The Surgeon's Work in Transition: Should Surgeons Spend More Time Outside the Hospital?

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Libby Zion was an 18-year-old college student who died in a New York City emergency room in 1984. Her father, a newspaper columnist and former federal prosecutor, sued the hospital and campaigned against long working hours for residents. As a result, New York State passed the "Libby Zion Law" in 1989, limiting work hours for house officers [1]. Ever since then, events have moved steadily, albeit in fits and starts, toward a conclusion that now seems to have been inevitable. The national 30-hour workweek mandated for house officers by the Accreditation Council for Graduate Medical Education has begun, and the disruption of traditional work schedules will be dealt with more or less effectively in medical graduate training programs around the country [2].

We do not know what effect these changes will have on the profession of surgery, but most of us strongly suspect that it will not be good. At the very least, surgeons of the future are likely to have a work ethic that is different from the one we acquired during and after our training. In fact, a shift in attitude toward work seems to be well underway already. Applications to general surgical training programs have been in progressive decline over the last few years. Much of the decline seems to be related to changes in professional expectations of medical students. These students want controlled working hours and more dedicated time for family and leisure activities [3]. Perhaps the mandatory reduction in work schedule for residents will reawaken interest in surgical training. In any case, it appears that the era of the "24/7" availability of surgeons and 16 to 18 hour workdays (only 4 to 8 hours on weekend days with an occasional weekend off) may be ending and slowly fading into oblivion.

Assuming that this scenario of surgery's future is accurate, does it contain lessons for those of us still caught up in the old paradigm? Is there something to be said for or, perhaps, something to be gained from cardiothoracic surgeons joining the trend by adopting a more friendly family or personal lifestyle attitude toward the distribution of our waking hours?

The question of more time for surgeons outside the hospital was debated at the Southern Thoracic Surgical Association Annual Meeting in November 2002. The topic of the debate was "The surgeon's work in transition: surgeons should cut back on time in the hospital to spend more time with family and personal interests." Ross Ungerleider argued the affirmative position, and Joseph Coselli argued the negative position. Their positions are presented with the assistance of co-authors in the following essays.

References

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Steve White was on vacation with his wife. They had left the cold, windblown climate of their upper Midwest town very early that morning. Steve always told his wife that thoracic surgeons do not mind getting up early. She always preferred to keep the blinds drawn so as not to awaken from the first light of dawn. However, when they traveled together he invariably booked them on the first flight out of town, thus requiring them both to wake up shortly after she, a night person, would ordi-
nearly be going to bed. Steve had begun his practice 18
months ago after 9 grueling years of training. He and
Meg met, courted, married, and had 2 children during his
residency. Although Meg quit her job after their son was
born, she remained occupied with raising the family, but
Steve continued to spend time at the hospital. If they
could just make it through Steve’s residency, his nights
on call, and the constant pressures to do things right for
his attendings, then life would get better. They would
find a job in a town where they could raise their children
and have a more normal family lifestyle.

This was more than a year ago and as far as Meg could
tell, there had not been much of a change. Steve now
tooled for his partners, in order to uphold his share of the
responsibility. He kept reminding his wife that life would
improve once he was more established with his partners
and they knew he was not a slacker. He always seemed to
say “yes” to work, which according to her perspective
meant he was saying “no” to her and the children. Just
getting Steve to agree to this vacation was huge. He was,
of course, delayed at the hospital the night before, so
Meg had to go to the dry cleaners and the bank, which
were the errands that he was supposed to handle on his
way home. Ironically, she planned on that occurring,
because Steve was always detained.

For this vacation, Steve brought his computer, his last
6 months of issues of The Annals of Thoracic Surgery, his
long-range pager, and his cell phone. He had instructed
his partners to call if things got out of hand, because he
could come back. This was, after all, just a vacation, and
he could abort it if necessary. He felt relief being able to
tell that to his partners, which indicated his dedication to
helping make the practice work. He knew that he really
would not want to come back, yet he was curious why he
felt ambivalent about leaving. He was also bringing his
golf clubs, a swimsuit, and a candle (a surprise for Meg
on their first night together in their Caribbean hotel). It
was the candle he bought for their first date, and every
now and then he represented it to her as an offering of his
romanticism.

