The Pleasure of Surgery

My Pleasure in Being a Surgeon

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It is a great honor having been elected President of the European Surgical Association. I think you were right to choose a president from Portugal. You cannot argue with the true European dimensions of our society. You demonstrate this by involving every one of its members, not only the ones from the most wealthy and developed countries. But I am not sure whether you are fully aware of the consequences of your choice. You have chosen someone who truly believes that modern general surgery walks the path of subspecialization and referral centers, striving for excellence.1

Nowadays, modern medicine requires a new organizational model. The steady progress of medicine, with the subsequent increase in scientific literature, progress in understanding diseases and their cause, and new means of diagnosis, and therapeutic approaches—whether they are medical, surgical, or technological—demands a simultaneous and multidisciplinary approach to the most complex pathologies. Currently, we cannot be skilled in all fields of general surgery; therefore, it is essential—particularly in tertiary centers—for all departments to engage in limited fields. The era of everyone doing everything—without caseload enabling us to gain experience, for all departments to engage in limited fields. The era of everyone doing everything—without caseload enabling us to gain experience, skills, and training capacity—is definitely over.2 In the early and mid-20th century, several surgical specialties became independent and formed new specialties. Orthopedics, neurosurgery, urology, gynecology, cardiothoracic surgery, vascular surgery, plastic surgery, etc, naturally arose from general surgery. More recently, newer fields have been arising from what was left of general surgery, such as head and neck, digestive, breast, and also bariatric surgical procedures. Even within the new specialties, new subspecialties are now being divided with the same need for caseload and experience.

In digestive surgery, there are 3 fields that seem obvious to me: esophagus and stomach surgery, hepatobiliary and pancreatic (HPB) surgery, and rectal surgery. This general surgery “reform” has been taking place for several years in many European countries with positive results, first and foremost, for the quality of treatment provided to patients with decreased postoperative mortality and morbidity, as well as long-term results. There are also positive results regarding the rationality of technical and medical resources with great economic benefits. Consistent with this way of thinking, we created, 10 years ago, the Lisbon HBP and Transplantation Centre in Portugal. The person who went with me to Cambridge, England, when I specialized in liver transplantation with Sir Roy Calne, was my wife Manuela, who is here today. When, 10 years ago, we officially created the Lisbon HBP and Transplantation Centre, we had the support of the one I believe to be the world’s greatest figure in HPB surgery, our dearest Prof Henri Bismuth. At that time, with his support, we proudly took the position as a metastasis specialist of Paul Brousse hospital, Centre Hépato-Biliaire. When we began operating according to his ideas and beliefs, we plagiarized his innovative “idea,” which is now over 30 years old.

I know—and haven’t forgotten—that I promised to tell you about the pleasures of surgery—my pleasure in being a surgeon and the sense of fulfillment and satisfaction of my professional path for over 40 years.

A lot has been written about the fact that fewer and fewer young doctors are choosing general surgery. I am not talking about some countries like the United States, where there are fewer students attending medical schools.2 In Portugal, there is no such problem. All annual vacancies published at the existing medical schools are quickly filled by the best secondary school pupils. Scoring less than 18 points out of 20 will not enable a student to be given a place at a medical school. Having enrolled at a university, they will only choose their specialty after 7 years have passed. But the best students rarely choose general surgery as their first option. Unfortunately, those choosing surgery either do not belong to the best or only did it because their most desired specialties were already chosen. Therefore, our problem is not our failure of attracting young students for surgery but rather developing a grooming policy that will make the best students want to be surgeons. Someone who only chooses a specialty as a second or third option to get a job in a big city will never be as enthusiastic and willing to grow as those who have chosen their true calling.

I have carefully read some of the Presidential Addresses from previous years, which were concerned about this matter. How to get young doctors to want to become surgeons? Peter Neuhaus3 goes as far as questioning “Why would young doctors choose to become surgeons?” Krister Hockerstedt4 also deals with this subject through surgeon self-esteem, which used to be high in the past and is lower today. Felix Harder5 and Raimund Margreiter1 also deal with this subject. What do they all have in common? Trying to figure out what has stopped young doctors from being attracted to general surgery

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and what has made those applying not as enthusiastic, skilled, and interested, as they should apparently be. It seems obvious to me that we could achieve this by helping them look at surgery with pleasure throughout their difficult training years, so they can enjoy the delights of progressive autonomy, which is different at various developmental stages, and continue it into their daily lives after training is over (Fig. 1).

