

From Scalpel to Systems: Navigating the Second Curve with Drucker

Prologue

"We brought no food. No water. No blankets. And no money, all of which was desperately needed at the time. We brought just music."

I was thirteen years old when I first visited Tohoku, Japan, with my violin after the Great East Japan Earthquake in 2011. I didn't know it then, but that visit would shape the rest of my life. I believed I was merely sharing music to cheer survivors in temporary shelters, as part of a charity concert. But as I played among the ruins, something within me shifted. A woman approached me after the concert and said, "We don't need more words. What you just performed was all we needed, the music. It helps us breathe." These words didn't just comfort me, who was suffering from a sense of guilt for not bringing anything that was in need, but they defined me. Healing and bringing comfort to people, I realized, begins before any diagnosis or prescription. I have continued to visit the Tohoku area for 13 consecutive years since 2011, as a professional violinist, as a concert manager, and later as a medical professional.

Growing up in a remote village in Japan, the violin had been my sanctuary. It gave me discipline, expression, and purpose. I performed in concert halls as a soloist, joined multiple music competitions, played in orchestras, and engaged in many, many charity concerts, believing that music had the power to reach where language faltered. But over time, I began to realize its limits. Music could comfort, but it could not cure. It could console, but not change access to care. As I grew older, I sought ways to make my impulse to bring comfort to people in a more tangible, structured, and impactful way. This led me into medicine, then surgery, and ultimately to the question that Peter Drucker would later help me answer: How can we act not just with compassion, but with effectiveness? How do we know when our original path, however noble, must give way to something better aligned with purpose? What follows is the story of how I moved across the curves: the pursuit of excellence, the search for strategy, and now, the obligation to return, not to fix, but to reimagine.

First Curve

I studied medicine at Tohoku University School of Medicine in Sendai, the very region where I first felt the urge to bring comfort to people and heal. I hoped to translate the compassion I had learned through music into healthcare. During medical school, I was fortunate to have opportunities to lead multiple research projects, focusing on people with dementia and chronic disease, and conduct international research on how music therapy improved the quality of life for people with cognitive dysfunction. This not only gave me a chance to meet patients and conduct interviews, but also taught me how complex health issues and systems are, even in a country like Japan, where universal health coverage is established with affordable healthcare. After graduation, I believed that surgical mastery was the highest form of compassion since it can actually "cure" and physically remove the tumor.

I began a residency at the most competitive and prestigious hospital in Tokyo, specializing in general surgery with an aspiration to become a thoracic surgeon. There was skill in stitching, beauty in the procedures, and prestige in doing complex surgeries. For a time, I felt aligned. But over time, I sensed a growing chasm between what we fixed and what we ignored. I remember one patient, a woman in her fifties, who underwent a series of complex wound reconstructions. Her vitals were stable. Her charts are immaculate. But with each visit, I watched something in her fade, even though her vitals were stable. One day, I ran into her in the hallway, slumped quietly in her wheelchair. She looked up at me and whispered, almost apologetically, "*It feels like I'm disappearing.*" In that moment, I could no longer ignore the question I had buried beneath routines and rounds: Is healing just the absence of illness, or is it the restoration of meaning?

In the operating room, I followed orders without question. When a patient died and I instinctively reached out to hold her hand, a senior surgeon told me coldly, "She's already dead. Don't waste time. Do the job I told you." My act of empathy was dismissed as inefficiency. Being the only female surgical resident came with constant scrutiny. I was determined to stay quiet at that time, afraid of jeopardizing the career I had worked so hard to get. I started sleeping for very few hours a night, surviving on caffeine and adrenaline. I smiled on rounds, but inside, I was shrinking. I began to feel like a machine, not someone who brings comfort.

Worse than the exhaustion was the erosion of purpose. The deeper I went into the system, the more it seemed to reject what brought me there in the first place: presence, compassion, and reflection. I became skilled at procedures and gained knowledge, but I no longer knew why I was doing them. I wasn't sure what I believed in anymore. I was caught in a paradox: succeeding, but lost. At some point, I stopped playing the violin.