This was Steve’s first vacation since he had joined the
practice. His role models in residency training at the
university rarely seemed to take vacation time. In fact, he
recalled how often they would make comments around
the operating table that ridiculed the banality of being
with the family. Steve, himself, had been asked to page a
few of his professors away from their families on week-
ends, so that they could have an excuse to leave some
onerosous function. It seemed to Steve that being a surgeon
provided some of his mentors with a socially acceptable
excuse for abandoning their families. This bothered him
a bit, but over the years of training he noticed how
comfortable he felt around the hospital and especially in
the operating room. He got most of what he wanted,
when he wanted it. And he was treated with such
deference. When he got home, he did not have the same
cloak. Meg treated him like a regular person, and it just
was not as much fun. During his first year of practice he
worked as though he were still a resident. He covered the
practice whenever he was needed. He was, after all, the
junior partner, and he had dues to pay.

The flight with Meg was a reconnection with their
hopes. For the first time that he could remember in
months, they had fun together. They flew first class. They
drank wine and talked about all the things they could do
without the kids. When they got off the plane it was
sticky warm. After hours of being confined to a seat in
an airplane, the tropical air relaxed them like it was a
drug. The hotel had a driver waiting for them. Steve did
not have to do anything, and it felt good. He was thinking
about how much Meg would love the candle. It was when
they were checking into the hotel that he got the
message.

“Dr and Mrs White, welcome to our beautiful island
paradise. We will do everything we can to make your stay
wonderful. I noticed that there is a message for you. Let
me retrieve it. It will only take a moment.”

Steve looked at Meg. “Do you think your mother is
having a problem with Sarah? She was not so happy
about our leaving?” He felt some of his senses tightening.
It was hard to relax after being found. He was used to
bracing himself into this mode of getting ready to deal
with a problem; he did it every time his pager went off.

“I do not think so. Mom knew how much I was looking
forward to this. I can not imagine her bothering us unless
it was an emergency.” They shared an apprehensive
look.

The manager handed Steve an envelope addressed to
Dr Steven White. He opened it and read it: “Please call
ASAP.” The note was from his senior partner, Preston,
and it included his cell phone number. Now all of the
connection between Steve and Meg dissipated. He
reached into his pocket for his cell phone.

Damn! No service on the island. Steve needed a phone.
He found one in the lobby. Meg went to check into their
room.

It was the mayor. He was unstable and needing urgent
surgery for acute aortic insufficiency from endocarditis.
Steve’s partner was going to perform the operation, but
he wanted Steve’s help. Preston thought the mayor
would benefit from a Ross procedure, an operation that
Steve had acquired a lot of experience with when he was
in his residency. Preston was still learning the Ross
procedure, and with Steve’s help, he was getting pretty
good at it. However, he did not want to do this one alone,
because this was the mayor for God’s sake! This would be
hugely important to their practice. Television and the
Press would be following this story closely. Everything
had to go well. He hated to ask, but this was so important.
Besides, Steve had said he could come back if things got
out of hand. Meg could enjoy the island for a few days
and Steve could be back the day after surgery.

“Sure,” Steve said numbly. It was not what he meant,
not what he wanted, but it was what he said. “I will look
into the flights back. I need to tell Meg. I will call you
when I have some information.”

“Thanks, Steve. You have been a wonderful partner.
This is what we have to do sometimes.”

“Right,” thought Steve, as he placed the receiver in the
cradle and tried to refocus on where Meg might be. He reached into his pocket for his card key for bungalow 15. Life wasn’t fair!

