

Do surgeons have a sell-by date?

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When should surgeons retire? Do they have a defined shelf life and a sell-by date? At what point should they chuck in the scalpel and hang up their gloves? The answer to these questions for young and old surgeons is found by them merely looking around themselves: the young to make continuous mental notes about what to do (and not to do) when they get older; older surgeons to do so as a reality or insight check. The first gaze is at the theory and understanding that underpins surgery – academic surgery if you will – and the second gaze is at the craft of cutting, for surgeons are really just journeymen-craftsmen, the better ones with well-developed cognitive and manipulative skills.

My mental note-taking about the theory of surgery started several decades ago when, as a young trainee, I noted that some elderly surgeons secretly felt, and sometimes stated, that the total mastectomy was the only proper operation. I also subsequently noted that, at meetings and congresses, older surgeons sometimes vehemently supported the use of vagotomy and antrectomy as the best solution for peptic ulceration. They missed the stunned and polite silence that would follow such atavism. Perhaps in today's world the surgeon who maintains that laparotomy is safer, better and more thorough than laparoscopy in most situations, should start thinking about planning for retirement. Another marker of age is when the speaker gravely announces that there is nothing better than a good history and thorough clinical examination, the problem being that the subject in question is the use of MRI for breast screening patients who carry the BRCA1/2 gene. That is time for them to start planning for retirement.

There is also sadness in all this. I was jarred when I heard a group of students referring to a retired, most distinguished Emeritus Professor and previous Head of Department, staying on after retirement to teach: "There was this funny little old guy with round glasses who bumbled about hernias." In this was the pathos of the returned Maria Callas to the Royal Festival Hall, with half the audience leaving on hearing her cracked voice, or of the elderly rocker in concert with his guitar and exuberant wig. A later sad experience was in San Francisco at the end of the College meeting: the Famous Name of yesteryear and his wife were swept aside unrecognised as the sea of surgeons rushed out for cabs.

Do surgical skills deteriorate? I think they do as after sixty I found my operative skills were becoming coarser. Less often would one stand back and think "now that's how to do a thyroidectomy!" Operating includes encountering the unexpected anomaly, difficulty or complication, and avoiding it or correcting it effortlessly, sometimes without

one's assistant even noticing. This rapid reflexive activity becomes blunted. After leaving vascular surgery in my early thirties, I look back and remember finding the upper end of an abdominal aortic aneurysm with a rotten pastry vascular wall an exciting challenge; I would now regard it as sheer sweating terror. Some older vascular colleagues in this and other countries have succumbed to the whisky bottle. Yet other elderly surgeons four-letter-word their way through bloody operations.

Surgery is like a professional sport, but with a limited, but longer, place in the sun. The young lion-surgeons of midlife start losing teeth in their late forties and early fifties, and the new unforgiving pack is at their heels. The new young cohort of surgeons are arrogant, unforgiving, self-assured, and condescending to their older colleagues. In fact, they are just like you were, remember?

I think the ideal solution is a period of transition to retirement. This should be a bridge of lessening activity to the other side which is cessation of professional activity.

In academic and public hospitals many contrive to stay on as they were, but in a more dilute form. They want to help out with outpatient consultations ["a lifetime's experience"], or teach students ["sharing their wisdom"], or assist at surgery ["help the youngsters with the more complex operations"]. There may be relegation to smaller and more obscure offices. Some have called such stayers-on as "the ghost that walks", and their occasional comment at clinical meetings are major head-turners as they suddenly propose a porto-caval shunt.

In contrast to the stayers-on, some pick up their golf clubs, close the door and leave. They even decline the invitation to the annual eponymous lecture [and dinner] as they would be away fishing at the time. Yet between the two extremes is an intermediate satisfactory transition for some. Academics may find alternative careers in Faculties. Well organised group practices in the private sector allow freedom from night and weekend work, and selection of smaller procedures.

Some just continue operating until they kill someone, or kill themselves. Their rat race, the rat exercise wheel, is so well established that they cannot relinquish it. Their entire living breathing life is surgery. They have woven a lifetime surgical cocoon around themselves, a cocoon that can only be regarded as blinkered pathos. They have missed out and will miss out on the pleasures and satisfactions of our limited human lifespans.

Long before the event, surgeons should confront the inevitability of retirement and then plan for it. Most cannot do either.