Are Surgeons Capable of Introspection?

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The philosophy of the wisest man that ever existed is mainly derived from the act of introspection.

William Godwin

Think of introspection as just another “time out.” Perhaps surgeons would feel better working from a checklist of exploratory questions to ask when thinking about their thoughts and actions? Surgeons might consider introspection a cognitive “operation” that requires planning. And, of course, there are risks to the process of digging around in one’s mind uncovering notions about good and evil and the role of chance and uncertainty in one’s practice and life.

Risks, benefits, and outcomes rule the surgical ethos. In the domain of palliative care, where a confrontation with one’s own mortality is unavoidable, these elements may be seen as the core of introspection. When one considers the ramifications of the action-oriented “surgical personality,” it becomes apparent that self-reflection may be anathema to some practitioners. Both surgeons and non-surgeons have written extensively about surgical personality traits and how they may impact the way surgeons conduct their work.1–6 This article probes the underbelly of what most observers agree is a unique surgical persona and discusses how it confounds the act of introspection.

In his insightful 1995 memoir, A Miracle and a Privilege, Francis D. Moore7 wrote regarding end of life care, “Responsible physicians should join forces with the public to write a new chapter in medical education that places care in death in its proper context. It is tricky. It is dangerous. We need it and people are ready for it. It will relieve more suffering than did the discovery of anesthesia 150 years ago.” Insight distilled from a lifetime of research and practice sparkle throughout Dr Moore’s book, a repository of knowledge that not surprisingly includes the above quote referring to palliative care as part of a surgeon’s responsibilities. Other physicians have also been aware of the need for self-reflection to understand the impact of their professional deeds on
patients. In discussing the need for self-awareness, Timothy Quill wrote, “Unfortu-
nately, most physicians are given little encouragement or training in looking inside
themselves and exploring potential sources of strong reactions and identifications. In
fact, there may frequently be a conspiracy to suppress such reactions in the belief
that they should not exist in a ‘professional’ physician-patient relationship.” Subvert-
ing one’s strong personal feelings in the service of helping others may, at first, seem
unquestionably altruistic. Yet, a failure to understand one’s own emotions could over
time culminate in resentment and anger toward patients, emotions that can easily spill
into the clinical encounter. Quill added, “A truly self-aware clinician will be able to
determine if the source of a strong reaction is the clinician him- or herself, the patient,
or the interaction of the two.” And as one might suspect, this issue is not new. In 1923,
Deaver and Reimann wrote, “Complacency and smug satisfaction are danger signals
decadence, just as wholesome discontent and healthy introspection and self-
criticism are indications of the will and desire for improvement.”

Challenges offered by the current surgical environment as well as the impact of the
surgical personality will influence a surgeon’s willingness to include palliative care as
an important aspect of his or her practice. However, to do so will no doubt nudge us
away from the danger signals of decadence.

**CHALLENGES OF THE TWENTY-FIRST CENTURY SURGICAL ENVIRONMENT**

Both academic surgeons and private practitioners face enormous challenges today.
The litany of issues runs a familiar course from a surgeon shortage, reduced reim-
bursement, mounting clinical work, cognitive and technical overload secondary to
minimally invasive surgery superimposed upon traditional open techniques, a severe
reduction in trainee duty hours and the consequent educational dilemmas, and
oppressive regulatory oversight. Getting the work done safely and efficiently is time-
consuming. Few moments remain at the end of the day for self-reflection. One might
worry that too much introspection could be harmful. I will argue that without regular
self-assessment a surgeon may fall into the trap of depression, substance abuse, or
full-blown burnout.

Surgeons have always paid a price for their dedication to the ideal of providing the
personal continuity of care they feel is a unique aspect of the management of operative
patients. The result of this self-imposed burden is fatigue and frustration. Only 75% of
surgeons recently surveyed stated that they enjoy the practice of surgery and 30% to
40% suffered from burnout. This syndrome is characterized by depersonalization
and a loss of interest in one’s patients, as well as in the performance of the technical
work itself. Not only are these surgeons a threat to their patients’ safety, they also risk
the consequences of burnout, namely poor clinical performance, divorce, and
alcoholism. Paradoxically, becoming more rather than less involved with sick
patients could provide an opportunity for surgeons to explore their feelings and views
about death and other end-of-life issues. The overwhelming impact of a confrontation
with a dying patient often serves to place one’s own day-to-day conundrums in
perspective. Measuring one’s good fortune against the faltering final steps of another
human being seems to me to be life’s ultimate metric.