My approach will not be very scientific, but it is rather based on my personal experience, which triggered my choices, my progress, and the different responsibilities I have had in relation to the several steps that I have overcome. The “fuel” of my enthusiasm, my perseverance, and overcoming difficulties has been based on 2 ingredients: ambition, which was explained so well in Daniel Jaeck’s 2008 Presidential Address, and, even more importantly, the pleasure with which I have experienced these past 40 years of surgery. Those who are more skeptical may think that I am exaggerating. How can you feel joy from a mistake, and can you not feel a sense of guilt after complications or even the death of a patient? I will try to show you that this is possible by giving you examples of what I have experienced. I believe it is possible to experience the anguish of the death of a patient with a clean conscience by overcoming a mistake by having the patient and his or her family understand and even accept it.

I have been fortunate that ever since I have been aware of my existence, whenever I was asked that stupid question you get asked as a child, “What do you want to be when you grow up?” I knew the answer. I never wanted to be a fireman, a policeman, or even a football player. My mother told me that my answer was always the same: I wanted to be a doctor. Of course, the fact that my father was a doctor had a lot to do with this. But it is a little more weird and unnatural for a young teenager to want to be a surgeon. I am telling you about this part of my life because my father used to despise surgeons; he considered them as second-class specialists and would even mention arrogantly that he prescribed antibiotics, aspirin, cardiotonics, etc, and even surgeons, when needed!

The need for attractiveness that I am trying to instill in my students, when they come into contact with surgery for the first time, is explained to them in their first lesson of the year. The subject is always the same: The history of surgery. I show this class my enthusiasm for the path that I have chosen. I tell them how worthwhile it has been and that I have achieved professional success. By telling them the great progress achieved throughout the last century, I try to convince them that there is still a lot to undergo, that basic and clinical research is essential, and that there will continue to be innovation and new technologies motivating them. Throughout the remaining classes, my assistants and I try to make them live a surgeon’s day-to-day life by taking part in staff meetings, appointments, wards, and, of course, in the operating room, where nurses play a pivotal role. They are the ones who teach them how to behave in the operating theatre, and the students begin to understand the importance of specialized scrub nurses in the performance of the surgical teams. Then, they are encouraged to work extra hours in the emergency department and showing up at any time when surgery is taking place.

We have to try and attract medical students to our specialty by showing them the pleasure of our profession every day, using our experience without the need to talk about it all the time. As William Halsted used to say: “There are men who teach best by not teaching at all.” At this stage, students are assessed for future surgical choices; their leadership qualities in nontechnical subjects such as emotional skills, resilience, and communication skills are essential. When medical students go along with their professors and see them enjoying their work while taking part and observing surgical procedures, multidisciplinary meetings where the surgeons are the leaders, some of them become aware of a desire to be surgeons, which did not exist at the beginning. When choosing the residency, what matters the most are the experiences and examples lived and to

FIGURE 1. The pleasures of a surgeon’s life. OR indicates operating room.
a lesser extent the wages they will be receiving. If medical students engage in the daily life of a well-structured surgery department with a strong leadership that is emotionally competent, if they observe the pleasure of young doctors carrying out their duties, or if they witness immediate surgical therapy results, then they will certainly choose the same profession.

When I became a general surgery resident, I was glowing with joy. Not only had I to work a weekly 24-hour emergency department shift but I was also volunteering for an extra shift. Once my ward duties were over, I would go back to the operating room. I was always available to assist in whatever way was needed. Everything was carried out with such readiness and joy. I still recall the thrill of my first appendectomy as a surgeon, right before I became a resident. My first strangulated hernia, my first perforated ulcer, and so forth. My “reward” was not only my salary but also being able to assist in more complicated surgical procedures and being progressively promoted to senior surgeon for different surgical procedures. This is what I practice with my residents. I know what pleases them about surgery because I ask them. I am concerned with their families and their rest; I even force them to take breaks. I try to get them to read other things besides medical books, telling them, just like Sir William Osler used to say, that the “one who only knows medicine, not even medicine knows.” A surgical team must function like a family and be supportive within a highly competitive environment. It should enjoy its successes and support each other when failing. During my days as a resident, leadership was based on authority acquired through knowledge, technical excellence, and capacities to teach and research. If we apply this now, it is not enough. Any leader doing this will naturally hear complaints from his young surgeons and residents regarding the long hours and lack of learning conditions and opportunities. Today, nontechnical matters such as emotional competence and communication skills are essential additional qualities of a leader.9 Having our residents feeling tired but happy doing their job with true pleasure is the key to success. Throughout their last years as residents, we must progressively give them training responsibilities and prepare them for the most difficult parts of a doctor-patient relationship: the capacity to admit and take responsibility for mistakes and adverse events. I always tell them some episodes in my professional life, where I had to recognize a serious mistake and its respective consequences.

