

Time for a Cool Change: Getting off on the Right Foot in a New Job

Curt Tribble, MD

David A. Harrison Distinguished Educator, Division of Cardiac Surgery, University of Virginia, Charlottesville, VA, USA

INTRODUCTION

There are these two young fish swimming along and they happen to meet an older fish swimming the other way, who nods at them and says, "Morning, boys. How's the water?" And the two young fish swim on for a bit, and then eventually one of them looks at the other and goes, "What the hell is water?"

—David Foster Wallace

As a Thoracic Surgery resident approaching the end of your training, you may well have been in a single training program, perhaps mostly in a single hospital, for nearly a quarter of your life at the time of your graduation from residency. In a few months you will be going to work in other institutions in which you, obviously, have never worked. This transition will be challenging at best, and discombobulating at worst. You have been 'swimming in the water' of one place, likely taking a lot of that environment for granted, much as the young fish, described by David Foster Wallace in his book entitled *This Is Water*, did not comprehend the 'environment' in which they were living. [Wallace, 2009]

This transition to a new place and to a new role in which you will now be an 'independent practitioner' will be the largest 'lurch' of your life up to this point. That is, your first five years out of training will likely encompass the steepest learning curve of your life. While you will have colleagues, both locally and from your training days, that you can seek advice from, you will be more responsible for your patients and your practice than you have ever been before. There are some strategies that you can employ to navigate this transition into your 'first job.' However, some, perhaps even many, of these strategies are not explicitly taught in most residencies. I will offer some suggestions, based on my experiences working in four different major medical centers over more than 40 years, while acknowledging that it is not feasible to cover every imaginable pertinent topic. Therefore, there will almost certainly be times when you just need 'to phone home' to seek counsel from your prior mentors and colleagues.

Let's get started....

—The Matrix

*Deep inside of a parallel universe,
It's getting harder and harder to tell what came first ...*

—Parallel Universe, Red Hot Chili Peppers

When you arrive at a new place you will, most likely, feel, at least occasionally, that you have entered an alternate or parallel universe. Almost everything will seem out of place or off in some way. While in the latter stages of your training, you have been part of teams that worked like efficient pit crews (at least most of the time), everything in your new institution will feel as though you and your teams are moving in slow motion, as they get used to you and you get used to them. You will have to adjust to this new reality, at least until you settle in. Get to know the folks that you'll be working with. Go out of your way to learn their names. I would often make notes of the names of the folks that I was working with in my pocket notebook to help me remember who I had been working with on a given day. I myself have always asked my colleagues, at any level of the organization, to address me by my first name. Though there are pro's and con's to this strategy, I have always prioritized collaborative teamwork over a 'top down' hierarchal approach, a potentially problematic, or even dangerous, style of communicating that was well described by Malcolm Gladwell in his book, *Outliers*. [Gladwell, 2008 & Ohlheiser, 2013]

You want to assure your colleagues that they can speak up if they have something that they think might benefit your patients. You can always ask that a suggestion be made later, if you are at a point where you are maxing out your bandwidth, at any given moment. For example, if you are sewing the toe of a small coronary artery anastomosis, and someone asks you what drips you want to use at the end of the case, it is perfectly okay to ask them to 'hold that question till later.' Virtually no one will find that off-putting. [Marvil, 2017]

GIVE 'EM A HEADS UP: FAVORITE INSTRUMENTS

Well before you 'parachute in' to your new working environment, you should think (and will likely be asked) about what instruments and other supplies you will want to have available for you. You may be surprised to find that some of your favorite instruments are not universally available.

I created a list of instruments I put together when I realized how many things I was used to using in my own practice that were NOT universally available in other hospitals. (Appendix) As you scroll through this list, you will likely see

Correspondence: Curt Tribble, MD, Professor of Cardiothoracic Surgery, University of Virginia Health System, Division of Cardiac Surgery, Box 800679, Charlottesville, VA 22908; 434-243-9250 (e-mail: ctribble@virginia.edu).

some familiar items, but I will assure you that there is a fairly high likelihood that at least some of them will not be immediately available to you in your new institution. I found that, if I provided my list to the operating room staff at the institution that I was going to join, they would do their best to round up all (or at least most) of these things for me.