Thus, my argument is that surgeons who routinely abandon their dying patients to
the care of others have not only tossed away an opportunity to help their patients
accomplish the chores of dying, but they have also lost an opportunity to cultivate
self-knowledge. Some surgeons may not feel comfortable talking to dying patients.
However, at least one study refutes this tenacious allegation. Too often palliative
surgical care is viewed as a matter of operative intervention, the employment of
procedures designed to relieve suffering. That aspect of a surgeon’s work with the dying is important, but operating at the end of life is only a part of how they may help patients with incurable disease.

THE VARIABLE ENDOWMENT OF REFLECTIVE THOUGHT—LEVELS OF CARING

Not all surgeons limit themselves by adhering to the constrained professional paradigm referred to as the “action as success” principle. In fact, many academic and community surgeons frequently reflect on the challenges of their surgical practices with genuine insight. To be fair to the others, busy practitioners have little time to reflect on their daily actions—excluding the painful soul-searching all surgeons indulge in when complications arise. For some practitioners the notion of looking inward is both rewarding and troublesome. It is for precisely this reason that surgeons would benefit from taking moments here and there to consider the weight of their work, particularly when it involves terminally sick patients.

Daniel Callahan describes four levels of potential involvement in patient care. These categories may serve as a framework for surgeons to determine how deeply to get involved when asked to participate in a particular patient’s care. Callahan writes derisively about modern medicine’s preoccupation with cure, “For its part, scientific medicine seems to have said that it is not its task to understand and give meaning to suffering but to rid our lives of it. Meaning, like caring, is for the losers.” In contrast to employing a purely scientific biomedical model of patient management, caring surgeons may become truly engaged in their patient’s care by encouraging an ongoing dialog to explore the patient’s hopes and fears about dying.

Imagine that a surgeon has been asked to consult on an elderly jaundiced patient with a forty-pound weight loss and an epigastric mass. Suspecting an inoperable pancreatic cancer, he or she summon up a snapshot overview of what may be going on with the patient and where the relentless clinical course will go. The surgeon’s involvement will be easier to formulate if the consult is framed with the following levels of possible interaction in mind:

- Cognitive involvement (providing one’s assessment of the diagnosis and the patient’s treatment options)
- Emotional involvement (acknowledging the patient’s fear, anxiety, dread, etc)
- Values (making certain one understands that his or her values and what the patient believes is important may differ)
- Relationships (Is the patient open to the opinions of others? To the surgeon’s opinion? Does the surgeon know the family members and what they think?)

The surgeon’s opinion regarding the choice of a biliary or gastric bypass, or neither, as well as other operative possibilities is the cognitive element of the consult. The discussion may be suffused with the patient’s (and the surgeon’s) anxieties regarding the threat of shortening the patient’s life as a consequence of postoperative complications, as well as the patient’s values regarding how hard to fight. And the family may enter the consultation dialog and deepen the surgeon’s involvement. Thus, a surgical consult may be singularly focused on the wisdom of surgical intervention or may become intimate and ongoing.

DOES THE SURGICAL PERSONALITY EXCLUDE INTROSPECTION?

Three well-known anthropologists as well as a number of surgeons have studied and recorded what are perceived to be the primary elements of a surgical personality.
Some observers have debated the existence of personality traits specific to surgeons, but most agree surgeons share common thinking habits and behavior patterns (stereotypical responses) in given situations. This article highlights the contributions of Charles Bosk, Joan Cassell, Pearl Katz, and other investigators who have delineated the characteristics felt to be typical of the surgeons they observed or surveyed. This information emerged from the 1970s and 1980s. When blended with more recent contributions from surgeons themselves, it constitutes timeless insight into the workings of the surgical mind and will inform this discussion of introspection.

Long before Henry the VIII directed the creation of the Company of Barber Surgeons in London in 1540, physicians and surgeons had separated themselves from one another along elitist and intellectual lines. Surgeons were uneducated and crude, yet increasingly effective at managing superficial surgical diseases such as abscesses, fractures, dislocations, and wounds. The origins of surgery reflect the very antithesis of introspection. With anesthesia far in the future, cutting for bladder stones and excising surface tumors were operations attempted by skilled surgeons employing personal courage, as well as alcoholic beverages and sedative nostrums, for their luckless patients. Before ether, nitrous oxide, and chloroform, surgeons made their reputations by demonstrating remarkable hand speed.

