[Click on Above Link for Clearer View] By Guest Writer, Dr. Josephine Elia, “Engineer. Bookworm. Learner. Writer.” (A NOTE TO THE READER: This is one of the rare times I feel convicted to publish another’s work on this page. It’s a testament to my estimation of the article, which was originally published on the author’s blog [see details at the end of the article]. If you're one who seriously strives for excellence or shun mediocrity in its various forms, you will be richly rewarded by this insightful piece. Do yourself a favor: Add value to your life by taking time to read Josephine’s “Anatomy of Excellence.” Remember, EAGLES read, but Chickens watch TV and engage in hollow chats on the phone & on social media. —Samuel Koranteng-Pipim
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A post on the anatomy of excellence befittingly takes some grit to go through. But I refuse to dilute it to a bite-sized listicle and I trust your intellect. Excellence deserves the 3500 words. Read it through at once or bookmark it to read it in pieces, but it’s worth getting to the end.

What makes people excel? What makes some stand out from the rest?

When we measure our performance against the crowd, we typically benchmark ourselves against this somewhat amorphous concept of the average. Average is an interesting concept because it can be understood both as praise or insult. In many areas of our lives, bowling, height, and playing guitar–we’ve all got some—average is probably our fate. But, as Atul Gawande writes in his book,
Better: A Surgeon’s Notes on Performance
, “in your surgeon, your child’s pediatrician, your police department, your local high school? When the stakes are our lives and the lives of our children, we want no one to settle for average.” For high stakes situations, “what is troubling is not just being average but settling for it.”

In
Better
, Gawande writes about the three things that make a person successful in medicine: diligence, moral clarity, and ingenuity. I here take the liberty to add to his list and compile the 5 virtues of excellence—the anatomy of excellence:

Diligence
Commitment to do right
Personal responsibility
Ingenuity
The striving towards something better.

1. DILIGENCE

Diligence is the drive to complete the littlest tasks that seem insignificant day in and day out. It is easily overlooked and underestimated because of its simplicity. Gawande writes,

The first is diligence, the necessity of giving sufficient attention to detail to avoid error and prevail against obstacles. Diligence seems an easy and minor virtue. (You just pay attention, right?) But it is neither. Diligence is both central to performance and fiendishly hard.

Why is diligence important? It’s important because it’s a mindset, an approach of doing things that’s in it for the long haul. It bears the stamp of the person’s character, not just natural

talent, which in the greater scheme of things is more important. Character is what we're looking for in the person we've entrusted work to. Some things cannot be achieved without diligence. Many are filtered out from achieving great things because they don't want to do the tedious thing; they're turned off by the unglamorous work.

Gawande describes an example of diligence by describing the tireless efforts to minimize patient infections in hospitals due to contacts with doctors and nurses. The solution is simple: they need to wash their hands–wash them well and often. As it turns out, implementing this easy and known solution is not straightforward at all. People get lax, forgetful, lazy, and busy.

Stopping the epidemics spreading in our hospitals is not a problem of ignorance–of not having the know-how about what to do. It is a problem of compliance–a failure of an individual to apply that know-how correctly.

The efforts to monitor this behavior faced many failures. They didn't work or worked only temporarily, because changing human behavior is hard. You have to read the book to grasp the frustrations in maintaining this high level awareness of hand washing. The antidote of these infections is diligence–both in the medical practitioners and in the individuals responsible to supervise safety.

Through trials and errors, they found a way to motivate medical workers to wash their hands consistently, which was a valuable lesson in itself. Many of the previous efforts were top-down. This time around, they obtained inputs from everyone on the floor, creating a wider ownership to the hospital's performance and a culture of accountability where everyone was watching out for everyone else.

There will not be a time when washing hands will not be important in hospital work. This is not a phase–diligence is necessary, forever.

We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right–one after the other, no slipups, no goofs, everyone pitching in. We are used to thinking of doctoring as a solitary, intellectual task. But making medicine go right is less often like making a difficult diagnosis than life making sure everyone washes their hands.

Small details matter. And diligent people who pay attention to these details consistently stand out from the rest.

People underestimate the importance of diligence as a virtue. No doubt this has something to do with how supremely mundane it seems. It is defined as 'the constant and earnest effort to accomplish what is undertaken.' There is a flavor of simplistic relentlessness to it. And if it were an individual's primary goal in life, that life would indeed seem narrow and unambitious.

