A Surgeon at Night

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Introduction

Like many important lessons in surgery, this one came at night. Hospitals change when the sun goes down—mere survival becomes paramount. Particularly early in training, we learn who we are as doctors at night. The feelings of fear and confidence meld together. Unlike in the operating room, rarely is anyone looking over your shoulder at night. During the day, we present our best selves to our colleagues and patients. At night, though, we are tired and often our defenses are worn down.

Typically, we review labs and radiology studies prior to seeing the patient because it's more efficient. However, the emotional side effect is detachment. The patient becomes a sick colon that we'll have to remove. As residents, we rationalize our reactions because this practice optimizes the time that we spend on each consult. With so many patients to see and only 80 hours a week to do so, every second counts. The need is even more acute at night; we just try to stay afloat until our replacements arrive at 6 am.

One night, I was paged about a female patient reported to have the most holy and coveted of all nontraumatic surgical diagnoses—an acute abdomen. I rushed to review her CT scan, searching for any indication that surgery was necessary. Like a shark who smells blood, I was following the trail that led straight to the OR.

The case seemed innocuous enough. From her CT, the patient looked frail—not terribly young or healthy even before her most recent intestinal insult. Her internal organs all showed the signs of age. I felt so smart after my computer biopsy—ready to go forth and operate. She was another sick colon to me, one of many in a steady stream of cutting, dissecting, sewing, and ultimately learning.

The attending came in to see the patient. She is the type of physician who I would want taking care of my mother's, my wife's, even my own, sick colon. She simply talked to the patient. And I listened. The patient lived alone, albeit with much help from family and friends, so she was unwilling to do anything that would compromise her independence. Admittedly, when I saw her labs, CT scan, and finally her in person, I immediately thought, "nursing home." After talking to her, we chose not to operate. I never found out the details of what happened to her after that, an underappreciated side effect of night rotations. However, I do know that staying out of the OR was the right decision that night.

So much of our training seems diametrically opposed to restraint, to knowing when to stop. At times, it even appears at odds with rational thought. The gray area between the appendectomy and the Whipple, the gunshot wound to the abdomen and the aortic dissection, is where we learn how to be doctors. Those brief moments sitting on the bed and listening are what patients remember. They don't see the quality of an anastomosis or the empty right-upper quadrant anxious to receive a new liver. They see and hear and feel who we are as people when we talk to them and, more important, when we listen to them. At night, as the frenetic pace of the day slows, everyone—patients, families, physicians—realizes the toll that the day has taken. I learned that sometimes we all need to simply sit down and listen. It may be the best medicine.