Steve walked, reflectively along the beautifully manicured, fragrant path that led toward bungalows 11 to 24. When he got to bungalow 15, he was not finished thinking. He was not sure what to say to Meg. He was not really sure what to say to himself. If it were not for Meg being here with him, he would have no problem with going back. In fact, he was aware that there was a part of him that felt he belonged back in the hospital. He was very comfortable with that part. It was like being on a well-traveled path. This is what you have to do in this line of work. It was the dutiful thing. A health professional is supposed to put the lives of others first, right? What about Meg’s life? What about his life? Throughout residency, he tried so hard to please others. There were so many demands from others. He learned how to accommodate and this became his well-traveled path; it was why there was a strong force compelling him to return to work. He knew that feeling of self-sacrifice and delayed gratification; it had become a way of life. He could slide into it the way an alcoholic decides to have another drink. Had work become an addiction? How could he deny the importance of helping Preston do a Ross procedure on the mayor? And it would be so good for the practice. The media coverage alone would bring them countless patients. Preston would be so appreciative. Meg would, once again, understand. She would understand. She would be disappointed, but she would understand. How many times could he disappoint Meg? She was incredible, but she was human. Listen to her in there singing. She is so happy to be here. I will not be asking her to leave. I will be back in a few days after I do the professional, dutiful thing. I will be proud of myself. Steve sacrifices himself again. You can count on Steve. Damn—a bungalow, candlelight, and Meg! Can I choose myself and still be a professional? I do not want to go back. I want to stay here. I mean, I could go back, and I know Preston needs me, and it would be so good for our practice. It is just a couple of days. It is not like I am canceling the whole vacation, and if I do not go, I will feel so guilty. I guess I do not really get to choose myself unless no one else needs me. Meg will understand. I can suck it up. The air feels so good here. I want to take a walk on the beach and hold Meg’s hand, come back to the bungalow, and relight our candle.

We will leave Steve here at the threshold of his bungalow, struggling with a no-win dilemma. In some form, we have all dealt with this dilemma. We have been “enculturated” to put our profession first before ourselves, our family, our being human. During training, thoracic surgeons are never taught balance. Can you be professional as a dutiful thoracic surgeon and be balanced?

How does Steve make the correct decision? In fact, is there a correct decision?

What is required of Steve is to create a life of balance and fluid movement among three important conceptual aspects in his personal system. For example, he must learn the importance of valuing and respecting himself, his relationship with Meg (family, or others), and his medical practice (partners, patients, and media, which are the context of his job). To ignore or consistently choose one system ingredient (self, other, or context) over another will create an unbalanced and rigid lifestyle, putting Steve, his wife, and his medical practice in jeopardy. It may be possible for one aspect in Steve’s system to grow and thrive temporarily, if it is consistently being chosen over other aspects in the system; however, even the chosen aspect will eventually suffer if one or both of the other aspects is destroyed.

What is the price to us of not having balance? Steve makes the well-traveled decision and returns to work. Once again, Meg understands. The statistics are grim. If Steve continues to make the decision that work comes first before his needs, including his relationship with Meg and their children, he may end up chronically depressed or with a substance abuse problem, which has been recorded as high as 8% to 12% among physicians, or he may even end up with both problems. With a little additional stress, such as his health or finances, he could become suicidal. The risk of suicide is higher in physicians than in the nonmedical population. Each year it would take the equivalent of one to two average-size graduating classes of medical school to replace the physicians who commit suicide. The risk seems especially high for those who are driven, ambitious, individualistic, and compulsive. The previous description represents the profile of a thoracic surgeon [1, 2].

Suicide is an extreme. More likely, the physician may end up divorced. That is not what Steve set out for when he bought that candle for his first date with Meg. It is a well-published fact that the divorce rate for physicians is 63% versus the national norm of 43%. The risk is highest for psychiatrists and surgeons, and this is especially true for female surgeons. More frightening is the fact that those couples who do stay married report a higher incidence of being unhappy [1, 2].

