Fun

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As a medical student, I worked with a surgeon whose demeanor I adored. In clinic, he guided patients with cancer through a morass of treatment options, assuaging their fears, neither minimizing their distress nor giving them false hope. In the operating room, he favored classical music and took obvious joy in teaching: without warning, he would erupt into a flawless Scottish accent and engage me with basic anatomy questions, gently prodding me toward confidence in identifying the gallbladder, the spleen, and various blood vessels in the abdominal cavity. One day as he held a scalpel over a patient's belly, ready to make the incision at the beginning of a case, he turned to me and asked, "Why am I doing this?"

Having prepared the night before, I started to explain that the patient had previously been diagnosed with gastric cancer and had undergone curative surgery, but was now suffering from the most common cause of bowel obstruction — "adhesions," internal scars left by her prior surgery around which loops of her intestine had twisted, causing unremitting vomiting of bright-green bile. This routine surgery would relieve the twisting, and her symptoms. But the surgeon stopped me midway through my explanation: "No," he said, smiling behind his mask and drawing the knife through her skin, "we're doing this because it's fun."

At its best, surgery is an inimitable thrill: a live human body in Technicolor, laid open like an anatomy textbook; skilled, focused surgeons with a grace and economy of movement reminiscent of ballet. The teamwork of the operating room, another thrill: the savvy scrub nurse who predicts the surgeon's next moves and hands over a necessary instrument before being asked, the anesthesiologist titrating potent medications, the jovial banter of professionals going about their ordinary and extraordinary day. And, afterward, the instant gratification: a cancer resected, a dysfunctional gland excised, a problem solved, a body closed. There is always the possibility of surprise, of error, of misdiagnosis; anything can happen, but when it's going well, the sensation is what I imagine it feels like to take flight. "Fun" seemed an odd word to describe it — even flippant, considering what was at stake — but even as a medical student, I knew what the surgeon was trying to express. He had found flow — a state of happiness derived from complete absorption in an experience.[1]

Thirty minutes in, the chief resident, who was assisting in the case, paused. "That's really firm," he said, and the attending surgeon agreed. "Do you think the cancer has come back?" he asked, and with a jolt I remembered the patient's husband in the preoperative area, rubbing his wife's feet in silence as she lay, miserable and nauseated, under a thin blanket. I willed the surgeons' intuition to be wrong. With sharp scissors, they took a sample of the firm flesh around her stomach and sent it to the pathologist, who looked at it under the microscope and confirmed it: the obstruction wasn't caused by adhesions at all, but by a previously undetected recurrence of her cancer. It was a brutal turn of events for the patient, as she lay asleep and unaware under the drapes. My face burned and my glasses fogged up; tears rolled down my cheeks, soaking my surgical mask. I felt intense shame: How could we have been so callous as to think of surgery as *fun*?

In medical school, my classmates and I were trained explicitly and implicitly[2] to suppress natural human reactions: treating patients requires a certain comfort with things that nonclinicians would consider horrifying or disgusting. Such suppression is, on some level, a necessary practicality: we can't optimally treat a patient if we are too sickened by the sight of a wound to examine it thoroughly; we won't be able to earn the trust or maintain the dignity of our patients if we react to the odors that accompany illness the way we would have before medical school; and, of course, I can't see to operate if I'm crying.

So some detachment from the emotional impact of illness is necessary to be an effective physician — but it turns out to be surprisingly easy to temporarily suspend understanding that the person under the drapes is more than a collection of anatomical landmarks and that even the most routine surgery is usually a scary event for the person undergoing

it. This attitude reflects a central tension of being a doctor: we require the ability to find the work fulfilling and technically fascinating on its own merits, even when the disease, or the operation, has disastrous implications for the patient. But how does professional enjoyment interact with empathy for the patient who's at the heart of the work? Is it wrong to find pleasure in the rhythms of the hospital, even to the point of temporarily forgetting the patient's plight? Is it morally justifiable to enjoy an activity predicated upon the pain and suffering of others — when the suffering of another person is, in fact, a necessary precondition for that activity? This central tension is certainly not limited to surgery — a medical attending I know recently described in excited tones the rush she feels when running a code. She finds the adrenaline, and the pride in knowing exactly what to do, to be irresistible.

Back in the operating room, the attending and the chief resident removed as much of the cancer as they could, and eventually I stopped crying, grateful that, though I'm sure they noticed, they didn't say a word. The mood in the room had changed: together we carried the weight of the patient's new diagnosis, and at the conclusion of the operation the attending and the chief resident carefully closed the incision they had made. The attending went out to talk to the patient's husband, and I stayed by the patient's side until she was transferred to the postoperative care unit, wondering whether I possessed the emotional fortitude to pursue a career that included unwelcome surprises like this one.

Five years later, at a narrative medicine conference, I found myself explaining my decision to pursue fellowship training in surgery for head and neck cancer — a devastating disease that can rob patients of their ability to speak, swallow, and smile and whose occult recurrence is common. Even the most innocuous-sounding symptom can represent a hidden cancer, one that can transform a routine operation or follow-up visit into a dramatically different conversation. "How can you do that work?" asked the conference organizer, a legendary empath, and when I balked, she took my arm, looked into my eyes, and repeated her question: "I mean, *how can you do that work?*"

Surgical training has, for me, required learning to balance sometimes-conflicting needs: to maintain distance in the operating room and to make time afterward to reflect on the emotional havoc that the disease can wreak. I feel the sadness of my patients' stories, even — and sometimes especially — after appreciating the beauty of their anatomy or applauding a "great case" in the operating room. I have learned to value both as crucial aspects of the work, and the triumphant moments provide a kind of insulation against the days with terrible twists. Caring for people through a disease that can rob them of essential aspects of their humanity is challenging, but also inherently fulfilling — and so my response is not to feel ashamed of enjoying the work, but to feel both the thrill and the sadness fully. I wish I had been able to crystallize this balance on the spot. Instead, I looked back at the conference organizer and stammered: "I just — because it's fun."

Disclosure forms provided by the author are available at NEJM.org.

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DOI: 10.1056/NEJMp1909360