hughes, as a ". . . bargain. . . between those who receive. . . (our). . . service and those who give it. . . "[5] We are allowed a ". . . license to do dangerous things. . . "[5]

Most importantly, Hughes states that this bargain is not *forever*: "Licenses of. . . these kinds. . . lie at the root of. . . suspicion which most laymen feel toward professionals, and of that anger which burns chronically. . . and. . . at times becomes popular reaction."[5]

None of the alternative models listed above affirms the patient/doctor interaction. Some demean it. And I submit to you that unless we consistently deal with our problems by framing them in terms of the individual patient/physician relationship we will dilute the "bargain" that keeps our profession from quickly being redefined as "guild, estate, or perhaps simply an important trade"[6,7]

But society asks us how we can possibly balance what is best for the individual patient and what is best for some larger community? My answer is that we do this every day. Each of us pursues a series of discussions during

every patient interaction that represents an integrated assessment of treatment options, outcome possibilities, and acceptable choices for a particular patient and his or her family. Here we can use the example of a patient with metastatic liver cancer from a metachronous colorectal primary. How often have you discussed with such a patient and his/her family that unresectable but asymptomatic liver metastases deserve no treatment - no surgery, no cryosurgery, no radiofrequency ablation, and certainly no chemotherapy. The key to your discussion starts with knowing the data: (1) treatment won't change survival, and; (2) asymptomatic individuals can't be palliated. But perhaps the most important aspect of implementing your decision not to treat will be to convince your patient that he or she will not be abandoned. You know the patient will die of the disease. But you are committed to providing continuing care, advice, and help in defining conventional or even experimental therapy approaches if and when they become appropriate. This kind of advice and this kind of care take more time and energy than offering false hope through inappropriate treatment. If you are as fortunate as I, you have benefited from working with a good partner or two in medical or radiation oncology affirming your decisions and participating in the continuing care. This longitudinal involvement between you and the patient and the patient's family is demanding, but the particular outcome has addressed in a very practical way what is best for the patient and what is best for "the larger group." Although not easily conceptualized as fitting any particular economic model of health care rationing, the practical outcome of such individual doctor-patient interactions, multiplied thousands of times throughout our careers, ends up accomplishing tough choices which are most often best for the patient and also fit into the broader social consideration of resource allocation.

Another frequently self-perceived and sometimes popularized stress point (and a corollary of another of my "BIG" problems listed above) is our profession's need to project authority (or to put a better light on it), assure patient confidence at the same time we realize that nothing we do in prevention, diagnosis, and treatment is optimal. The conundrum is how we tell patients we don't know what is best, without destroying their faith in us or "the healing process"? Again I would suggest that the resolution comes out clearly in analyzing our daily interactions with patients. I will cite a single example. Others would be equally appropriate.

The example is clinical research. Transmitting to our patients a *partnered* commitment to progress in treating their particular illness by formal inclusion into a clinical trial takes time, energy, and skill. If done well, it increases confidence in us and in our profession. Even in clinical trials with so-called "negative" outcome, conclusions of importance will influence standards of care. Examples abound:

Gastric cancer - is bigger surgery better?
Liver metastases - preoperative staging accuracy?
Postresection survival?
Options to resection?
Colon cancer - laparoscopic vs. open colectomy?
Rectal cancer - sphincter preservation vs. abdominoperineal resection? Total mesorectal excision vs. adjuvant therapy?

Immediate direct benefits include new and often unsuspected knowledge, occasionally new treatment options. Even more important indirect benefits are worth stressing:

Defining and assuring standards of surgical quality control

Advancing our knowledge of disease natural history

Assuming intellectual leadership in treating patients with prevalent solid cancers

Assuring our patients and students of our commitment to continually improve skills and knowledge

What we are doing here in our commitment to clinical research is changing the underlying precept of the surgical discipline from static, fixed, dogmatic, and based on revelation to a discipline based on science, and an ever improving knowledge of disease biology and patient preference. None of this is in any way antithetical to the heart of our professional and individual contract with a patient. In fact, the discussion between you and the patient and the patient's family preceding trial inclusion affirms the best in our advocacy for improved patient care.

The second common experience which underpins and shapes our shared value system is teaching. All of us teach (and are taught) all of the time. After caring for patients, teaching our students, residents, fellows, and junior colleagues is our greatest gratification. Most of us can identify ourselves as part of one of several obvious surgical family trees.

The creation of our clinical/intellectual/academic progeny is programed into us. I am proud of my own surgical ancestry: Spencer/Localio/Dumont/Rappapport; Waddell/Starzl/Eiseman/Pierce/Rutherford; Wilson/Moore/Mannick/Murray.