Looking back, Drucker's notion of 'planned abandonment' would have offered a lens I needed: the recognition that not all successful practices are sustainable ones (Drucker, 1999). I had stayed in surgical residency because I was still succeeding. Without a single doubt, on paper, I was thriving. I had a prestigious title, steady income, and recognition. But beneath the surface, I was fraying. Success was no longer the right measure. The curve had not yet declined, but its purpose had faded. That was the moment. The true moment to let go is not when things fail, but when they cease to make sense.

The Inflection Point

The next curve did not appear with clarity, but with questions. What was I truly trying to accomplish? "What was our task?" (Drucker, 2006). I wanted to learn and understand how the healthcare system, policy, technology, and business could come together to build a more human, equitable healthcare system. Handy warns that if we wait until the curve visibly drops, it is already too late to begin anew (Handy, 2015). Letting go of clinical practice was not easy, but it was essential.

After a long thought and reflection, I decided to pursue a master's degree in the US, studying public health and an MBA, seeking tools that could help me heal on a different scale. Handy describes the Second Curve as the beginning of a new arc while the old still ascends, a shift made not from desperation, but insight (Handy, 2015). I realized that healing required more than clinical precision; it required institutional alignment with what people value.

Second Curve: Redefining Effectiveness

Entering graduate school, I expected to gain skills in statistics, finance, systems thinking, and regulatory science. I did not expect to confront the moral architecture of institutions. Yet it was precisely this confrontation that marked the true beginning of my second curve. In a course on value-based healthcare, we examined how different nations define success. For instance, the Japanese healthcare system prioritizes access and affordability, reflected in its relatively efficient universal health insurance system. As of now, Japan's total health expenditure accounted for 10.7% of its GDP, which is below the U.S. but above the OECD average (OECD, 2023). The country also has the longest life expectancy in the world, at 84.5 years; yet, despite these strengths, challenges persist in aligning services with patient-centered outcomes (World Bank, 2023).

One striking example is the role of the elderly. People over age 65 account for over 29% of the Japanese population, and they consumed approximately 64% of all hospital expenditures as early as 2011 (Matsuda, 2019). Yet, few Japanese hospitals systematically incorporate patient-reported outcome measures (PROMs), such as quality of life or emotional well-being, into decision-making processes. As I reviewed these statistics, I began to question a system that prioritized access but often left dignity unmeasured and unheard. Guided by Drucker's question, 'What is our task?', I came to understand that true healing goes beyond physical recovery. It means giving people back their voice.

Meanwhile, I was also learning that inefficiency is embedded in the very institutions aspiring to reform. In the U.S., administrative costs consume approximately 25% of total healthcare spending, double that of comparable high-income nations (Tseng, Kaplan, & Richman, 2020). Physicians spend an average of 16 minutes per patient visit on electronic documentation, contributing to record-high burnout levels (Tai-Seale et al., 2017). The very tools designed to enhance care were eroding the time and trust required to deliver it.

In modern medicine, we have optimized for efficiency, scheduling surgeries and turning over beds quickly, but often at the expense of human connection. Patients frequently leave without feeling truly seen or heard (Berwick, 2009; Epstein & Street, 2011; Tai-Seale et al., 2017). I began to see that my job was no longer just a healthcare provider, but to reimagine the systems that define what healthcare means. That realization didn't arrive all at once. It unfolded in moments, discussions with professors, reflections on policy failures, quiet reviews of clinical notes where the pain had been underscored, and voices unheard. I also doubt my purpose in the difficulties of getting a job in this field, especially in the U.S. In Japan, I had at least my

credentials as a doctor and a proven record. But in the U.S., I was nobody. I have applied to 100 internships in hospital management and consulting, not gotten a single offer. Having a solid purpose is important, but we also need to live and have an income. This added extra hardship to move forward.

One of Drucker's greatest insights was that purpose must precede structure. A strategy without a mission is noise. In my classes focusing on operations, I started building health service maps centered not on resource flow, but on lived experience: how patients move through uncertainty, how families make decisions, and how providers communicate care. These became the instruments I now use, not to operate on bodies, but to repair systems. As I began experiencing real-world projects through school projects and extracurriculars, such as evaluating early-stage health ventures and assisting community engagement in policy modeling, I understood what Drucker meant when he said: Drucker meant it when he said, "*Management is doing things right; leadership is doing the right things*" (Drucker, 2006). My true second curve had arrived, not defined by tools, but by questions.