Understood, however, as the prerequisite of great accomplishment, diligence stands as one of the most difficult challenges facing any group of people who take on tasks of risk and consequence. It sets a high, seemingly impossible, expectation for performance and human behavior.

2. COMMITMENT TO DO RIGHT

Moral clarity is doing the right thing because it is right. It wouldn't be a distinguishing virtue if it were easy, because often the right thing to do is not the easiest, cheapest, or most expedient

option. When other priorities conflict, which approach would one take? Yes, this approach requires a certain moral compass, a belief that there are ethics associated with your work.

In medicine, human lives are at stake. A mistake or wrong decision by a doctor or surgeon can result in life or death. This makes medicine an inherently moral profession. But even when we don't see the results of our mistake as immediately as doctors do, it doesn't mean that our own work is not moral in nature. I've argued before that every work has a moral component that requires us to do the right thing [
http://www.josephineelia.com/engine...
]. We may not see the direct consequences, but it doesn't mean we are not culpable or responsible for our mistakes.

Gawande explores the difficult questions on the right thing to do with regards to physical boundaries, doctors' mistakes, and doctors' involvement in the death penalty. The first, he thinks about nakedness and the boundaries that should be in place to ensure trust between patient and doctor. In the second, he asks how much should doctors be paid and how much should doctors pay when mistakes happen? Lastly, he examines the decisions of doctors who, one way or another, are involved in the death penalty. These are hard and uncomfortable questions to ask, but the act of asking these hard questions–what is the right thing to do–is a mark of excellence.

The easy thing for any doctor or nurse is simply to follow the written rules. But each of us has a duty not to follow rules and laws blindly. In medicine, we face conflicts about what the right and best actions are in all kinds of areas: relief of suffering for the terminally ill, provision of narcotics for patients with chronic pain, withdrawal of life-sustaining treatment for the critically ill, abortion, and executions, to name just a few. All have been the subject of professional rules and government regulation, and at times those rules and regulations have been and will be wrong. We may then be called on to make a choice. We must do our best to choose intelligently and wisely.

Above all, we have to be prepared to recognize when using our abilities skillfully comes into conflict with using them rightly.

Part of the commitment to do right is to acknowledge the limit of our knowledge. When do we know what to do, and when do we not know what to do? What do we do at that point? When there's a possibility of us being wrong, do we have the guts to quiet down our ego and seek the help of others? In facing hard cases, doctors are faced with decisions on whether to keep pushing or stop fighting. In commenting on the ones that display self-awareness,

Sometimes they still pushed too long and not long enough. But at least they stopped to wonder, to reconsider the path they were on. They asked colleagues for another perspective. They set aside their egos.

This insight is wiser and harder to grasp than it might seem. When someone has come to you for your expertise and your expertise has failed, what do you have left? You have only your character to fall back upon–and sometimes it's only your pride that comes through. You may simply deny your plan has failed, deny that more can't be done. You may become angry. You may blame the person–"She didn't follow my instructions!" You may dread just seeing that person again. I have done all these things. But they never come to any good.

In the end, no guidelines can tell us what we have power over and what we don't. In the face of uncertainty, wisdom is to err on the side of pushing, to not give up. But you have to be ready to recognize when pushing is only ego, only weakness. You have to be ready to recognize when the pushing can turn to harm.

In a way, our task is to "Always Fight." But our fight is not always to do more. It is to do right by our patients, even though what is right is not always clear.

The right thing to do may be a vague concept, but perhaps it is good that it is vague. The key here is the striving to seek what is right and to commit ourselves to pursue it. This is what sets the excellent ones apart from the majority who is satisfied to follow rules blindly.

3. PERSONAL RESPONSIBILITY

I have found that it's possible to get rid of a problem by pushing it around, postponing it, or tagging enough people in the effort until it becomes someone else's problem. When you spread the responsibility of a certain task out, it's easier to blame it on another person.

This is NOT problem solving. And not what excellent people do.

What they do instead is this: they lean (hard) into their problem, take ownership of the task, and make it their personal responsibility to get it done and get it done well.

This is a rant against the "Not my problem" syndrome. Imagine the person charged with uploading videos to a website, but the videos are long and people can't find what they're looking for–the key message as promised in the title–easily. He throws up his hands and says, "Not my problem. I did my job." In other words, the perfecting of the video is not his job; it's someone else's problem. What can I do, I'm just an uploader?