During the training years, thoracic surgeons become masters at delayed gratification. Residents spend years coping with the high level of demand required of them in surgery, often harboring the expectation that later they will be rewarded with a happier, more balanced life [2].

Perhaps Steve makes the decision that Meg will not understand and that if his marriage is to survive, he just cannot return to work. After awhile, making decisions to placate Meg, Steve begins to resent her. She is holding him back. She used to understand and support him. If it were not for her demands, he would be happy. How did this happen—this gradual slide into unhappiness? He just cannot keep everybody happy anymore. When did this become his responsibility?

What about his happiness? Why is life so hard? What would Steve do for Steve if there were only Steve to satisfy? The unsettling reality is he has no idea. He has spent so long in a culture that has taught him to take care of others, often demanded him to take care of others, to the point that he has no idea of how to take care of himself. He has derived his happiness from serving the
needs and demands of others. When his pager goes off, he has ambivalence. He hates to be bothered, but at least it creates something important and meaningful and he knows he has to respond. This is why he has not taken a vacation. During his years of training, he has lost his existence. No wonder he is out of balance.

We do not have solutions for Steve's current dilemma. There is probably not a single correct decision. Steve has a "schema" that he has learned very well from his training and from his mentors in thoracic surgery. His training has defined the rules and code of conduct for him as a surgeon, and he has embraced it so that it feels comfortable and familiar to him. For Steve, to break the pattern responses of this schema would make him feel uncomfortable and unfamiliar. He has learned to work hard, take his responsibilities of being a surgeon seriously, and put his need for self-care and his need to spend time with his family last. Similar to most individuals who have developed survival schemas by incorporating rules and beliefs for success or survival, he is good at selecting information to reinforce this schema and blocking or ignoring information to the contrary. However, we could propose a schema that may be more helpful to Steve, a schema that emphasizes the importance of valuing one's self, others, and the context for making choices. Adoption of this schema would create a dynamic, fluid, and balanced process for living.

Virginia Satir [3] described this process of choice, which requires flexibility, balance and the ability to value one's self, others, and the context as "system-congruence" or "system-esteem." It becomes possible to create stability in one's life when the triadic components of self, other, and context are kept in balance over time and there is fluid movement among these elements in relationship to choice and value.

For example, in Steve's case one could argue the merits of Steve's returning to his medical practice to operate on the mayor and leaving Meg to vacation for a few days on her own. No one could deny the importance of putting a patient's care first, supporting his partner, or of protecting the reputation of his medical practice. Conversely, a case could be made for the importance of this time away with his wife. It certainly seems that it is a well-deserved and overdue break for the two of them. Also, what about Steve's own self-care? He needs down time as well. To get locked into a debate about any of these options would perhaps be getting so lost in the trees that one can no longer see the forest.

The more important discussion is to identify the learned (patterned) responses to which an individual continually chooses: (1) self, and ignores the needs of others and the context; (2) others, and continually puts his or her own needs last; (3) context, in which work is consistently chosen over the needs of one's family and self; or (4) self and others, by completely ignoring the validity of the context. Whether Steve stays in the Caribbean with his wife or goes home to operate on the mayor, it does not become an issue unless he has developed a lifestyle pattern that consistently pursues only one choice. Life becomes unbalanced when individuals repeatedly choose one or two aspects of the triad (self, other, or context) and ignore the others. System congruence and system-esteem are present when an individual (as well as the other members of the system) wholeheartedly choose to value and respect all three system components.

In a congruent system, Steve would not be locked into only one way of responding. The way Steve is presently functioning, he believes that his only choice is to choose context first. Although this schema of putting context first (his role as a surgeon, his care for his patients, and his responsibility to his partners) is what feels familiar and comfortable to Steve, he is also keenly aware of the painful cost to his marriage and to his own ability to be happy.