And I am even prouder of my surgical descendants:

Chief Residents 1985–1995

1984/1985	1985/1986	1986/1987	1987/1988
Rohrer	Bolduc	Purcell	Schwartz
Bartlett	Piccione	Hamilton	Francel
Stone	Topol	Hergrueter	Margolis
Hoffman	Fearon	Streitz	Ryan
Thayer	Pearle	Myers	Lewis
Pomposelli, F.	Burke, G.	Clayson	
1988/1989	1989/1990	1990/1991	1991/1992
McAuliffe	Darling	Falco	Baxter
Shaffer	Salem	Lowell	Foley
Cordeiro	Matory	Gray	Babineau
Freeman	Mills	Frissora	Wiltz
Tishko	Keith	Shikora	Zisk
	Burke, P.	Stuart	Saenz
1992/1993	1993/1994	1994/1995	1995
Barth	Cahill	Marcello	Pomfret
Kwolek	Dreesen	Calderone	Pomposelli, J.
Lesnikoski	Duffy	Ozari	Breen
Jicha	Lee	Tuttle-Newhall	Burns
Jimenez	Misare	Saltman	Difiore
Tan	Estes	Kenler	Rosenkrantz

Surgical Oncology Fellows 1976–1995

Harte	Wagner	Lee	Breen
Ravikumar	Meterissian	Edmiston	Joyce
Bleday	Petrick	Puder	D'Emilia
Lahey	Mafune	Barrett	Pories
Salem	Staniunas	Danaker	Weber
Bradley	Kastrinakis	Wiltz	Shibata
Hess	Chao	Schulze	
Hernandez	Miyama	Bagli	

Relationships in these surgical families never change. Our forebears continue to be our most important role models, and we continue to feel responsibility for and pride in accomplishment of our successors. This is where the real "return on investment" for most of us occurs. Perhaps Hollie Smith said it best in his 1985 Gregg Memorial lecture when he opined that most leaders in medicine ". . . can point to one or more individuals who shaped their lives far more than did curricular ingenuities."[8] And, "He teaches best who shows his student how to learn. . . not what to think."[8]

More specific than the general concept implied by the Latin derivation of the term doctor - teacher, docére - to teach, and the French derivative - docent, etc. is our peculiarly surgical hyperbole (now politically incorrect of course) of "see one, do one, teach one." What is at the heart of our "see, do, and teach" commitment is to transmit all that we know to our students and to our colleagues. Please note how different this core value is from the business concept of gaining proprietary advantage over market place competitors by keeping whatever it is that represents a valuable piece of knowledge to oneself for as long as possible. I propose to you that maintaining our special *collegial* commitment to the dissemination of best practice approaches and to publicizing with pride our increasingly formal analysis of outcomes, particularly by comparing our own results to regional and national standards, will be viewed favorably by society generally as a major component of patient advocacy.

The SSO and other leadership organizations, including the American Board of Surgery, the American Board of Medical Specialties, and the American College of Surgeons, are beginning to work together to subsume our general teaching commitment into a formal definition of "competence," and a promise to continuously measure "competence" once defined. These efforts come none too soon. I predict that an initial change will occur in measuring the more cognitive aspects of "competence." The present "static" 10-year recertification process will give way to a more dynamic concept of *maintenance* of certification. Parallel imperatives in better defining ethical, social, and technical "minimum acceptable" standards and beginning to think about ways to pilot assessment for these non-cognitive components will follow.

SUMMARY FROM THE JANUARY 2000 AMERICAN BOARD OF SURGERY RETREAT[9]

We subscribe to the concept of "maintenance of certification," mandating the certification of continued competence.

We partner with other groups (American College of Surgeons [ACS], American Board of Medical Specialties [ABMS], Society of Surgical Oncology [SSO], etc.) in assessing the different components of competencies.

Assessment of clinical "outcomes" is indispensable to this effort.

There are measurable elements imbedded in the concept of "maintenance of certification" which warrant a pilot assessment effort with selected diplomates.

The consequence is that soon you and I will be expected to assure ourselves and our patients that we participate in some formal mechanism to improve every aspect of what we do, whether it involves proof of participation in American College of Surgeons Oncology Group or SSO sponsored trials, other cooperative group studies such as the National Surgical Adjuvant Breast Project (NSABP), or perhaps participation in continuous improvement systems modeled on the outcomes analysis and feedback trials such as The Northern New England Cardiovascular Disease Study Group (a regional intervention to improve the hospital mortality associated with

coronary artery bypass graft surgery)[10] or Shukri Khuri's VA Hospital National Surgical Quality Improvement Program (NSQIP) experiment.[11] How these efforts will succeed, and equally important, how they will be perceived—either to the benefit or detriment of our standing as professionals—is most dependent on whether the process continues to be self-propelled or is applied externally by some nonphysician driven regulatory bureaucracy.

Finally, the importance of colleagues, the third shared experience that helps to create or sculpt our common values. As a surgical resident, I learned most from my fellow residents. As a young faculty member, I learned most from my peers. More recently, the age of my teachers seems to be decreasing, to the point that at present, most are (or were) my students. I believe it is fair to say that the importance of colleagues as fellow teachers and fellow students throughout our careers represents the third component critical to maintaining professionalism in medicine.