I cannot resist telling you about a mistake, for which I was mainly responsible, a patient I operated on 20 years ago for a hemoperitoneum after a laparoscopic cholecystectomy. The 75-year-old patient was from a very wealthy and influential family. I undertook a linear laparoscopic cholecystectomy, with no visible hemorrhage, and he was set to be discharged the following morning. The next morning, the patient seemed pale, although he was ready to go home. His hemoglobin level and a large hemoperitoneum let me to carry out an emergency laparotomy. The patient and his family knew this could happen, and although they had been caught by surprise due to how well the surgery had seemed to have gone, nobody argued. I performed a Kocher laparotomy and started treatment of a large hemoperitoneum without having identified its starting point. The patient had completely recovered and was discharged on the fourth day. The patient and his family congratulated me on my readiness and due performance. They were educated people who understood everything that had taken place.

Six months later, he presented with a tumor on the left upper quadrant of the abdomen, fever, anaorexia, and great prostration. I had a premonition of the diagnosis, a palpable mass in the left hypochondrium of stony consistency and some mobility. The immediate computed tomographic scan provided a diagnosis. The tumor was a textiloma. Despite the 2 swab counts at the end of the hemoperitoneum laparotomy, a swab had been left behind. The patient was calm and resigned himself to the surgery I proposed. I spoke of an eventual lesion turned into an abscess, although it was certainly not a malignant lesion.

The day following surgery, I came through the waiting room and there were close to 30 relatives there. In his room, it was only him and his wife, insisting on addressing me by my first name. The patient, sitting on the bed, in a good mood, asked me straight away: Doctor, was it a cancer? No, it was an easily treated localized infection. He would be fine within a few days. He did not let me go on, he kissed his wife, who had sat on the bed in the meantime, and began congratulating me. I had already saved his life 6 months before, and he assumed I had once again, and congratulated me as well as my readiness and skills. Everything was fantastic. I let him finish, thanked him for his compliments, but told him that I was not worthy of them. I told him the localized infection was the result of a swab that I had left inside his abdomen during the last surgery. I wanted him to know that my insurance would cover his hospital expenses and would negotiate with him a financial compensation. I ended my speech feeling relieved and prepared for what was to come. There was silence, which lasted for a few seconds but it felt like hours. He began slowly with a discouraging smile.

Doctor Eduardo, why did you tell me the truth? Why didn’t you only mention the infection? Why did I have to know about the swab? I have many friends, who are surgeons, and I sometimes hear them telling stories about forgotten swabs. I know they seldom tell patients the true nature of the problem. Why have you done it?

His wife, then sitting on a chair near the bed, was looking at me silently and seriously. I replied,

Only I know how hard it was to tell you the truth, but I could not take your compliments, while feeling guilty. Now that it has been said, I understand and accept that you may have lost your trust in me and wish another surgeon.

He looked at me and calmly asked me to leave the room because he wanted to speak to his wife first. I returned to the room later. They were once again seated on the bed side by side. And the patient said:

Doctor Barroso, I want you to keep on being my doctor. I still trust you. However, there are three unconditional conditions you will have to accept. The first condition is that you must not mention the forgotten swab to anyone. You must tell my family that it was only an abscess, not cancer, and that I will be fine. The second condition is that you must not activate your insurance; I do not want any compensation, since there was never a forgotten swab. The third condition is that you must maintain our doctor-patient relationship as normal as before, so I expect your fees when you discharge me.

