



First and Foremost, LISTEN!

Lessons Learned From Mentors and Peer Visitors

by Douglas G. Smith, MD

Mentors come to us in a variety of forms and ways. Sometimes, we find a mentor in a formal teacher/pupil relationship, with one person there to impart wisdom and the other there to absorb it. Occasionally, mentoring happens the way writer Jack Kerouac describes the Japanese word Satori: a kick in the head. As in, "Oh, I get it now. Lesson learned!"

But most of the time, the best mentoring happens by example, not words; by guiding, not dictating; and, most importantly, by listening. An effective listener provides a kind, thoughtful and understanding presence. A good listener evolves into a mentor, creating an atmosphere that allows others to draw their own conclusions from within and to learn their own lessons.

Mentoring relationships can be long term or brief. Sometimes, we select a mentor because we want to learn from his or her expertise, insights and intuitions. At other times, we discover mentors inadvertently. We might think we know a little about something, but along comes someone who provides us with

a clarifying point of view that makes us wiser in a way we hadn't imagined just a few seconds before. There are also times when we feel alone and don't know what to do and someone provides the listening and understanding we need.

I had planned to discuss the knee disarticulation in this column, but the passing of one of my mentors made me think about the valuable role mentors play in our lives. It also made me realize the extraordinary similarities between mentors and good peer visitors. Therefore, I'd like to devote this space to the values we find in mentors and how a peer visitor can be a mentor. I'll address the subject of knee disarticulations in my next column.



Listening, not lecturing

Mentor: a person looked upon for wise advice and guidance. While *Webster's Dictionary* gives a clear and concise definition of the word mentor, I believe the description could be expanded: "A mentor does not dictate what to do. A mentor listens and asks questions so that you can discover your own answers and develop your own options and plans." Mentors give of themselves by example, not by lecturing. They realize that your path will not mirror theirs. A good mentor does not try to make you into a clone.

This is one of the most important lessons for a new peer visitor to learn. The peer visitor's role is not to tell another person what to do. A good mentor does not say, "I did this so you should do this." That's a trap that new peer visitors can easily fall into. Good mentors and peer visitors guide by experience and example. They can provide insights, but, most importantly, they listen and empathize. The good ones realize that if they tell another person what to do – such as what kind of surgery to get, what kind of device to use and which prosthetist to choose – they're not teaching. They're dictating and run the risk of becoming a dictator.

Our group has started to discuss "The 90-10 Rule" for peer visitors. A novice peer visitor tends to talk 90 percent of the time and to listen only 10 percent of the time. A good, experienced peer visitor, on the other hand, listens 90 percent of the time and talks only 10 percent. Think of *Star Wars*. Yoda never tells Luke Skywalker what to do; he nudges him toward finding his own way. It's Darth Vader who tries to make everybody do what he wants.

Brand, Burgess and Hansen

I was saddened by the recent death of Paul Brand, a surgeon and author whose work with leprosy disproved many old theories about the disease and shed great light on its neuropathy. Among the books

authored by Dr. Brand is *The Gift of Pain*, which provides insights into how pain – avoided by most of us at almost any cost – is actually a protective blessing. "God designed the human body so that it is able to survive because of pain," Brand wrote. Without pain's warning signals that something is wrong, we carry on unaware of the damage being done.

Brand's curiosity refused to allow him to accept the thinking at the time that leprosy was a rotting flesh disease. Brand believed, and subsequently proved, that the "rotting" aspect of leprosy is just not true. The wounds, ulcers and infections are actually caused by trauma to areas of the body that don't have the protective gift of pain. For example, a person with terrible foot ulcers can have no idea there's a problem and walk for miles on injured feet because there's no protective feeling of pain that makes him or her stop. The insensate flesh is damaged by unrecognized injury, not rot.

While leprosy is rare in most of the developed world today, loss of protective sensation as a result of diabetes has become quite common. Though diabetes certainly is not leprosy, both diseases carry with them loss of protective sensation, which is called neuropathy. In both diseases, injury inflicted on an area of the body that does not have protective feeling can go unnoticed and worsen quickly.