The modern era of surgery with its advances in surgical techniques, as well as improved pre- and postoperative care, has eliminated the need for “prima donna” boldness and sheer extroversion. Joan Cassell reminds us of the reluctance to stereotype or label members of society even though she describes in detail specific traits of the surgeons she studied. As recently as three decades ago, trainees were inured to, “Be ballsy. Do it!” following in the footsteps of their male mentors (and ridiculing women who dared to enter the male-dominated cloister of surgeons).

In her 1991 book, Expected Miracles—surgeons at work, Cassell wrote regarding heroic curing versus healing illness, “Heroes ignore patients’ subjective experiences of being unwell, unfit. Patients suffering from illness are frequently labeled ‘complainers’ by heroic surgeons who knowing they excised disease, resent the patient’s unabated demand for care.” In the surgical world of the 1970s and 1980s, surgeons described themselves to Cassell as “macho” lovers of sports and cars, acting as if invulnerable, untiring, and fearless. She noted similarities between surgeons and test pilots, both masculine worlds of death-defying activities, long training periods, and high levels of technical skills. She also noted the following surgical personality traits: arrogance, certitude, activism, and qualities of strong leadership.

Thus, Cassell articulates the dilemma at the center of this discussion: “It may be the exceptional surgeon who is capable of recognizing and supporting the autonomy of patients, of allowing them to share decision-making, of acknowledging uncertainty in the face of decisions that must be made. Such people surely exist, but perhaps we cannot expect them to be the temperamental or behavioral norm among surgeons.” Why not? Should surgeons not expect more of themselves in today’s complex health care environment? If surgeons do not participate fully in their patients care, do they not feed the old prejudice of “surgeon-as-technician”?

Cassell wrote elsewhere of the surgeon’s personality traits, “As for sympathy, empathy, and an aptitude for human relations, these traditionally female traits seem somewhat peripheral to the most obvious and easily observed characteristics of a good surgeon, many of which are exhibited when the patient is unconscious.” She concludes that, because surgery is a public act, the surgeon’s relationship with disease is personal; surgical success is attributable (to the surgeon’s skill) and visible (in the operating room).
Pearl Katz’s 1990 book, *The Scalpel’s Edge*, is a rich trove of observations from her study of a large North American teaching hospital in the 1980s. She observed surgeons in action as well as documented their attitudes regarding their work, trainees, and peers. She noted that surgeons focus on the mechanical repair of the body in a hospital setting that fragments care (rounds aimed at specific postoperative goals) and provides scant opportunity for the surgeon to become intimately acquainted with his or her patients. Referring to the often unpleasant visceral nature of surgery, Katz writes, “Surgeon’s detachment from their patients may be understood as necessary protections for these routine sights, smells, acts, and dramatic confrontations with mortality…. It may be that if a surgeon were to empathize with each of his patients who are in fear, pain, and confusion and are sick and dying, his efficacy as a surgeon may be compromised.” Therein lies the rub for all who walk the invisible line between necessary detachment and appropriate intimacy with patients.

However, the skilled surgeon ought to be able to step away from the bright operating room lights, away from the invisible patient beneath the drapes—the dictates of sterility having removed any visible evidence of the humanity in the room—and later sit at the patient’s bedside and indulge in the empathetic exchange that postoperative patients seek. Commenting on surgeons’ tendency to boldly rebuff uncertainty, Katz states, “Thinking that emphasizes certainty diverges considerably from (scientific) thinking which emphasizes skepticism, questioning, knowledge-seeking, reflection, analysis, and verification.”