You will likely have some things that are not on this list that you like and will want to add to your own list, and there will be some things you don't care that much about and could live without. Of the instruments on this list, the two that seemed to be unfamiliar to most and that I really wanted to have available were the cow's horn dilator and the renal pedicle clamp. I found, and listed, the exact names and specifications of most of these instruments, as well as the companies that make them, which may make them easier to find and procure. Obviously, you may need to do your own research on other instruments that you are fond of, so that you can request that they be purchased for you.

MEET & GREET: BECOMING A CITIZEN OF THE INSTITUTION

You never have a second chance to make a first impression.

Meet folks in your new place, as much as feasible, early on. After all, you would rather not meet these people after some kind of problem has arisen. The people you need to meet and get to know fall into two main groups: administrators and clinical colleagues. The folks in each of these two categories are fairly different in a variety of ways, but many of them will be vital to your success as a clinician and to your peace of mind as a person.

The administrators will, of course, tend to have a focus on financial issues. However, many of those administrators who are easiest to work with have at least some background in healthcare. I think your goal should be to ally yourself with those who share your priorities, especially in providing the best possible care for the patients that all involved are collectively serving.

The clinicians that you will want to get to know will likely be in your own clinical realm, including cardiologists, pulmonologists, and anesthesiologists primarily. I have found that many people in a given institution know who 'the best doctors' are, in any given discipline. You can, and should, ask an array of different people for 'scouting reports,' including residents and other providers who know who they want to seek advice and help from, as you work on getting to know the people in your new environment.

You should consider reaching out to your new colleagues, perhaps via email, to briefly introduce yourself and to ask if you could buy them a libation of their choice at a time of mutual convenience and if you could pick their brains about the institution, their own favorite colleagues, and who they seek help or advice from. You will find that some of the best all-around doctors in any given institution are heart failure cardiologists, infectious disease experts, and general, vascular, and cardiothoracic surgeons.

CONSULTATIONS

Most of our patients do well, but not by much.

Good results are said to be all about patient selection, patient selection. This process begins by providing guidance to those who may be seeing patients for you and interacting with referring physicians prior to your giving your own recommendations to those seeking your advice about a particular patient. I created several documents to facilitate consultations that are frequently done, or at least started by, your various representatives, such as residents or advanced practice providers.

One of those documents was a document that I created and updated regularly that explained the most important issues to be considered in consultations for patients being considered for cardiovascular surgical operations. (Appendix) Those issues include anemia, liver dysfunction, or diffuse vascular disease, among other conditions. I found that it was quite common for a practitioner in another discipline to 'discover' a condition, often chronic, that might be treated with a cardiothoracic operation and, in essence, want to 'hand off' the patient, without further workup of these potentially complex issues. In other words, you can never assume that your referring doctors have thought about and worked up these ancillary issues with the thoroughness that the patients deserve. They, much more often than you might expect, want you to assume responsibility for preparing the patients they are referring for whatever operation they think the patient needs. You, and your team, must be ready to take on that responsibility. That is, you must take the time to properly prepare your patients, especially for relatively elective operations.

The second document that I created was my own History and Physical form, which I set up to correlate with the first document. (Appendix) This form, in essence, prompted the collection and contemplation of the common issues and comorbidities that a lot of cardiac surgical patients will have. I made certain that any risk factors that might be needed for The Society of Thoracic Surgeons (STS) database were recorded. If those who are starting these kinds of consultations or workups understand the background concepts and if they have a form that they can print out and collect this data on, they can present the patients to you in an organized and thorough manner, and they can then use these forms to create an appropriate document that can be cut & pasted into the electronic medical record.