Brand both listened to and watched his patients carefully in their daily lives to understand all that he could about them. Observing some of his patients in their homes, he saw small nocturnal animals chewing on their flesh while they slept. These patients, with the numbness of leprosy, could not feel the biting. Brand's prescription? A cat. The cat kept the bedroom "safe" and the wounds healed. This made Dr. Brand realize that surgical wounds could also heal, and he embarked on reconstructive surgery for those with leprosy who had deformities caused by muscle imbalance and injury.

People with leprosy may also lose their blink reflex. Brand's wife, eye surgeon

Margaret Brand, developed a procedure in which she connected a small tendon from the jaw to the eyelid, pairing mouth movement with blinking. She then had her patients keep small pebbles in their mouths throughout the day to stimulate mouth movement, which triggered their eyes to blink as well. This unusual treatment caused the rate of blindness from leprosy to drop significantly.

Drs. Paul and Margaret Brand helped change our erroneous view of leprosy as a rotting flesh disease and helped us understand that the disease attacks the nerves and takes away protective feeling. Paul Brand educated us that it's devastating when you lose the protective "gift" of pain, and his understanding of the effects of neuropathy helped us develop total contact casting for Charcot foot, saving many feet from amputation. He also developed tendon transfers to rebuild deformed hands, proving that reconstructive surgery could work, and people with leprosy saw their surgical wounds heal. The increased function brought about by these surgeries prevented people from losing their hands. While Dr. Brand is primarily known for his understanding of leprosy, his surgical advances in hand and foot reconstruction and in amputation surgery are remarkable. And his insights are also beneficial when studying the loss of sensation in people with diabetes. Diabetes affects the nerves, and this neuropathy produces numbness and causes small muscles not to work, which leads to deformity. In fact, most of the wound problems and deformities in the diabetic foot result from neuropathy.

I met Dr. Brand late in his career, after he retired and moved to Seattle in the late 1980s. His quiet style gave form to George Eliot's words: "Blessed is the influence of one true, loving human soul on another." Dr. Brand demonstrated an amazing gift of sitting down with patients and being caring, concerned, gentle and involved. He had a quiet way of educating the patient and anyone else in the room. Sometimes, when medical



instructors teach in front of the patient, the words go directly to the other medical personnel and the patient is left out of the loop. At other times, the teacher may talk to the patient, but use terminology and a speaking style that the person doesn't understand. When Dr. Brand came to our clinics, he had an incredible way of connecting with each patient, using a vocabulary and style that educated everybody in the room. It was a gift of listening, communicating and teaching. He had a quiet way of instilling a desire to alleviate difficult situations, along with the ability to inform, clarify and instill hope that there could be a workable course of treatment.

While Dr. Brand was very quiet, another mentor of mine, Dr. Ernest Burgess, radiated energy. I was fortunate enough to both study under and work with Dr. Burgess. Whenever I think of him, I am reminded of something that was said in a eulogy: "Dr. Burgess understood the ancient philosophers that the purpose of life is to create enthusiasm." His enthusiasm could almost rock you off of your feet. His work included the formation of the Prosthetics Research Study and the invention of The Seattle Foot, which helped start a revolution in prosthetic foot design.

Among surgeons, Dr. Burgess worked to redirect their thinking about amputations.

Rather than viewing amputation as a failure of treatment, he taught that it's far more beneficial for both the doctor and the patient to see it as reconstruction of a limb that has been rendered useless by disease, dysfunction or trauma. To him, it wasn't about failure at all. Rather, it was about restoring limbs and restarting lives.

The Amputee Coalition of America bestows the Burgess Award, named for Dr. Burgess, annually to honor a person dedicated to improving lives for people with limb loss. Dr. Burgess was constantly striving to improve amputation surgery, prosthetics, rehabilitation and our understanding of all issues pertaining to limb loss.