In the 1980s, surgeons favored action over cerebration. And, when debating clinical issues among themselves, surgeons for the better part of the twentieth century preferred heated exchanges, if not outright acrimonious dialog in discussing clinical trials and scientific data. Katz noted that the surgeons she observed expressed several traits including impatience, ill-disguised condescension, mild distrust, need for positive feedback about their performances, insistence on an unequal distribution of power, and secretiveness manifested as a poor ability to communicate with their colleagues. The image of the surgeon as masculine hero evolved to its highest form through the last decade of the twentieth century; war metaphors punctuated the surgical lexicon then and they continue to find their way into the language of lay people today. For example, obituaries refer to the inevitability of metastatic disease as “losing the battle with cancer.” The language of surgeons often includes references to “conquests,” “victories over disease,” “patient’s defenses,” and “taking the offensive against disease” by “heroes” and “warriors” who show courage through action. Thus, Katz concludes, “They reveal their proclivity for action in their use of language which not only prefers using active words and active tense, but also refers to battles and wars, strength and masculinity, while denigrating weakness, passivity, and femininity.”

This language hardly reflects the temperament of individuals inclined to practice introspection.

It is unclear how thoroughly today’s surgeons have discarded the traditional heroic stature Katz and Cassell observed and described. It is not only a matter of how the world at large envisions their work and general conduct; the issue also revolves around how surgeons view themselves. It is my sense that the heroic “militaristic” persona of surgeons has been modified and diluted by two recent advances: the entry of more women into surgery and the very different demands of minimally invasive surgery. Together, these two changes may significantly improve palliative surgical care.

In 1999, Ronald M. Epstein wrote in *JAMA*, “Exemplary physicians seem to have a capacity for critical self-reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information,
making evidence-based decisions, performing technical skills, and defining their own values.” By the end of the decade of the 1990s, minimally invasive surgery had changed the radical nature of operations and had similarly begun to modulate the surgeon’s image. Instruments and incisions had become smaller and hand delicacy proved to be even more essential than with open operations. Today, just as less tissue trauma continues to be of paramount importance, surgeons have been brought to adhere to strict behavioral standards. Managing conflict represents another nontechnical skill required of today’s surgical practitioners.17

One wonders if the traditional surgical personality will become obsolete.

**DOES PATIENT AUTONOMY IMPROVE WITH SURGEON INTROSPECTION?**

Choice remains at the heart of end-of-life decisions. The World Health Organization has emphasized the view that palliative care encompasses the total care of patients whose disease is not responsive to any curative treatment.18 It is the inability to accept the value of caring over the value of curing that often turns surgeons away from playing a role in the final chapter of their patient’s life. Despite discussions to the contrary, surgeons continue to view death as defeat—just as they interpret the need to open during a laparoscopic case as a crushing blow to their egos. Neither sentiment is appropriate, although not unexpected from highly motivated practitioners. The often repeated expression about surgeons, “Sometimes wrong, but never in doubt,” serves to highlight the issue: without a sense of self-doubt there is often little room in patient-surgeon communication for considering options, for choice, and for patient autonomy.

Thus, the two ideas being discussed often clash in the surgeon’s mind with the arrival of a need for palliation—the notion of patient autonomy versus the surgeon’s self-image as leader and action hero. Accustomed to directing patient care in the operating room and, to a lesser degree, in the office or clinic, surgeons may well step back in annoyance from patients who express a desire to be autonomous in matters of end-of-life care. To appreciate the difficulty surgeons may have with end-of-life care, they must compare the long-standing tradition of the surgeon’s self-image as action professional with other physicians’ efforts to foster personal awareness. For example, Longhurst19 emphasizes the need for doctors to understand how to see themselves as reflected in their patients’ responses to them, as well as the imperative to understand the impact on patients of the doctor’s subjective internal world of beliefs, values, attitudes and fantasies. Without self-knowledge, the surgeon may mistake his or her treatment choices for those of the patient.

Surgeons would do well to review the dysfunctional beliefs held by many doctors (convictions too often taken to heart by surgeons) as articulated by Martin20: (1) high physician expectations make the limitations of one’s knowledge a personal failure, (2) responsibility for patient care is to be borne by physicians alone, (3) altruistic devotion to one’s work and denial of self is desirable, and (4) it is professional to keep one’s uncertainties and emotions to oneself. These destructive and closely held beliefs are nothing if not a recipe for burnout. Other topics surgeons should consider for self-review as well as discussion with one’s peers include gender issues, one’s feelings and reactions to difficult patients, anger management, boundary issues, and personal bias about certain types of patients (eg, AIDS patients, alcoholics, the homeless). Understanding one’s anger is particularly important. Novak and colleagues21 state, in an article on personal awareness, “Self-knowledge about the sources and triggers of one’s anger and attitudes and skills related to conflict are particularly important because anger is a common response to illness, suffering, and death.”
Anthropologist Charles Bosk studied surgeons on the West Coast in the 1970s. Regarding the attitude of surgical trainees being inculcated into the “culture of surgeons” at that time, he concluded, “They treat all repressive sanctions as flowing from the arbitrary, capricious, dogmatic, and unreasonably autocratic personalities of attendings rather than from deeply held common sentiments shared by a community of fellow surgeons…. All shortcomings become attributable to personality and style.” Bosk reiterated the view that a surgeon’s unbridled optimism and certainty may serve as a form of denial about the possibility of failure. Katz reinforced this view that a scalpel-rattling posture by surgeons forces patients into a more passive role and thus reduces the likelihood of shared decision-making.