Whatever else a surgeon is, he is an internist and something more, not something less.

—Francis Moore, MD

I have been amazed at how efficient and thorough this process can become when handled in this way. A corollary to this advice is to remind your representatives to convey to all the protagonists (referring docs, patients, and patients' families) that your team is going to offer an opinion on a given patient only after a thorough workup has been completed and after

any modifiable risk factors have been treated or at least considered carefully.

PREPARING YOUR TEAMS FOR YOUR OPERATIONS

The question is not whether you have the will to win. The question is whether you have the will to prepare to win.

—Alabama Coach Bear Bryant

Once a decision to offer an operation has been made and that operation has been scheduled, the next set of suggestions I have relates to communicating with your operating room (OR) teams ahead of time (like the day or the evening before the case is to be done). I eventually learned that it was optimal to set up a system using a group email to send out notes the night before every operation (no matter how routine), in order to alert our teams about what we expected to do and what instruments, supplies, and medications that we might need for the planned operation. You know well that there are many different people (or teams of people) that are likely to be involved, especially in a cardiac case, including:

- Anesthesiologists
- Perfusionists
- The OR nurses
- Physician's Assistants
- Trainees
- ICU teams
- The instrument folks (who pull the trays for cases, often the night before a case)
- Pharmacists (for drips or other medications you may need)
- The blood bank staff

I have found that these emails are extremely popular with our teams and almost every time I would send one out, I would get notes of thanks and, not infrequently, some questions or suggestions. Those responses often saved time the next day, as we didn't have people from each of those groups calling us in the mornings to ask about things that were in these 'heads up' emails.

I eventually created a checklist that I would fill out and attach to those preop emails to both standardize the process and to save time. One of those checklists is in the appendix (OR Planning Checklist), which you might consider as a starting point for your own checklist, if you like this idea. In fact, one of my anesthesiology colleagues once told me that he estimated that these emails and checklists saved an average of about an hour in the operating room per case. I have often wondered if the time saved was even greater, taking into account the time saved by my not having to answer a dozen questions each morning before a case.

When we started using Epic, one of my former residents mentioned to me that he had created templates for all the operations that he commonly performed and saved them as Word documents on his computer. He pointed out that, for common operations, most of us would do those operations

the same way every day (with nuances added, depending on the circumstances, of course). I quickly realized several good things about this strategy, including:

- He was right, in that I could fill in the blanks on these templates, especially for a routine operation, in, literally, minutes after the operations and then cut & paste these notes into Epic, as the official op note.
- I also began to start creating these op notes ahead of time, as best I could, to save time on the day of the operation, when, not infrequently I'd be worn out by end of a long day or be caught up in the other chores that seem to constantly arise.
- A basic CABG note is included in the appendix, as an example.
- You can create an array of these operative templates, incorporating your own preferences, of course.
- Eventually, it occurred to me that, if I'd gone to the trouble to create a draft of the op note for the operation I expected to do the next day, I should attach that draft to the email I'd send out the night before, saying something like: "This is the operation I expect to do tomorrow If anyone has any suggestions about this plan, please let me know." (I was amazed at how often someone did have some questions or suggestions, I will admit.)
- All of these strategies are even more pertinent when you are in a new place.

HELP WITH 'RUNNING THE ROOM'

A strategy that I first employed, after I was past my own early learning curve and when we had new faculty members coming on board, was to offer to scrub with them early on, even if they didn't really need my advice about the cases they were doing. I told them that I would 'run the room' for them, so that they could focus on the technical aspects of the case. This approach recognizes that there are at least 5 groups of folks helping in an ordinary case (such as a coronary artery bypass operation), including anesthesiologists, perfusionists, physician's assistants, the scrub nurses, circulators, and, occasionally, other providers.