When I think of mentors, my thoughts also turn to a living one, Dr. Ted Hansen, an internationally renowned orthopedic surgeon who changed our thinking about trauma care, internal fixation and foot reconstruction. Dr. Hansen started putting metal internal fixation devices in open fractures at a time when many people were convinced it was the wrong thing to do. There were even murmurs that it was so radically outside the practice standards of the time that it might be dangerous. The common thinking was that since a metal object is a foreign body, it would attract bacteria, cause infection and make the situation worse. But Dr. Hansen was ahead of his time. He saw the effect of the device, rather than simply the device itself. Even though the device is a foreign body, its impact is more important than the device itself. He showed that by stopping the bone from moving, there is actually less irritation of the soft tissues, less bleeding, less infection and improved healing. His first papers on this method were landmark. Thirty years ago, the rule was never to put hardware in open fractures because it caused infection. Thanks to Dr. Hansen's insight and conviction of his beliefs, the general thinking now is to stabilize and align the bone with internal fixation because it will actually reduce infection. A 180-degree turnabout in

thinking is rare in medicine, but that's just what Ted Hansen accomplished.

Dr. Hansen remains constantly curious, and to this day he never puts on highfalutin airs. He is extraordinarily respectful to his patients. During an examination, he sits lower than his patients and spends the first exam massaging their feet. He asks questions so he can listen and learn. He asks the person, "What do you think we ought to do?" The first time I saw him do this, I thought, "Why is this fantastic, world-renowned surgeon asking what the patient thinks? He ought to be telling the patient what they should do." Later, it struck me that the patient's response often hit the mark, and Dr. Hansen would zero in on the pros and cons of a variety of treatments. At other times, he would say, "That's a great thought, but I don't think it would work because..." This would lead to, "Here's what I think might work."

Not every surgical procedure turns out perfectly, and Dr. Hansen, unlike most

surgeons, has a way of making people understand that. In foot reconstruction, when he says, "We got most of it, but we have to do a little fine-tuning," people understand without anger or a feeling of betrayal. He has a way of making people see that in complex surgical reconstructions, sometimes you're able to correct everything in one procedure and sometimes you're not. Convincing the person of this is no small accomplishment because, unfortunately, some mistakenly believe that surgery has only two results: Either it's 100 percent perfect or it's a disaster. When Dr. Hansen talks, people understand that surgery involves a whole spectrum of possible outcomes. He'll say, "Hey, it's 90 percent good. What we need to decide is whether it's worth the time, effort and your personal investment to try and get a little more." People naturally want a perfect outcome, but that's not always possible in foot reconstruction and in amputation surgery. With Dr. Hansen, they understand when he says, "We did the right amount," or, "We ought to do a little more."

Individuality, compassion and uniqueness characterize these surgeons. Connecting, educating and listening, each has been able to make the patient feel like an active player in the process. It's been "We" or "You and I," not "Me." Patients have been participants in their own treatment and recovery as their physicians established a dialogue with them, not a monologue.

Malchow, Novotny and Rossbach

A great mentor learns what it means to be professional. And to me, being professional doesn't mean acting like you know everything or making people do what you say. Being professional means listening, asking questions, creating a team.

And when it comes to understanding and sharing wisdom, I think of three other living mentors: Dee Malchow, Mary Novotny and Paddy Rossbach. Each of these women is a nurse, and each lives with limb loss. Each one also has the unique gift of understanding and conveying wisdom. These three healthcare professionals have amazing ways to help the new amputee and to educate other healthcare providers about issues that aren't always readily apparent to those without limb loss.

These three women help people see past their own barriers. Being an orthopedic surgeon, I thought for a long time that the ability to walk is the key factor that allows us to live an independent life. But Dee Malchow, who lost a foot as a teen-ager, got it through my head that it's not just walking that makes you live independently. It's also the often-overlooked but vital things like being able to get in and out of bed and on and off of the toilet. Because of her, I'm saying to myself, "Duh! Can't you see the obvious?" Dee Malchow has a way of being a living example of the good things that can be accomplished, learning from experience, and pushing ahead. She educates patients, nurses and physicians, getting people to refocus on what's really important.