I was astonished and moved. Of course, I was very pleased about not publicizing the swab. Not activating the insurance was a logical consequence. However, I could not accept the fact that I would have to charge him. We finally reached an agreement on this third condition, and I left the room feeling totally relieved. However, as I was walking down the corridor I realized his wife had followed me and requested me to stop. She wanted a word without her husband present. I must confess that there was no doubt in my mind that she was going to blame me and make me cancel the agreement I had made a few moments ago. As soon as she was near me, she stood very close to me and hugged me hard. She was a tall woman and her lips were on the same level as my ear. She only said 2 very tender words. The most beautiful words I have ever heard in my career. They were simply: “Courage, Eduardo.” I think that as I passed by the patient’s relatives on the waiting room, I must have had a big smile on my face. I did not need to say anything as they realized that everything was fine.
One of the arguments raised for the choice of surgery to be a less attractive one is that there is a great deal of litigation within its practices. This borders on paranoia in the United States. But it is also increasingly common in Europe. Patients and family members are becoming less tolerant to adverse events and complications. Even after having been strictly informed and all eventual complications have been explained, these facts are often misunderstood. In my long clinical experience, I have had surgical complications, which is normal, some were serious and some patients died. I consider it essential for a surgeon-patient relationship to begin with a careful explanation of what will happen, our results, and whether the technical, infrastructural, and human conditions have been met so that the surgery may be safely carried out.

We cannot overreact, nor terrify, but we cannot ensure full success. Of course, we cannot inform a patient beforehand of serious mistakes like operating on the wrong side or leaving foreign matter in the abdomen. And these are the cases that may leave patients or families outraged, as expected. Even when such mistakes occur, a clear and emotionally lucid relationship with the patient may lead to serious conflicts being dismissed.

“Courage, Eduardo” gave rise to a book on “hospital stories” where the different aspects of surgery are dealt with through clinical experiences, leading the medical association to recommend it to all medical students when it came out. So, it is essential to transmit to new graduates the pleasure of a clear conscience. I accept in all modesty that a modern, demanding, yet emotionally aware leadership is the key to overcoming the disappointments and frustrations of those who trusted us to educate them. Abusive or even dishonest leadership can be troublesome. What happened recently in Germany—where patient data were distorted in a transplant center so that some patients could go first and ensure transplants—is unacceptable. It is not only acceptable, but legitimate, in very selected cases, to gather transplant indications that are not exclusively imposed by evidence-based medicine. There may be an exception that proves the rule.

Of 1550 liver transplants, a dozen have certainly not followed our rules and our protocols. Discussing these exceptions in multidisciplinary meetings by presenting the transparency of our reasons will not only justify these “compassionate indications,” as it will instill in the students and young doctors human aspects and reasons, which may be present in some of our decisions. About 15 years ago, we discussed in our multidisciplinary meeting the case of a young 24-year-old mother with a 6-month-old daughter who had unresectable cancer in the setting of a hepatitis C virus–infected cirrhosis. It was completely beyond Milan and UCSF criteria. The entire staging showed a 20-cm central tumor. It was hard to convince my entire team of hepatologists and oncologists that a transplant was possible. All literature of the time placed young Patricia outside of transplant indications. An α-fetoprotein of 1000 supported the absence of indication.

I fought every step of the way for an exception to the protocol and I was finally able to obtain a nonunanimous, yet decisive, agreement. Patricia underwent a transplant; she lived a healthy and optimistic life for 9 years, but passed away 10 years later from brain and pulmonary metastases. The mother and the daughter had a happy, despite short, childhood. Purists may believe that this result did not justify the liver not having been transplanted into another patient on the list. However, for me, it was one of the greatest successes of our program. We should not be slaves to rules, since many of them are only based on raw statistics. We treat human beings; we must be aware of the rare times where these rules should be bent.

My pleasure in surgery and in being a surgeon had a different meaning after a certain time. The adventure of creating the HBP and Transplantation Centre with the help of Henri Bismuth—the perfect mix of ambition and pleasure—gripped all my coworkers, from seniors to newcomers.

Being recognized by my peers—who were the highest national and international scientific entities within a scientific society—increased my ambition and pleasure in surgery. What pleasure can I still expect to feel from the few years left before I retire? The pleasure of watching my surgeons doing a better job than I did. The pleasure of knowing that our project will continue after I retire. The pleasure of knowing that I tried to ensure a better future for surgery. However, such pleasures have their costs. I know I do not have the same power, nor the same feeling of being irreplaceable.

My present pleasure is to know that I did a good job in training my surgeons and that in the future they will do better than I did and to compromise them with the sense of formative responsibility. Five years before the mandatory retirement age, I know I will leave them with the enormous pleasure of an accomplished mission. Retirement is a state of mind. I know that afterward, I will be able to carry out other different tasks, with or without the power to influence the politicians who govern my country. But I must confess that I will end with joy, the happiness and enthusiasm that have been with me throughout my entire career. Being president of ESA will help me keep my self-esteem throughout these last years. It is a tremendous honor and privilege to be able to present you with this Presidential Address. Thank you all very much.

REFERENCES