Well, there are things he can do. He can point people to the minute and seconds where the key message appears, he can learn to cut and edit the videos, or at the very least, he can deliver the message to the right person on the team that can solve the problem.

If you're a part of a team and you have a message you want people to hear, then it is incumbent upon you to make sure people get that message as easily as they can. And yes, it IS your problem.

The key thing here is having personal stakes in the work, making sure that once you touch the task, it will come out better at the other end. It's about adding the maximum value to the product, as much as you possibly can.

Excellent people don't just accept the scope of their task blindly. They investigate the wider scope–why do they need to do this task, what is the context. Once it is done, who are the recipients of the results? How can they receive this as easy as possible? They make it their business to not just finish the job, but to complete it—complete throughout the life cycle of the job, not just when it's off their desk.

I don't deny that there are limits to what we can do, that at some point, it really is not your problem anymore. But the point here is the attitude, because likely, the person who tends to say, "It's not my problem. I've done all I can." is likely not the person who has pushed the farthest in his effort.

Lean into your problem and contribute. Not everything is your problem, but the ones that are on your plate, make them yours and finish them with finesse.

4. INGENUITY

Ingenuity is the creativity someone brings to the table to solve a problem. It is something that will not come out unless personal responsibility exists. This is the deep learning, the nonstop testing, and continual improvements in making your work, your craft, and your art better.

My favorite part of Gawande's book is the chapter titled "The Bell Curve." It tells the story of a small field in medicine that has been "far ahead of most others in measuring the results its practitioners achieve: cystic fibrosis care."

Part of improving performance is conducting diligent measurements, data gathering, and benchmarking. What doesn't get measure often doesn't get improved. The Cystic Fibrosis Foundation has collected data from treatment centers across the country since the 1960s. It all began with a pediatrician named LeRoy Matthews, who had a bold claim that his patients had an annual mortality rate of less than 2 percent at a time when the rest of the field averaged at more than 20 percent. The average patient died at the age of three.

The Foundation assigned another pediatrician, Warren Warwick, to investigate Matthews' claim. When the results came in, they confirmed that he was a positive deviant. In his center, the median estimated age of death was 21 years, seven times the age of patients treated in other centers. At the time, he had not had a single death among patients younger than 6 years old in 5 years.

Unlike pediatricians elsewhere, Matthews viewed CF not as a sudden affliction but as a cumulative disease and provided aggressive preventive treatment to stave it off long before his patients became visibly sick from it. He made his patients sleep each night in a plastic tent filled with a continuous aerosolized water mist so dense you could barely see through it. This thinned the tenacious mucus that clogged their airways, enabling them to cough it up. Using an innovation of British pediatricians, he also had family members clap on the children's chests daily to help loosen the mucus.

This one doctor changed the entire field. By 2003, the average life expectancy of a CF patient is 33 years.

Gawande visited two hospitals to compare treatment practices. First, he went to Cincinnati, a place that had middle ranking. He was surprised to be impressed by the quality of medical practice there. Everything was practiced "carefully and conscientiously—as well as anyone could ask for."

Then he went to Minneapolis, where he met Warwick, the doctor who did the study on Matthews many years ago. Having learned from Matthews, Warwick seemed to add something different to the treatment.

In an interaction with a high school patient named Janelle, Warwick started with the friendly banter between doctor and his teenage patient. He found out that there had been a slight dip in her lung-function. Three months earlier, she had been at 109 percent, better than kids without CF, and now she was at 90 percent.

Most people would have settled for 90 percent, but not Warwick. He started asking, why did it go down, asking Janelle to find out what had been going on in her life. Met with a series of "I don't know" plus attitude, he went on to do a lecture,

"'A person's daily risk of getting a bad lung illness with CF is 0.5 percent.' He wrote the number down. Janelle rolled her eyes. She began tapping her foot. 'The daily risk of getting a bad lung illness with CF plus treatment is 0.05 percent,' he went on, and he wrote that number down." He went on to describe the different between a 99.5 percent vs. 99.95 percent chance of staying well. On a given day, there seemed to be hardly any difference. But, showing his

calculations to the patient, in a year, it is the difference between an 83 percent and 16 percent of making it through the year without getting sick.