It is unlikely that Steve would do too much damage to his relationship with Meg by decreasing their time together in the Caribbean, if she frequently (over the course of time) felt chosen and valued in her relationship with Steve. It is the repetition of never being chosen that creates the discord. Steve's schema of putting context first is more of a problem than the ethics of this one situation.

Steve may have problems with his partners if they share his same schema of putting context first. Steve's partners would only be open to exploring other options with Steve for the mayor's surgery if their expectations (schemas) for appropriate surgical behavior allowed for the valuing of self, other, and context. Steve and his partners will have to relearn their schemas of choosing context first if they are going to develop balance and congruence in their lives. They need to share in and support one another in this change.

Just as Steve's culture (surgical training and mentoring) produced and reinforced this schema, it may also have to change for Steve to be able to function comfortably within it. The possibility for change to this culture may have been handed to us by the Accreditation Council for Graduate Medical Education (ACGME) in the form of the 80-hour workweek for residents and the core competencies for education (please see the website at www.ACGME.org). Rather than view these as obstacles for training competent thoracic surgeons, we can try to embrace them as an opportunity to begin emphasizing balance in the way our residents are trained. At the same time, we can begin examining how well we can make these changes for ourselves as we become the role models for the future.

References
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In recent years, a number of substantive changes have occurred in the training and practice of medicine and surgery. The pace of change is always accelerating. As surgeons, we initially believed that we were immune to many of the evolving issues and concerns regarding resident work hours and lifestyle debates. However, now that has all changed and we find ourselves in transition, trying to balance our professional lives with personal and professional responsibilities. This essay is intended to present opinions on the direction that our profession is heading and why we should remain concerned and engaged.

In his 1963 presidential address to the Thirteenth Annual Student American Medical Association Convention, Dr Michael E. DeBakey [1] proclaimed that “the demands of a physician’s practice are so rigorous, requiring such exclusiveness on the part of the doctor that he must forego almost all other aspects of life.” Four decades later, this philosophy continues to exist within organizations such as the American College of Surgeons [2] whose members pledge “to pursue the practice of general surgery with honesty and to place the welfare and the rights of [the] patient above all else.” However, healthcare within the United States has become a multibillion-dollar industry, and it is estimated that by the year 2007, American healthcare will cost more than 2 trillion dollars and will require 20% of the gross domestic product [3]. Jones [4] pointed out that in order to function effectively in today’s healthcare system we need guidelines to sustain a focus on the welfare of sick people and “to navigate in a trillion dollar industry, we need a compass: medical ethics.”

As surgeons, we are being forced to justify and balance three distinct areas of responsibility encompassing ethical, moral, and personal obligations in the face of escalating patient-care requirements. It is inarguable that surgeons should be able to spend more time with their families and pursue outside interests; however, the caveat lies within the word “should” and between “the devil and the details.”

Ethical Obligations

Ethical decision-making involves personal sacrifice and an unwavering conscience. As surgeons, our ethical obligations transcend self-interest, personal emergency, and social, political, and economic forces. We chose surgery as a profession for a myriad of different reasons; however, by doing so, we all agreed to function in a capacity that would be beneficial and helpful to our patients.

Developing an inner ethical being requires (1) a fundamental belief and a total and permanent commitment to an ideal and (2) full dedication to the good of others and to help people who are in need.

Moral Obligations

Moral development involves personal sacrifice, effort, resolution, work, and discipline, leaving little room for incompetence, selfishness, or even legitimate personal concerns like fatigue, lack of time, or demands by the family. In his 2001 presidential address to the Western Surgical Association, Dr. J. David Richardson [5] reminded us that “unlike other disciplines able to rely upon alternative caregivers, surgery does not lend itself to care by proxy.” One cannot discharge moral responsibility by giving it to someone else; it is non-transferable, that is, “you can delegate authority, but not responsibility” [6].