I would suggest that, when arriving at your new institution, you consider asking a colleague to come to the OR (especially for the 'critical parts' of a case) to help 'run the room' in this way. Asking someone to do this is not a sign of weakness. Rather, it's an acknowledgment of how distracting it can be to find yourself in an unfamiliar environment with many on your team asking you all sorts of questions while you are trying to focus completely on what you are doing, especially in 'the critical parts' of the case. Of course, your new associates may also have an occasional suggestion that you just might find useful.

TENDING TO THE POSTOPERATIVE 'CHORES'

I had another checklist for all the 'chores' I needed to do after the operations, as well, which I'd print out and tape in

my pocket notebook. I was amazed how often I was reminded by my checklist of something I might have forgotten when caught up in the press of a day (such as calling the referring doctors). A sample note of this type is also in the appendix and is labeled ‘postop ck list.’ I’d start filling out this checklist in the OR (noting cross clamp and perfusion times and other things I’d want to include in my op note, like the size and quality of coronaries bypassed or the size of a valve implanted or the ischemic time for a transplant), and then I’d keep looking at that checklist until I really had done all the things I needed to do.

LESSONS LEARNED

You will see in that postop checklist that one of the things I ‘made myself’ do was to write down some thoughts and reflections on each and every case.

Once I got in the habit of doing that, many years ago, I was amazed how often I really did have something worth writing down for almost every case. You can also use those notes to review cases with the residents or advance practitioners with whom you have operated later on (often the next day). [Merrill, Tribble. 2016]

COMMUNICATING WITH YOUR REFERRING PHYSICIANS

You should always strive to have the first communication with your referring physicians after an operation come from you, if at all possible. That is, you should contact them yourself and should not delegate that crucial task to assistants or residents. You can use a combination of methods for accomplishing this important communication, from calls to texts to emails, depending on the preference or availability of your referring docs.

I also created templates for notes to send referring docs about operative cases, as well as about consults and clinic patients. Having specific templates for all of these types of notes will make this process very efficient and thorough. I can assure you that your referring docs will love them and appreciate your communicating with them. Frequently a note or text can be much more straightforward for both you and for your colleagues than trying to reach them directly by phone, when they are often quite busy themselves.

GENIUS LOCI (‘THE SPIRIT OF A PLACE’)

I’ve learned that people will forget what you did. But, people will never forget how you made them feel.

—Maya Angelou

You should consider having regular meetings with all staff members who will, or even might, be important to the smooth functioning of your team. It is likely that monthly meetings will be optimal, at least once you get settled into your new

institution. I have found these meetings to be extremely valuable. Besides receiving ‘reports from the front,’ these meetings are an excellent opportunity to empower your colleagues in the system to speak up and contribute. While some of the obvious participants will include operating room nurses, perfusionists, colleagues from anesthesiology, the Society of Thoracic Surgeons database coordinator, and your surgical colleagues, I found it was also useful to invite and include the folks from sterile supply, the blood bank staff, pharmacists, your clinic staff, and others. In fact, in my experience, creating this type of team atmosphere was engaging for many, often prompting others that might have been overlooked at first to ask to be invited. These meetings will help you establish a collegial environment, which can be described as *genius loci*, or ‘the spirit of a place.’ [Junger, 2016 & Merrill, Tribble, 2016]

THE SITUATION ROOM: DAILY MORNING MEETING OR MORNING REPORT

Depending on your circumstances, you should consider, at least early in your tenure at a new place, meeting with your team early in the morning, prior to the start time of your operating rooms or clinic. The general idea is that your various associates (residents, physician extenders, and even medical students) can ‘divide and conquer’ in checking in on the patients who are in the hospital. These folks can then give terse reviews of the patients to you (and, depending on their interest, to your colleagues), and you can assign someone to pull up any appropriate images on a screen. Obviously, meetings of this sort are good for patient care and they are also a valuable way to teach all of your associates. I have found meetings such as this to be very efficient and effective. Some, especially in busier services, have found that using emailed summaries can be an effective and efficient way to accomplish this goal. [Sanfey, 2008 & Tribble & Merrill, 2014]

CREATING A TEAM ENVIRONMENT FRIENDLY TO LEARNING

Everyone in this room will have a different view of what is going on. If you see something, say something.