He eventually found out that Janelle had a new boyfriend and some new school changes that disrupted her treatments. He then insisted on Janelle to come for a few days to catch up on lost grounds. The interaction ended with this, “We’ve failed, Janelle… It’s important to acknowledge when we’ve failed.”

Gawande reflects on the core of Warwick’s worldview that makes his center better than average,

He believed that excellence came from seeing, on a daily basis, the difference between being 99.5 percent successful and being 99.95 percent successful. Many things human beings do are like that, of course: catching fly balls, manufacturing microchips, delivering overnight packages. Medicine’s distinction is that lives are lost in those slim margins.

Warwick’s combination of focus, aggressiveness, and inventiveness is what makes him extraordinary. He thinks hard about his patients, he pushes them, and he does not hesitate to improvise.

His ingenuity led him to innovate unconventional solutions to CF, inventing a new stethoscope, a new cough, and a mechanized chest-thumping vest for patients to wear.

When you lean hard into a problem, diligent in paying attention to details, committed to do the right thing for your patient, and use your individuality and creativity in trying new solutions, all of that opens up doors of innovation, solutions that are uniquely you. None of this will come out of superficial work.

5. SOMETHING BETTER

In the CF discussion, even though Matthews and Warwick’s methods had improved the entire field, their centers managed to stay ahead of the pack. From the gathering of data over the years, patterns emerged.

“You look at the rates of improvement in different quartiles, and it’s the centers in the top quartile that are improving fastest,” Marshall says. “They are at risk of breaking away.” What the best may have, above all, is a capacity to learn and change–and to do so faster than everyone else.

Humanity is gifted with this infinite capacity to grow and those who know how to do this out of their own volition, excel. It is the striving toward something better that distinguishes those at the high end of the bell curve.

Paul Kalanithi, another doctor, writes in
When Breath Becomes Air
that “the defining characteristic of the organism is striving.” In
Mind, Character, and Personality
, Vol 1, Ellen White writes, “‘Something better’ is the watchword of education, the law of all true living.”

There’s always something better to do, some way better to try.

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Gawande concludes that to be successful in medicine is to have and practice these ingredients of excellence.

We are used to thinking that a doctor's ability depends mainly on science and skill. The lesson from Minneapolis–and indeed from battlefield medical tents in Iraq, villages with outbreaks of polio, birthing rooms across the country, and all the other places I have described in this book–is that these may be the easiest parts of care. Even doctors with great knowledge and technical skill can have mediocre results; more nebulous factors like aggressiveness and diligence and ingenuity can matter enormously.

The great news is that this is accessible to everyone. Everyone can be diligent, commit to do right, claim personal responsibility, try new things, and strive to be better.

True success in medicine is not easy. It requires will, attention to detail, and creativity. But the lesson I took from India was that it is possible anywhere and by anyone. I can imagine few places with more difficult conditions. Yet astonishing successes could be found. And each one began, I noticed, remarkably simply: with a readiness to recognize problems and a determination to remedy them.

Arriving at meaningful solutions is an inevitably slow and difficult process. Nonetheless, what I saw was: better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.

These are not natural-born talents. These are the stuffs of discipline, attitude, and approach to life, work, and learning. It can be acquired and practiced by all. Do one, and you may already do better than your peers. But do all of them and you can't help but be excellent.

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hails from Indonesia, but now resides in Chicago. She holds chemical engineering degrees from MIT (B.Sc) and Princeton University (Ph.D). Regarding her philosophy of learning, she writes: "I believe that life is about learning, that education never stops, and that we need to always strive towards the betterment of ourselves, our work, and our relationships. I find it most thrilling when I meet like-minded people who strive to live the same way."
Josephine was one of our students at the CAMPUS Missionary Training Program in Ann Arbor, Michigan, when I served as Founder/Director (1999-2011). I've always respected her as an Eagle in a world of chickens. We share other things in common: "Engineer. Bookworm. Learner. Writer." The above article was originally published on Josephine's blog:
http://www.josephineelia.com/anatomy-of-excellence/.
If you want to sign up for her bi-weekly updates, you can sign up for
Josephine's Letter
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http://www.josephineelia.com/josephines-letter/
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Oh, now that you've read the article, don't forget to share your comments. Don't just "LIKE" the article. Let me know what you think!