Personal Obligations

Satisfying our daily personal obligations with surgical responsibilities represents one of the most difficult aspects of the surgical lifestyle, as we are often criticized for not spending enough time taking care of our families or ourselves. However, we believe the surgical profession offers a service of high significant personal value. To accomplish this goal, we must (1) reinstate the principle of “just doing what is right”; (2) work without ulterior motives; and (3) display commitment and availability with no questions asked.

Alexis Carrel [7] once wrote, “To accomplish our destiny, it is not enough to merely guard prudently against road accidents. We must also cover before nightfall the distance assigned to each of us.” Winston Churchill [8] said, “It is no use saying, ‘we are doing our best.’ You have got to succeed in doing what is necessary.” General Dwight D. Eisenhower [9] very eloquently stated, “We succeed only as we identify in life, or in war, or in anything else, a single overruling objective, and make all other considerations bend to that one objective.”

Comment

Advocating these concepts represents a difficult challenge. It seems as though putting our patients first has become something of an archaic concept, even though, we have an ethical obligation to the patient and society to provide good care, which is referred to as the “social contract.” Society moves in the direction in which needs exist, and as physicians we not only must meet the needs, but we must also preserve certain basic principles essential to the proper provision of medical care. The surgical profession must be allowed to return to its original mission and renegotiate the social contract in order to become more balanced, because as we all know, “good medical care is rarely cheap and cheap medical care is rarely good” [1].

From both theoretical and practical standpoints, surgi-
cal training and practice go beyond the realm of simple commitment and reside firmly in hard work. In observing current medical students and residents, many have noted that there is a political incorrectness to the hard work that is so necessary to fulfill the commitment. Even with the current resident work hour restrictions, the number of unfilled general surgery residency programs in the United States increased from 5 in 1997 to 41 in 2001 [10]. Prior studies have noted that lifestyle, especially a “controllable lifestyle,” is a major contributing factor in specialty choice by students [10]. We are not arguing that a balance between purposeful hard work and personal responsibilities should be overlooked; however, many surgical problems demand immediate attention. We agree with Dr Richardson [5] when he stated that “lifestyle as a buzzword cannot be allowed to be a ‘cop-out’ for failure to have adequate surgeons and other physicians to meet societal needs” or eventually, our society will be “served” by a medical community that is less talented and definitely less interested in providing medical services in the tradition of its predecessors. Great care must be taken to support and refresh those aspects of American medicine that have sustained it as the most noble of vocations, that have enriched our professional lives, and that have set us apart as the steadfast protector for the interests of our patients.

In conclusion, as surgeons we continue to work through the night, long past the time when our colleagues have gone home, because that is how we have been trained. Attitudes such as this should not be changed, but rather embraced, because to our patients, we represent “hope.” In the words of Stephen Paget [11], “We serve three masters: our profession, our patients, and our own people. For if a doctor’s life may not be a divine vocation, then no life is a vocation, and nothing is divine.”

References

Concluding Remarks

Robert M. Sade, MD

Should surgeons spend more time with family and personal interests and less time in hospitals? Drs Coselli and Conklin and Drs Dickey and Ungerleider have provided conflicting answers in their respective essays. Their views, taken together, however, do not exhaust all possibilities. Additional insights may be gained by considering fundamental aspects of human behavior as understood by ancient philosophers. To them, Aristotle in particular, the most important of the virtues was phronesis, which has been roughly translated as “prudence” or “practical wisdom,” though neither term captures its essence. Phronesis is the wisdom that helps us recognize those particular goals and virtues, both professional and personal, that are of greatest value to us as individuals. By applying this wisdom, we can choose a path that will correctly align our personal goals and virtues so that our individual and unique human potentials can be most fully realized [1].