—M.C. Wilhelm, MD

One of my favorite mentors in my residency days would start every operation with this line about everyone in the room having a different view. First of all, it was obviously true and, at least once in a while, really contributed to a good outcome. In addition, it was amazingly empowering to all involved. It just sets an optimal tone for a team based environment.

On a related note, I have always liked naming everyone in the room during the time out that precedes every case. A recent idea that is being suggested is to write everyone’s name and role on a white board in the room. I really like this idea as well and plan to begin to use it.

Smart people often don't amount to much. What really matters is being imaginative, being creative, and being innovative. And, most important of all, just being good.

—Walter Isaccson, 2018

Talk, talk, talk. Explaining, during procedures, what you are doing and why you are doing that particular thing has several virtues, including that you will be helping your new team members get used to your way of doing things and that expressing your thoughts aloud will actually help you clarify your own thoughts. Furthermore, if you are talking to your team, they will be more likely to ask you questions, at least some of which will be pertinent and, possibly, may be of help to you at times. [Tribble & Merrill, 2014]

TALKING TO FAMILIES

You will, of course, want to talk to the families of your patients after completing your operations, as well as at other times. While I could make a lot of suggestions about that process, I will point out that I have found that the best time to talk to families is after the patient is in the ICU or Recovery Room. You'd like to avoid having to talk to them twice, once early and then again if your patient's status changes, which it sometimes will, early after an operation. And, for those who are operating with residents, I think the best strategy is to talk to your patients' families with your trainee, not only to teach them how to conduct those crucial conversations, but also to 'empower' the residents in the eyes of the family. After all, the families will often see more of the residents than they will of you in the postop period. If you are not working with residents, you may find it helpful to get an advanced practitioner who has been or who will be involved in the care of your patients to accompany you when you talk to the families, for basically the same reasons as you might have a resident talk to them with you. [Tribble, 2017]

NOTES & LETTERS

You will need to get in the habit of writing letters of a wide variety, which, again, will most likely be a new skill for you to develop. We have written about this subject in the past. [Tribble, 2019] One of the best and most efficient ways to go about this important task is to create templates that you can fill in expeditiously. Not only is the use of templates efficient, it is also a way to ensure that you are conveying the desired information thoroughly. [Tribble, 2016]

RUNNING YOUR CLINIC

You will, of course have to set up a clinic to see your new and your established patients. Your reputation at your new institution will likely be created as much by how you manage your clinic as by any other one thing you do. AND, you likely

have not spent much time in clinics as a resident, at least not in the final stages of your training. We have written in detail previously about various aspects of running a thoracic and cardiovascular clinic. [Tribble, 2020]

THE CONTINUOUS EVALUATION OF RESULTS

You will certainly want to record and study your results. This process can, and, often should, be informal (writing reflectively and regularly), while some of these examinations will be in a more formal setting, such as Morbidity and Mortality conferences. [Tribble, 2016] While you are still a relative newcomer at your new institution, you might consider doing your own presentations at M&M conferences, rather than relying on others to do these presentations. I can assure you that you will gain the respect of your peers if you take on this responsibility early in your tenure at a new institution. [Tribble, 2016]

MULTIDISCIPLINARY MEETINGS

You should attend as many meetings pertinent to your clinical practice as is feasible, such as valve conferences, heart team meetings, ERAS (Early Recovery After Surgery) conferences, and morbidity and mortality conferences. You will likely not have spent all that much time in meetings of this sort (other than M&M conferences) during your training, but it will be crucial for you to make time for them in your new role. There will be a lot for you to convey to your new colleagues about how you would like to work with these groups to optimize the care of your patients. [Tribble, 2014] One of the essential skills needed for managing these kinds of meeting is to learn to use disarming, collaborative questions such as those outlined in Jim Ryan's book *Wait, What?* [Ryan, 2017] These five questions, which can 'pour oil on the water' in many situations include:

- Wait, what?
- I wonder ?
- Couldn't we at least ...?
- How can I help?
- What truly matters?