Unfortunately, the detail of how we relate to one another, argumentative, critical, often times instituting or responding to public challenge, may easily be misconstrued by a society not familiar with our intellectual grounding in science. The essentials of progress in any scientific knowledge base—whether clinical or basic—is to move postulate to dogma, debunk dogma, and then create new postulates to better explain and predict larger data sets. This untidy process occurs by open dissemination of experimental design, peer review of results, publication of analyses and conclusions, and, finally, ultimate affirmation or modification by the test of reproducibility. What we must do is to assure as best we can that the public debate is framed to our profession's best advantage. Thus, questions about total mesorectal excision vs. abdominoperineal resection plus chemotherapy, or D_2 vs. D_1 gastrectomy, or early breast cancer treatment with or without axillary node dissection, should not be caricatured by debating physicians or by people watching the physicians debate the issues as chaotic, unseemly, and *merely* argumentative. What should be projected is an acknowledgment that each of these questions is part of a *dynamic* process of establishing what is the current best approach for a particular patient's problem. The issues are often not easy to test. The results are often not straightforward. And the whole thing can seem quite messy. But the "first principle" should be articulated again and again, and that is, as a profession we are committed to establishing what is best for the patient, and we are never satisfied that we have reached an optimum.

In summary, articulating and disseminating what I have tried to convince you is our unique set of professional values cannot be assumed. How we are perceived by our students and by society will be determined by how well we adhere to our values, how well we articulate them, and how these values are judged to benefit those outside of medicine. I am assuming (even hoping) that this leadership obligation will extend for some of you beyond surgery as a purely technical discipline. What I have learned over the years about leadership, starting with my role as a surgeon, then as a surgical leader, and most recently as Dean/Vice President at a major academic center, may be of interest to you.

Leadership
A) Strategic issues
B) Tactical issues
C) Implementation lessons

A) Strategic issues:

	Surgeon	Surgical leader	Leader
Personal values	+++	+++	+++
Vision/reality	+	++	+++
Decision making	+++	+++	+++

B) Tactical issues:

	Surgeon	Surgical leader	Leader
Credibility (Personal expertise)	+++	+++	+++
Creativity	++	++	+++
Communication (Includes listening)	+	++	+++
	Surgeon	Surgical leader	Leader
Consistency (the price of honesty)	+	++	+++
Mission-oriented (Big goals)	++	++	+++
Resilience (Positivity)	++	++	+++
	Surgeon	Surgical leader	Leader
Delegate and depend (On colleagues)	−	+	+++
Process/outcome Equally important	−	+	+++
Signs of fallibility	−	−	++

If we are to succeed in maintaining our profession as we now recognize it (and I truly believe this is what is at stake), both the *message* and the *messenger* must be convincing. I have attempted to make the case that many of our shared values represent a superb "message." I have also postulated that surgeons, particularly those of us who care predominantly for patients with cancer, can and should be most effective messengers if we choose to assume that responsibility. We must remember that a large part of our historical "leverage" in being granted our professions' cultural, social, and economic authority is disappearing. The "market model," legitimized by so

many Nobel Laureates in economics at my present university has obliterated distinctions between medicine and business. As William Sullivan has written in his recent Hastings Center Report entitled "What Is Left of Professionalism After Managed Care?" "To the degree that organized medicine. . . (and particularly surgery). . . has stressed its technical proficiency to the exclusion of other traditional traits of professionalism, such as concern for the good of patients, it has unwittingly contributed to what has grown into the most serious threat to its existence. . . "[12]

Quite simply, if "professional" means only "expert technologist," or highly skilled "knowledge worker," then managed care and its attendant transformations could easily be welcomed by our society (and particularly our business leaders) as an expected rationalization of an inefficient health care industry. But if our values, in addition to our technical expertise are part of what we emphasize to each other and to the public, we will begin ". . . to redefine our identity around a public mission." You and I know that the logical endpoint of our present market-based ideology that " . . . somehow everyone will be better off if there is ceaseless scrambling for the best deal"[12] is just plain wrong in medicine. The redefinition of doctors as "providers" and patients, as "consumers" is equally insulting to both parties and is finally beginning to put us into a new partnership with our patients and their families. This is the best interpretation of the recent anti-HMO political revisionism. There is no reason why we should not "lead" with our values and extend the doctor-patient partnership into a new "civic professionalism."[12] We should celebrate together and publicly what Osler encapsulated as the unique ethic of our profession: "We are not here to get all we can out of life, but to make the lives of others happier."[13]

This may sound trite, but remember how popular the musings of Lewis Thomas have been both to physicians and non-physicians.[14–17] It all comes down to "doing well by doing good."

It is not far reaching to conclude that our core values can be fundamental to the future of the profession and equally important to preserving ". . . the decency and stability that are essential to civilized society."[18]

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