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Not the Last Word

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Not the Last Word: I Have Seen the Moment of My Greatness Flicker

Joseph Bernstein MD[1]

One of my favorite teachers—I will call him Dr. Burt—was no longer operating when I met him as a second-year resident. At age 76, Dr. Burt was seeing outpatients and writing books, work he continued until his passing 20 years later.

Dr. Burt had given up surgery shortly before I met him. Once I got to know him well enough, I mustered up the courage to ask how he knew it was time to put the scalpel down. Dr. Burt said, "I stopped operating at age 75, because my friends in the operating room let me know I was getting slow. When I had a big case, they took the clock down off the wall and replaced it with a calendar."

Not many of us will share Dr. Burt's self-awareness or his self-deprecating sense of humor. Even less common is the ability to read the handwriting—or calendar—on the wall with such equanimity. How, then, should we approach the issue of the aging surgeon?

Let's begin at the end. All of us are going to die, few fortunate enough to do so all at once. Most of us will face a gradual, uneven decline. Some of the diminishing capacities associated with aging are only peripherally related to the practice of surgery while others sit at its core. For example, with aging, we commonly see a loss of dexterity, diminished focus, and most devastating of all, for some, a fading recognition of these very changes.

The process of aging creates two parallel problems: one for the surgeon who gives the care, and a second for society on the receiving end.

The societal problem is easily defined. Although patients are likely to value the experience and wisdom that comes with age, they do not want to be treated by doctors who are no longer competent. On the other hand, the societal problem is not so easily solved. Our screening tests for detecting the performance decline associated with aging are rudimentary at best, critics argue, and enforcement may inadvertently violate age-discrimination laws.

Given the complexity of the societal problem and the need for collective action to address it, I will focus on the issue of aging from the surgeon's perspective. This area is no less complex, but here, an individual's actions might make a marginal difference.

We can start by acknowledging that many surgeons might want to continue working even as their abilities diminish. For one thing, owing to poor planning or random financial setbacks, some senior surgeons may need the paycheck. And even without financial need, going to work offers a sense of purpose, mastery, and camaraderie that's hard to duplicate elsewhere. But beyond that, admitting to yourself that your fastball is not so fast can be so psychologically distressing that one might keep pitching, so to speak, in a furious but futile attempt to refute reality.

In T. S. Eliot's first poem, "The Love Song of J. Alfred Prufrock" [2], the narrator describes this distress memorably:

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"Though I have seen my head (grown slightly bald) brought in upon a platter,
I am no prophet — and here's no great matter;
I have seen the moment of my greatness flicker,
And I have seen the eternal Footman hold my coat, and snicker,
And in short, I was afraid."

Surgeons who have devoted years to training and decades to practice might see the imposition of a forced retirement as an alarming disruption, a flickering of their (relative) greatness. It certainly seems that way to me. But we don't have to succumb to fear, either.

There is an ancient "art of dying," as Dr. Lydia Dugdale reminds us [1], and this art, the *ars moriendi,* can be applied to the death of one's professional prowess too, I think. Dr. Dugdale put it this way: "To die well, you have to live well. That means recognizing your finitude and wrestling with related questions of meaning and purpose within the context of a community" [3].

To my ears, Dr. Dugdale's advice is, in broad terms, that we can best cope with decline by preparing for it. Surgeons do not have to lose their sense of purpose as they age. By preparing mindfully for an inevitable decline, surgeons can stop operating and yet continue to contribute to their community, thereby retaining their sense of purpose. A surgeon's journey might lead to teaching, assisting at surgery (without full responsibility), or even taking on work outside of medicine altogether.

The key is preparation. One cannot quit a busy surgical practice and expect to be welcomed with open arms in new areas, particularly by those who have spent years honing their skills in those domains. Expertise and acceptance must be earned. Teaching, for example, is not something one will do well merely by knowing the subject matter; one must learn and apply good pedagogy. In essence, thriving in these new roles requires more than just business as usual—it requires reinvention.

The process of reinvention can be eased by beginning work in new areas while still active in one's present role. The athletes who make the best transition to the broadcaster's booth after their playing days are over are those who experimented with this role while their playing careers were still active. This same mindset will assist physicians in their transition as well.

Another affirmative step a young surgeon can take is to learn as much as possible about what's to come, so obstacles can be anticipated and pitfalls avoided. Kudos to Dr. Zuckerman [4] for writing about this and hopefully others will follow. Still, our formal educational programs must pick up the slack. I would like to see information about the biological effects of aging and retirement planning introduced in the standard orthopaedic residency curriculum. Better still, these subjects should be part of the tests residents must take (Fig. 1 and 2).

Eliot's Prufrock must not be our example. Surgeons must be willing to disturb the universe while they are still young and can plan ahead. We all deserve to navigate life's passages, including retirement, with grace and purpose. We may not do it as well as Dr. Burt, but with openness to reinvention as our greatness flickers, we can become the authors of our next chapters, with endings that embrace thoughtful transition.

Lydia Dugdale MD, MAR

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Dr. Bernstein rightly underscores the deep integration between dying well and living well. As the *ars moriendi* ("art of dying") handbooks teach [1], those who wish to die well must prepare for death by attending to what it means to live well. For surgeons, Dr. Bernstein says this might mean anticipating the redistribution of operating room time to other activities, such as teaching, assisting in surgery, reinventing oneself, and/or determining in advance how to contribute to community life after surgeons can no longer operate. Dr. Bernstein expects that such consideration during the run of surgeons' careers will equip them to transition well to a life after surgery that is imbued with purpose.