SKUNK WORKS: STARTING A NEW PROGRAM

If you will be starting a new program of some sort in your new institution, such as a transplant program, a ventricular assist device program, or a robotics program, you should consider having a meeting (or a series of meetings) with as many of 'the protagonists' as possible. [Tribble, 1991] Some people have called these sorts of group meetings 'skunk works' which is a colorful way of describing a small group of people who will focus on a project or goal for the sake of innovation or improvement. The keys are to use small groups, with a specific focus, meeting over a short time frame. When we started our living related lobar lung

transplant program, we held several meetings of this sort with our teams, acknowledging that these cases would be the only time any of us would be involved in a process in which three different patients could suffer untoward consequences (the two lobar donors and the recipient). These meetings were very productive and helpful.



(The author and his partner after an early living donor lung transplant.)

ON BECOMING A TEACHER

A cornerstone of the [great teacher] theory was that great teachers had great personalities and that the greatest teachers had outrageous personalities. I did not like decorum or rectitude in a classroom. I preferred a highly oxygenated atmosphere, a climate of intemperance, rhetoric, and feverish melodrama. And I wanted my teachers to make me smart.

—Pat Conroy, 1980

You should always be teaching, even in an environment that may not be as academic as your training program likely was. For one thing, the old adage that to teach is to learn twice holds true. Also, teaching others with whom you are working will build camaraderie and loyalty. And, probably most importantly, you will be enhancing the abilities of those who are trying to be of help to you. They want you to help make them smart. However, you will likely not want to be thought of as being quite as colorful as Pat Conroy wanted his teachers to be in an earlier era. [Tribble, 2017]

HEALTH MAINTENANCE

Does how you feel affect the way you perform?

—Doug Newburg, 2006

If you are like most of us, you likely have some ground to make up after the ‘last chance power drive’ you have been on during your training. And, the opportunity to ‘do a reset’ on your fitness and health maintenance plans, as you settle into a new routine, should not be squandered! We have, in the past, addressed many of the issues you should consider in developing or enhancing your health goals. [Tribble, 2016] And, obviously, the answer to Dr. Newburg’s question of “does how you feel affect the way you perform?” is: of course it does! Therefore, you must pay attention to your health and fitness and to how you feel, both for yourself and for those you are caring for.

LAGNIAPPE

Every night, Edna and I go out on the lake and supervise the sunset. It’s hard not to acknowledge the benefits of this activity when practiced regularly.

—John Bower, MD, 2014

Finally, you should strive to find time to enjoy the small things in life. You will never regret ‘supervising the sunset,’ even if you are not able to do it every day.

SUMMARY

We, your teachers and mentors, have done our best to prepare you for what comes next in your careers. We will always remain ready to lend an ear or a hand, should you need either. As you depart your homes of these many years, we wish you well, with this old Irish blessing:

*May the road rise up to meet you.
May the wind always be at your back.
May the sun shine warm upon your face,
and the rains fall soft upon your fields.
And until we meet again,
May God hold you in the palm of His hand.*

Appendix: Forms, Letters, and Lists, Available upon Request

- Favorite instrument list
- Guide to consultations on complex patients
- Structured history & physical form
- Preoperative planning note
- Sample templates for operative notes
- Postoperative check list
- Letters to referring doctors

REFERENCES

Wallace, David Foster. 2009. This Is Water: Some Thoughts, Delivered

on a Significant Occasion, about Living a Compassionate Life. Little, Brown and Company, New York. (ISBN 978-0-316—6822-2)

Red Hot Chili Peppers. 1999. Parallel Universe. <https://www.youtube.com/watch?v=N5Vgm6-KO3o> (Accessed 5-22)

Gladwell, M. 2008. *Outliers*. Little, Brown and Company. New York.