Similarly, surgeons have traditionally criticized other physicians for their contemplative demeanor, often portraying internists as procrastinators who may compromise the surgeon’s conviction that “a chance to cut is a chance to cure.” In 1923, Deaver and Reimann wrote, “…we daily have in our power to be the means of correcting mistakes in the interpretation of the language of living pathology, and thus save an otherwise condemned sufferer from medical procrastination.” Is it really procrastination? Or is it introspection? This sort of historically perpetuated surgical certainty (dare I call it hubris?) and the impulse for action—even though it is absolutely necessary at times—can only be subdued with honest self-examination.

The issue at hand, then, is whether or not surgeons have evolved to a professional station compatible with introspection. Without introspection, surgeons are unlikely to overcome their penchant for control and domination of patients as well as trainees. Yet, there is reason to be hopeful. The fact that McCahill and colleagues, who reported that surgeons surveyed in 2002 did not consider the avoidance of dying patients to be an issue, also revealed that the two biggest ethical dilemmas in surgical oncology were providing honest information without destroying hope and preserving patient choice. Certainly, this report suggests that the surveyed surgeons had engaged in self-reflection and had willingly confronted these major barriers to the provision of palliative care (in contrast to the paternal attitude noted in years past by anthropologists).

THE SURGEON’S DILEMMA—THE ALLURE OF THE MECHANICAL

Laparoscopic surgery has not only added impersonal physical distance between the surgeon and the patient, it has generated a new industry dedicated to making interesting instruments and miniature cameras and TV screens that illuminate and expose a new surgical environment. Minimally invasive surgery is a magnificent technical tour de force. Robots add to biomechanical proficiency as well as to the geography of indifference. Using a robotic operating system, the surgeon sits across from the patient and manipulates remote control “arms” that direct delicate instruments in the patient’s belly, pelvis, or chest on the far side of the room. And, of course, the marginally absurd extension of this robotic event is telesurgery, in which the patient lies in a hospital across the nation or on the far side of the ocean from the operator. Clearly, there are reasonable applications for remote surgical technology. However, under these circumstances the patient-physician relationship is further burdened with the potential for poor communication.

Not that the traditional open operations are any less technical or less manufactured. Staplers come with variable loads, reticulated handles, and anvils requiring special expertise and attention to detail. Intracorporeal suturing and knot-tying have added to the modern surgeon’s technical skills. And with 121 “essential” operations to learn, the surgical trainee discovers the impossibility of mastering both open and minimally
invasive operations in 5 years of training. Rather than the 10,000 hours of deliberate practice recommended by Ericsson and colleagues\textsuperscript{24} when mastering chess or a musical instrument, surgical residents average between 1,100 and 2,700 hours of actual operating time.\textsuperscript{25,26} Hence, surgical educators have become understandably preoccupied with the issue of technical competence at a time when the sheer number of operations available to the public is unmanageable by any single surgeon.

When are surgeons and trainees supposed to reflect on and master the nuances of palliative surgical care? There is only one answer. The attitude of caring in conjunction with curing must be ever-present on the front burner of surgical education. Caring must be modeled by the faculty. Insights gained from introspection by the teaching faculty should be shared with residents and medical students because almost 40\% of residents in a recent study felt inadequately trained to discuss with their patients the withholding or withdrawal of life-sustaining therapy.\textsuperscript{27} Surgeons must learn to be open with their intimate thoughts about caring for dying patients and seek opportunities to reveal themselves in their encounter with their learners.