Mary Novotny, who has a hip disarticulation, is a strong believer in the power of the individual. When she hears, "No, you can't do that," she takes it as a challenge. Because of her high-level amputation, she was told, "You'll never wear a prosthesis." She wears one every day. Because a person with a high-level amputation uses more energy to walk, she was told, "You don't have the strength to go to nursing school." She went to nursing school. Because orthopedic nursing is more physical than many other types of nursing, she heard, "No, you can't be an orthopedic nurse." She became an orthopedic nurse. Some implied that she couldn't be a leader. She's both a leader and an innovative thinker. She founded the Amputee Coalition of America and has begun, through a new effort, to take the amputee consumer movement to the international arena. She leads constantly by example.

Paddy Rossbach, who lost a foot as a child, is another high-energy person. She shares the gifts of insight, understanding and humor. When doing peer visits, she's often asked about body image. A patient once said to her, "I hate looking down at myself. My body looks wrong. Don't you hate looking down at your missing foot?" And she responded, "Well, since I was so young when I lost it, I've actually never

thought about that. Let me go home and try it." Later, she looked at herself in a full-length mirror and thought, "If I saw two feet, that would look strange." She has a humorous way of using herself as an example to open people's minds to new ways of looking at things. She highlights that differences are okay.

You can see Paddy Rossbach's energy level kick into a higher gear when she's with children. She has a special place in her heart for kids. She's a driving force in ACA activities and learning programs for kids with amputations, such as the Limb Loss Education & Awareness Program and the Youth Camp.

"Knowledge speaks, but wisdom listens"

Each of these people, my mentors, has the ability to get people's minds moving in a new direction. None of them is afraid to take a chance with good ideas, but they are not reckless. And they're all willing

to take the time to create understanding. Paul Brand took decades to educate the world about leprosy. Ernest Burgess' philosophies on amputations are still being promoted today. Ted Hansen saw his ideas slammed by his medical colleagues at first, then be accepted in small niches, and, finally, take off worldwide, all within about a decade. Some of his revolutionary concepts about foot care have gained acceptance more slowly. Mentors have different styles and employ different ways of communicating, but they tend to share a common characteristic: They are curious people with creative minds who want themselves and others to do well.

These same attributes are also vital to good peer visitations. A good peer visitor can be a mentor by listening and setting an example. Just being present tells the person, "I've been where you are, and I know you can find ways to make your life complete again." Peer visits, if done well, are moments for the mentor to shine.

Inexperienced peer visitors can mistakenly believe they are there to tell the person, "Here's what you need to do." They leave after the meeting with the feeling that everything went well. Unfortunately, what they don't see is that the person they just visited can actually feel worse. He or she has been overwhelmed with information overload. What the person actually wanted from a peer visit was a chance to talk about confusion, pain and feelings. Instead, he or she got yet another lecture from yet another person telling him or her what to do. Those feelings of being overwhelmed and helpless just got worse, not better.

The Amputee Coalition of America provides extremely helpful information about peer visits and support. As the ACA notes, an untrained peer visitor can do more harm than good. Well-trained peer visitors, the ACA says, "are sensitive listeners who will use their developed skills in communication to facilitate the new amputee's own recovery and self-exploration so they may make good decisions for themselves."

Peer visitors can become living examples of accomplishment, achievement and how a person overcomes something as dramatic as limb loss. The really effective peer visitors make a positive difference and don't brag, dictate or claim to have all the answers. When the new amputee says, "I don't understand," or even, "I'm scared," they say, "It's okay to feel that way." They practice "The 90-10 Rule," listening most of the time and talking only when appropriate. By their example, the person sees that the path will keep moving forward and that there will be answers. Like Yoda, they know where to find the line between enlightenment and the dark side.

Jimi Hendrix may be far better known as a guitar player than a philosopher, but he was right on the mark when he said, "Knowledge speaks, but wisdom listens." ■