Handy warned that clinging to obsolete definitions of success can prevent organizations and individuals from pivoting when their relevance begins to fade. I was witnessing that reality. Hospitals were measuring efficiency, not efficacy. Ministries were targeting cost, not coherence. And all the while, patients, the most vulnerable state in their lives and who should be the center of the narrative, were being asked to fit into systems designed without their input.

Returning to Responsibility: Systems as Moral Acts

As I am finishing my first year of master's study, the question is no longer just what I want to build, but how I would do that. Drucker often argued that the most important task of management was not efficiency or control, but the creation of meaning (Drucker, 2006). If my first curve had been about personal excellence, and my second about reframing strategy, this new phase was about stewardship, returning to institutions not to criticize, but to co-design.

In my recent experience joining the St. Gallen Symposium, I noticed the "success" pattern from many other participants who are working to support health innovation initiatives; they not only build tools but also build trust. They try to deploy systems, but also listen, and listen carefully. It reminded me of Drucker's warning: 'The most important thing in communication is hearing what isn't said.' In healthcare, those silences are everywhere, in how we exclude non-digital natives from digital solutions, how we forget to ask what matters most, and how we reward volume over voice. My contribution was not to engineer new diagnostics or analytics but to advocate for design embedded in empathy and accountability. This is what Drucker called 'responsible freedom', freedom anchored in shared purpose.

Handy emphasized that institutions thrive when they become communities with a cause. My collaborations with stakeholders, from clinicians to caregivers to community organizers, revealed a shared hunger: not just for efficiency, but for coherence. It is not enough to add new

technologies to old systems. We must align innovations with institutional values. That is my task for now, not to manage change, but to define what is worth changing.

For example, the integration of Patient-Reported Outcome Measures (PROMs) into regional healthcare evaluation systems can redefine what we measure—and thus, what we manage. PROMs have been shown to improve patient satisfaction and clinician decision-making in multiple studies, and the measures have been shown to increase patient satisfaction by up to 12% and improve clinician responsiveness (Black, 2013; Boyce et al., 2014; Chen et al., 2013). PROMs have been shown to increase patient satisfaction by up to 12% and improve clinician responsiveness. If implemented in just 30% of regional hospitals in Japan, where PROM usage remains under 10%, the impact could reshape resource allocation, enabling prioritization based on lived experience, not just clinical throughput. Instead of optimizing for cost-per-case, we could begin designing for value-per-life.

However, the value of PROMs is not realized through measurement alone—it requires institutional integration. Currently, PROMs are rarely linked to funding or accountability mechanisms in Japan, making them "heard but not heeded." A policy mechanism that ties PROM outcomes to performance-based funding, as piloted in parts of the NHS and Ontario, could serve as a scalable model. For example, if PROM-based indicators were used to determine 5% of hospital reimbursement, even modest improvements in reported quality of life could drive millions in redirected funding. This would not only incentivize attentiveness to patient experience but embed it structurally into decision-making.

Redefining effectiveness in this way is not just an operational shift, it is a moral one. As Drucker insisted, "The purpose of an organization is to enable ordinary people to do extraordinary things" (Drucker, 2006). The extraordinary thing, I now believe, is not growth for its own sake, but dignity by design.

Conclusion: Curves as a Way of Life

Handy's Second Curve and Drucker's philosophy together offer not just strategy, but a way to live and lead. Their wisdom has taught me to distinguish momentum from meaning, and performance from purpose. They remind us that the right time to pivot is before the decline, that the greatest danger in turbulence is acting with yesterday's logic, and that progress is not always growth; it is often redefinition.

The Second Curve is not merely a phase; it is a discipline. To embrace it requires courage, to let go before certainty disappears. But it also demands clarity: the humility and also the courage to ask, "What is our task?" And the integrity to act when the answer changes. For me, that journey has meant leaving surgery, questioning systems, and now, contributing to reimagine them.

I have not abandoned my first purpose that led me to medicine; I have rather redefined my tool to make that happen. My instrument is no longer a scalpel, nor even a violin, but a question: What does it mean to design for dignity? As more professionals, leaders, and institutions face similar

crossroads, I hope they see the Second Curve not as a detour, but as the main path, the path where meaning lives.

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