Ohlheiser, Abby. 2013. Malcolm Gladwell's Cockpit Culture Theory and the Asian Crash. *The Atlantic*. <https://www.theatlantic.com/national/archive/2013/07/malcolm-gladwells-cockpit-culture-theory-everywhere-after-asiana-crash/313442/> (Accessed 5-22)

Marvil P & Tribble C. 2017. Lessons from Crew Resource Management for Cardiac Surgeons. *The Heart Surgery Forum* 20(2): 1-5.

Kleppel, N. 2014. Gibbon Fulfilled. *J Am Coll Surg* 219: 164-5.

Bear Bryant Quotes. <https://tide1009.com/the-best-bear-bryant-quotes/> (Accessed 5-22)

Merrill W, Tribble C. 2016. Toward a More Perfect Union of Patient Care and Education. *Ann Thorac Surg* 101(3): 837-40.

Lowe, L. 2021. Remember Maya Angelou By Reading 75 of Her Most Inspiring Quotes. *Parade Magazine*. <https://parade.com/2358/lindsay-low/maya-angelous-most-inspiring-quotes/> (Accessed 5-22)

Junger, S. 2016. *Tribe: On Homecoming and Belonging*. Hachette Book Group. New York.

Sanfey H, Stiles B, Hedrick T, Sawyer R. 2008. Morning Report: Combining Education with Patient Handover. *The Surgeon* 6(2): 94-100.

Tribble C, Merrill W. 2014. The Way We Talk is the Way We Teach. *J Thorac Cardiovasc Surg* 147: 1155-9.

Isaacson, W. 2018. Commencement Address, University of Mississippi. <https://news.olemiss.edu/walter-isaacson-urges-um-grads-embrace-creativity-collaboration/> (Accessed 5-22)

Tribble C. 2017. Grandmother Rules: Crucial Conversations with Patients and Families. *The Heart Surgery Forum* 20(1): 002- 006.

Tribble C. 2016. On Becoming a Doctor of Humane Letters. *Heart Surg*

Forum 19: 150-2.

Tribble C. 2019. Are You Making Yourself Clear? You Can't Communicate, or Think, Effectively If You Can't Write Clearly. *The Heart Surgery Forum* 22(2): 121-126.

Tribble C. 2020. The Well-Tempered Clinic: The Clinical and Educational Importance of Cardiovascular Surgical Clinics. *The Heart Surgery Forum* 23: 712-717.

Tribble C. 2016. A Practical Minded Obsession: With the Possibility and Consequence of Failure. *The Heart Surgery Forum* 19: 001-004.

Ryan, James E. 2017. *Wait, What? And Life's Other Essential Questions*. Harper Collins, New York

Tribble C, Kern J, Findley L, Daniel T, Truwit J, Rose C, Lewis B, Kron I. 1991. First Single Lung Transplant in Virginia. *Va Med Q* 118: 166-7.

Conroy, P. 1980. <https://quotepark.com/quotes/1793586-pat-conroy-i-developed-the-great-teacher-theory-late-in-my-fr/> (Accessed 5-22)

Tribble C. 2017. A Shift to the Left: Teaching the Craft of Cardiac Surgery. *The Heart Surgery Forum* 20: 269-73

Newburg D. 2006. *The Most Important Lesson No One Ever Taught Me*. Xlibris Corporation, Bloomington, IN.

Tribble C. 2016. Always Keep Your Clothes in the Car. *The Heart Surgery Forum* 19: 237-240.

In Honor of John Bower, MD. <https://www.umc.edu/SoPH/About-Us/John-D-Bower.html> (Accessed 5-22)

ACKNOWLEDGEMENT

While I adopted or developed the concepts and practices described in this treatise throughout my years of training and practice, most of them were influenced, and often greatly improved, by Walter H, Merrill, MD, my partner and friend of many years.