Although I applaud Dr. Bernstein for anticipating how surgeons might age and ultimately die well, he omits an important part of what the *ars moriendi* handbooks teach. As I describe in my book, *The Lost Art of Dying: Reviving Forgotten Wisdom* [1], central to the notion of a good death was the sort of character a person displays in living and dying. The earliest of these medieval handbooks

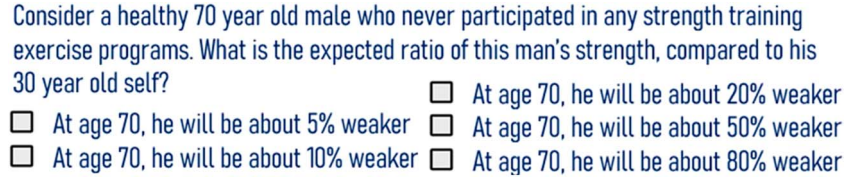

Fig 1. A sample In-Training examination question, assessing knowledge about the biology of aging.

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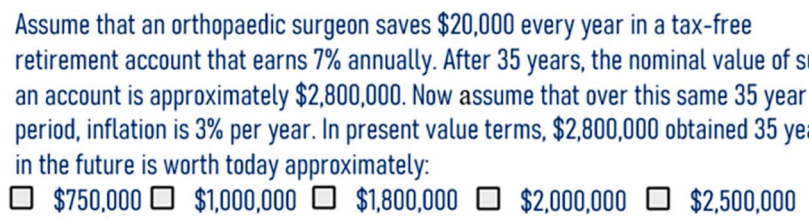

Fig 2. A sample In-Training examination question, assessing one's ability to convert future dollar amount to their net present value (an essential retirement planning skill).

taught that people die and thus live poorly if their lives are marked by pride, greed, impatience, despair, and doubt. By contrast, to die well means to die with a character of humility, generosity, patience, hope, and faith. But such habits or virtues do not simply happen to people on their deathbeds. Rather, they must be cultivated over a lifetime. Just as surgeons learn the skills necessary to perform complex operations by practicing for years, so too must we practice the character traits necessary for good living and dying. Only through practice does such excellence of character become second nature.

As a primary care doctor, my patients routinely tell me that they are not worried about their surgeon's bedside manner, as long as the surgeon is technically competent. Although this may be an appropriate perspective for a consumer-patient whose primary interest is an excellent surgical outcome, society lets surgeons off the hook by giving them permission to neglect cultivating their competencies of character alongside their technical competence. All of us in healthcare must spur one another on to become the best human beings we can possibly be.

Since antiquity, the cultivation of a life of virtue was intrinsic to human flourishing and to the well-being of individuals as well as communities. As a concept, virtue was also tied to function—the virtues of a thing are what enabled it to perform excellently. By extension, the virtues of a physician help physicians become as good as possible for their work as physicians. When people cultivate the virtues that enable them to flourish as human beings, all of society stands to benefit.

By reminding us of our finitude, Dr. Bernstein encourages us to anticipate and prepare for life after practice, and eventually, for death. But if we only attend to what we will do, and not to who or what we are becoming, we are likely to die poorly, despite our efforts. Fortunately for those of us reading these words, it is not too late.

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Of the several themes Dr. Bernstein discusses in his thoughtful piece about retirement, the two I find most important are the concept that aging with both physical and mental decline are unavoidable, and that planning one's retirement is as important as planning every other aspect of one's life.

Orthopaedic surgeons, by necessity, are academically successful, but also usually are well rounded, having pursued a rich variety of extracurricular interests and skills during their academic careers. In my experience, this is why most orthopaedic surgeons are happy and interesting people. In their early years, orthopaedic surgeons must exhibit extraordinary motivation and dedication to their training, becoming the best they can be. This requires a singleness of purpose, and so necessarily, many of the life-enhancing activities outside of surgery must be put on hold during this period of development. In many cases, the result is a surgeon who envisions little in life beyond his or her career, making it difficult to conceptualize the need to retire. In my experience, the most successful surgeons are those who can achieve an acceptable work-life balance. This typically requires a resilient life partner, sympathetic family, and close friends who can understand the demands of a surgical career, as well as a commitment to life activities outside of surgery that make their lives more rewarding. In my case, these outside interests provide something to look forward to as I wind down my clinical practice.

The final stage of a career in surgery begins with an awareness that our capacity to perform in all aspects of our lives is becoming a challenge. It becomes clear that something has to change. That old person looking back at you in the mirror is trying to tell you something. Although this awareness occurs at different times and ages for every individual, it is inevitable. I found it extremely helpful to learn as much as I could from the retired surgeons in my life. Both good and bad examples were plentiful. For me, the best examples were those surgeons who gave up surgery when they still were at peak performance, as well as those who deliberately developed interests and skills beyond surgery that enriched their lives and provided opportunities to stay involved in orthopaedics if that is what they desired.

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As pointed out by Dr. Bernstein, planning for this is critical and must begin well before the transition to retirement begins. This cannot be an afterthought. Keep in mind those aspects of life besides surgery that make you happy, and be disciplined in setting aside the time to make them part of your routine. We all recognize that planning for financial security after retirement is critical. The need to envision a meaningful life without surgery is just as important.

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