**SURGEON SELF-REFLECTION ENCOURAGES PATIENT’S SELF-STORY**

A fact and a story when set next to each other ignite and illuminate the notion that, when encouraged to speak freely, patients flood the therapeutic encounter with meaning. The eighteen seconds that pass before a doctor interrupts his or her patient when taking a history,\textsuperscript{28} stands in stark contrast to Rita Charon’s\textsuperscript{29} story of the man who burst into tears when given a chance to tell his illness story. No one had listened to him before his visit to her clinic. Charon concludes, “…not only is diagnosis encoded in the narratives patients tell of symptoms, but deep and therapeutically consequential understandings of the persons who bear symptoms are made possible in the course of hearing the narratives told of illness.” Herein lies the severest challenge for surgeons whose personalities push them toward action, intervention, and instant discovery of solutions. Often the patient’s personal narrative melts like ice cubes when the surgeon’s blowtorch queries about the medical history narrow the focus to establishing a diagnosis. Rather than initially attempting to gain an understanding of the patient’s perspective (dread, anxiety, fears) about the illness, the surgeon’s “wired” clinical aggressiveness may set a tone of paternalism that shrinks the resolve of even the most autonomy-minded patient.

Limited time for each clinical encounter is the reality that frustrates an unimpeded verbal exchange between surgeon and patient. Nonetheless, even if it means another office visit or returning to the bedside at the end of the day, the patient must be given an opportunity to express his or her thoughts about possible treatment options versus no therapy. A patient who has received bad news must be given time to assimilate the life-changing information, to express fears and hopes, as well as to ask questions to expand his or her understanding of the prognosis. An introspective surgeon will share his or her carefully thought out concerns and will acknowledge and reflect the emotions in the room. By opening up the dialog and allowing the patient to indulge in his or her illness narrative, surgeons may discover ways around what moments earlier seemed like insurmountable barriers in defining the next step in the patient’s care. By encouraging an open discussion regarding treatment options, the restrained (listening) surgeon may hear useful (as well as meaningful) dialog from the patient that brings the patient closer to moments of self-discovery and insight into the meaning of the illness.

Caring by the surgeon after the scalpel’s job is done should continue long after curing proves futile. Part of the physician’s job is to encourage the patient near the
end of his or her life to do the sometimes strained work of dying—to settle emotional accounts with friends and family, to finalize personal and financial matters, and to reflect on the meaning of their life and death. This art must be taught as well. Thus, when talking to surgical residents and medical students about end of life care, faculty members are encouraged to model self-reflection and to share their own emotional reactions to the cases under discussion. Teachers are asked to encourage the trainee’s own personal reflection by asking the following questions: (1) what is most challenging about working with this patient and family, (2) what is most satisfying about working with this patient and family (3) how is the trainee reacting emotionally to this patient, and (4) have the trainee’s past experiences in any way enhanced or hindered his or her work with this patient and family? 

IRONIC SUFFERING AND A LACK OF INTROSPECTION

Sometimes a surgeon fails to exhibit “situational awareness.” It starts with insensitivity—a failure to see the actual person behind the bandages or under the drapes. Usually, surgeons deal with their patients holistically from a physiologic point of view. This entails attention to fluid and electrolyte status, blood volume, wound care, urine output, oral intake, and so forth. It is a lot to review with every patient on the list—especially if the institution supports fast-tracking. The surgeon can easily fail to notice the emotional state of the person lying there, terrified, assuming the cancer operation did not work because the surgical team does not discuss the patient’s real issue: “Am I going to make it?” Imagine the following communication imbroglio:

Did you get it all, Doctor?
The procedure went very smoothly, you know…technically.
When will you get the path report?
I expect you’ll be home before it arrives…that’s how well you’re doing.
Will I need chemo?
We have a terrific group of medical oncologists here. I’m going to refer you to my favorite. She’ll answer all of your questions, believe me.
But… Doctor, the cancer…
Gone, the operation was a piece of cake.