Drs Coselli and Conklin have spelled out the professional goals and virtues needed for a successful professional life as a surgeon. We have been deeply inculcated with a group of virtues that characterize an excellent surgeon: (1) fidelity: being loyal to our patients before all other loyalties; (2) productiveness: working long hours to do the most we can for our patients; (3) rationality: learning what a surgeon needs to know; (4) integrity: making our actions consistent with our knowledge and beliefs; (5) reliability: being available when needed; (6) compassion: recognizing and sympathizing with the suffering of our patients; and (7) effacement of self interest: placing the best interests of our patients ahead of our own. Drs Coselli and Conklin suggest to us that although many other things are important, professional life should take precedence over all else.

This familiar picture is precisely the target of Drs Dickey and Ungerleider’s essay. They point to some needs and values of surgeons that extend well outside the arena of professional life: leisure activities, relaxation, and communicating with those closest to us. Beyond those that they cite, there are many other values as well: painting landscapes or repairing motorcycles (creativity), developing and teaching Sunday school classes (spiritual
engagement), reading a novel for escape (relaxation) or enrichment (intellectual growth), or writing a novel (avocation), and so forth down a virtually endless list. Drs Dickey and Ungerleider stress the importance of balance in making choices between pursuing personal goals and responding to professional demands.

These two essays cover a great deal of territory. Yet we wonder whether either viewpoint identifies the right way for a surgeon to achieve a truly fulfilling life. As human beings we all share certain needs, such as nutrition, friendships, and health, yet each of us has a one-of-a-kind blend of specific needs, desires, talents, interests, and tastes. Therefore we each have a unique path to follow if we are to achieve full realization of our individual potentials as human beings, including both our professional and personal lives.

How should we interact with our patients, colleagues, hospitals, spouses, children, friends, and others? How much time should we spend on solitary activities or with others? How much time should we spend on our profession or personal interests? In other words, how should we best utilize our limited time, energy, and resources? Dr Coselli’s answer may be right for him, or not. Dr Ungerleider’s answer may be right for him, or not. We cannot make that judgment; only they individually have access to personal information and insights that make such judgments possible. For some of us, heavy emphasis will be on the professional, for some, on the personal, and for many, on a roughly even mix of the two. Our essayists have given us ample food for thought, but in the end we must try to know our unique selves, and we must each design our individual paths to personal fulfillment. This is perhaps the most difficult of all human enterprises, and this may be the reason why philosophers from many centuries ago recognized that striving for self-knowledge and the determination to act on that knowledge comprise the most important of the virtues (ie, phronesis).

As for the future of the surgical ethic, crystal balls are notoriously cloudy by nature, and mine is no more revealing than anyone else’s. The trend toward shorter work schedules and a bigger share of our time for personal activities is evidenced by medical students’ attitudes toward lifestyle [2] and mandatory work limita-


tions for residents [3], as well as advice such as that offered by Drs Dickey and Ungerleider. The evidence for an imminent transition to a personal lifestyle-friendly surgical profession seems compelling. Yet, although the ghastly vision (ghastly for many of us at any rate) of a 40-hour workweek for surgeons may seem just around the corner, it may not come to pass, at least not in our lifetimes. It is not that the nature of surgery necessarily demands workaholic surgeons; surgeons in other countries and other cultures have well-controlled schedules and a work ethic that accommodates a life outside of surgery. It is more that dedication to the well-being of our patients, the intensely personal nature of surgery (eg, how many internists or pediatricians have talked to a patient at dawn, held her heart in his hands in the morning, and talked to her again in the afternoon to tell her that her problem has been fixed), and our deeply embedded work ethic may combine to make the “24/7” surgeon a thing of the future as well as the past. Drs Coselli and Conklin’s contribution suggests the possibility of continuing survival of the traditional surgical work ethic, and also provides us with reasons to believe that it may even be a good idea.

What will the practice of surgery look like in the future? This is not clear, but there is one certainty: change is inevitable. We need to prepare for whatever shifts occur as best we can. We may even hope to guide the process of change, perhaps in our profession, but certainly in ourselves. Drs Dickey, Ungerleider, Coselli, and Conklin have helped us to imagine how we may be better surgeons and better human beings, and for that we are grateful.

References
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