Ivan Illyich had a busy family who failed to acknowledge his desperate plight. Of course to give his family their due, Ivan Illyich did everything humanly possible to deny his clinical symptoms until the very last moment. In the novella, The Death of Ivan Illyich (essential reading for anyone involved in palliative care), Tolstoy bores deeply into the soul of a desperate man to reveal the secret anguish the dying experience while still among the living. And although Ivan Illyich brought his self-serving and aloof persona to his deathbed, he had to travel an unimaginable psychic distance in the act of dying to discover a fundamental human truth. As his life slipped away, Ivan Illyich’s family went about their lives as if he were doing quite well. The crisp story defines ironic suffering. No one in his family would discuss his illness with him in a meaningful way. No one would acknowledge that Ivan Illyich was, in fact, dying before their eyes.

ARE WOMEN SURGEONS BETTER AT INTROSPECTION THAN MALE SURGEONS?

The short courageous history of women entering the ranks of surgery in the 1970s and 1980s (as documented in several enlightening books) reads like a portrayal of surgeons as abusive husbands. At every turn men derided, discouraged, and humiliated women attempting to become competent surgeons. What is remarkable about this
unimaginable resistance to change is, ironically, the old saw which is said to have origi-
ninated with John Bell who, in describing the ideal surgeon, suggested he possess, “The
brain of an Apollo, the heart of a lion, a clear eye, and a woman’s touch.”34

My experience with talented female surgical residents reinforces my conviction that
they can function at any level on the male macho “toughness” scale while preserving
inveterate empathy for their patients. As caregivers for everyone from children to
grandparents, women have always shown unique insight into guardianship. Clearly,
women have carried the burden of caring for elderly parents while a majority of
them held fulltime jobs and managed a family. How could men believe that women
would not make exceptional surgeons? With the waning of the surgical personality
and, perhaps, if they listen, men may learn, standing at the side of women surgeons,
the lessons and rewards residing in the domain of introspection. It seems certain that
in the early days of female surgical resident training, male mentors lured women away
from their natural self-reflective instincts and toward male indifference.

INTROSPECTION AT THE END OF A SURGEON’S CAREER

At this juncture, my thoughts drift to a consideration of a parallel course between the
end of a surgeon’s career with the termination of a patient’s life. As when confronting
death, completing a professional life ought to include the hard work of closure. The
“tidying up” process at the end of a productive career requires no less intellectual
and emotional diligence than that of the closure necessary for the dying. And, in
fact, the events of these two seemingly disparate life events may overlap.

Offering thanks to family members and colleagues (as well as apologies for past
“incidents”) may be just as satisfying for a retiring surgeon as receiving empathetic
words and closure are for a dying patient. In other words, the overarching opportuni-
ties dangling before the retiring surgeon are similar to the opportunities presented to
a dying person—namely that of accomplishing life’s final goals. The surgeon who has
reflected on his or her professional and personal existence as an essential part of a life
well lived will not have difficulty defining the goals of retirement. Among these goals
might be involvement in surgical education, especially discussing end-of-life issues
with residents. With the surgeon’s own demise squarely located in the gauzy distance
of retirement, the seasoned clinician possesses a unique perspective on life that
medical students and residents are rarely exposed to in their training.

Not infrequently surgeons retire only to return to part-time work either in their former
offices or in some administrative or teaching capacity at their hospital. Certainly there
are many surgeons who will have planned properly for retirement and will slip without
a ripple into the well-deserved and comforting waters of self-indulgence. But, some
surgeons who might otherwise have been labeled with attention-deficit/hyperactivity
disorder before it became fashionable, still find meaning in continuing to caring for
patients and in teaching tomorrow’s doctors as age creeps up.

The time for introspection is at the beginning of a career, not at the end. The habit of
introspection may serve to enrich a surgeon’s career with insight, as well as inform the
empathetic care needed by cured and dying patients alike. And much like “the second
effect” of opioid administration, although the intent of self-reflection is to improve
patient care, the foreseen but unpredictable second consequence of introspection
may be the arrival of profound insight into the meaning of one’s life.

SUMMARY

The traditional action-oriented surgical personality, although essential in the service of
solving emergent operative dilemmas, may serve as a barrier to introspection.
Certainly, challenges of the twenty-first century practice environment, not the least of which are time constraints, also distract from self-reflection. Without engaging in moments of introspection, surgeons risk not only abandoning dying patients in their time of need, but leave the surgeons themselves at risk for burnout and its dire consequences. The increase in the number of women in surgery, as well as the less heroic image of surgeons performing laparoscopic operations, may reorient traditional extroverted behavior toward a persona of professional grace.

REFERENCES