Review Article

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The Surgeon: Between God-like Perception and Human Reality

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ABSTRACT

Introduction: *The final year of surgical residency represents a critical transition where individual responsibility shifts from supervised practice toward professional autonomy. Historically, the surgeon has been perceived as a "god-like" figure—a psychological defense mechanism for both the patient and the physician. However, this "God Complex" has evolved into a double-edged sword, closely linked to professional burnout and medical error.*

Methods: *A critical narrative review was conducted using a systematic approach across PubMed, Google Scholar, and medical humanities databases, analyzing the surgical personality and the history of surgery.*

Discussion: *From the myth of Asclepius to the pioneers of the 20th century, surgical identity has fluctuated between technical divinity and human fallibility. While self-confidence serves as a necessary "armor" during intraoperative crises, its excess leads to isolation and error. The emergence of the "Second Victim" syndrome following a complication stands as the definitive proof of the surgeon's humanity.*

Conclusion: *Excellence does not require a choice between divinity and humanity, but rather their integration. Fusing technical precision with Laín Entralgo's "loving objectification" allows the surgeon to transcend mechanical repair toward compassionate healing, finding greatness in the recognition of shared biological vulnerability.*

Keywords: *Surgery, God Complex, Medical Error, Second Victim.*

Introduction

The final year of a general surgery residency represents a critical part in the specialist's training. It is the point at which direct supervision begins to diminish, and the weight of individual responsibility settles upon the shoulders of the physician in training. It is at this threshold that the question arises: What elements constitute the divine essence of the surgeon, and which anchor them to their humanity?

For centuries, society and often the culture of surgery itself has perpetuated the myth of the surgeon as a demigod. This construct comes from a profound psychological need on the part of both the patient and the operator. When a human being undergoes anesthesia, surrendering their autonomy and consciousness to a stranger, the latter must project absolute, almost theological certainty. Voltaire asserts that those tasked with the restoration of health "partake of divinity," as preserving and renewing is almost as noble as the divine act of creation [1,2,3].

However, this projection of divinity is a double-edged sword hanging over the head of every surgeon. Omnipotence is an unsustainable burden for a fallible biological organism. Abundant medical literature highlights the consequences of sustaining this myth: alarming rates of burnout, depression, and suicide among surgeons [4,5].

This article aims to understand this dichotomy, exploring how the "God Complex" served as a historical defense mechanism before the era of patient safety, and how that same complex has today become a barrier to excellence [5].

Methods

The present study was designed as a critical narrative review, utilizing a systematic approach for the selection and synthesis of evidence. A literature search was conducted across PubMed, Google Scholar, and medical humanities databases, using MeSH terms such as 'Surgeons personality', 'Medical Errors', 'Burnout, Professional', and 'History of Medicine'. Given the heterogeneous nature of this research, a narrative review allows for the integration of concepts that would not be possible under restrictive criteria.

Discussion

Mythological Origin

To understand the perception of the modern surgeon, it is necessary to examine its origins, where the profound significance of the sacred and the mythical becomes evident.

The central figure in the symbolism of the surgeon is Asclepius, son of Apollo and the mortal Coronis. This mixed lineage is fundamental to understanding the hybrid nature of our profession. The myth recounts that Apollo extracted Asclepius from the womb of Coronis. Asclepius was then entrusted for his education to the centaur Chiron, who taught him the arts of medicine and surgery [6, 7].

However, the story of Asclepius serves as a warning regarding the limits of medical intervention. His skill grew to such an extent that he could resurrect the dead, utilizing the blood of the Gorgon bestowed upon him by Athena. This ability to reverse death transgressed the natural order and provoked the wrath of Zeus, who struck Asclepius down with a thunderbolt to restore cosmic balance. Thus, it can be understood that technical excellence taken to the extreme of defying God is an impure act. The universal emblem of medicine, the Rod of Asclepius, reinforces this connection to the sacred [6].

Evolution of the Surgeon in the Middle Ages

During the Middle Ages, surgery experienced a decline in its divine status. Separated from academic medicine, surgical practice was left in the hands of barber-surgeons. They performed bloodletting, drained abscesses, and amputated limbs, but lacked the intellectual prestige of university physicians [7]. During this period, the surgeon was more human than ever: a manual laborer [8].

The renaissance of surgical "divinity" arrived with the Scientific Revolution and, crucially, the 19th century. The introduction of anesthesia (Morton, 1846) and antisepsis (Lister, 1867) radically transformed the landscape. The surgeon was now able to invade the abdomen, thorax, and skull in ways previously unimaginable [4,9].

In this context, the modern "God Complex" emerged. Figures such as William Halsted in the United States and Theodor Billroth in Europe were not only surgeons of brilliant technique but also authoritarian personalities who demanded absolute perfection. The operating room became a temple where the surgeon's word was absolute law. This hierarchy was justified by the premise that, amidst the chaos of surgery, only an infallible will could direct the course of the intervention [9].

The 20th century witnessed the rise of cardiac surgery pioneers. Figures such as Michael DeBakey and C. Walton Lillehei performed high-risk operations, and their achievements reinforced the idea that the surgeon-through sheer will, intellect, and technique-could conquer death itself [10,11].

Psychology of the Surgeon

Literature suggests that a hesitant surgeon is a danger to the patient. In situations of massive hemorrhage, anatomical distortion, or intraoperative crisis, doubt can be lethal. The surgeon must believe, in that critical moment, that they are the only person in the world capable of resolving the problem.

This self-confidence is not mere vanity; it is a necessary coping mechanism. It allows the surgeon to execute precise technical maneuvers under extreme pressure [2,4,12].

Studies on the personality of surgeons reveal elevated levels of narcissistic traits; this narcissism acts as a psychological shield. If the surgeon were to fully internalize the immense risk that each incision entails, doubt would be inevitable. Therefore, the "God Complex" is not simply a flaw, but a necessary armor for the surgeon [2,13,14].

However, this virtue of confidence has its counterpart. When confidence transforms into hubris, it can result in excessive risk-taking, disregard for the surgical team, and an inability to admit mistakes [5].

The case of surgeon Ian Paterson in the United Kingdom, cited in the literature as an extreme example, illustrates how the "God Complex" can become malignant. Paterson performed unnecessary and harmful procedures (incomplete mastectomies) driven by a narcissism that prevented him from questioning his own judgment, operating in isolation and rejecting peer supervision [15].

Studies on overconfidence in medicine show that physicians often overestimate their diagnostic accuracy. In many cases, the most confident surgeons are the most prone to error due to premature diagnostic closure or underestimating the complexity of the case. Hubris impedes learning and jeopardizes patient safety [5,16].

Despite the attempt to maintain control, the surgical act is always performed under the shadow of uncertainty. Catastrophe is always present: suture dehiscence, pulmonary embolism, unexpected hemorrhage. Unlike a God who knows the future, the surgeon lives in the anguish of probability. Recognizing this uncertainty brings the surgeon closer to human reality.

"To err is human," declared the famous Institute of Medicine report (To Err Is Human), but in traditional surgery, an error is treated as a sin. The surgeon must be perfect, as an erroneous dissection or an incorrect clinical judgment has immediate consequences[17].

Charles Bosk, in his book Forgive and Remember, distinguishes between types of errors in surgical training:

- **Technical Errors:** Failures in manual execution. They are forgivable if acknowledged and learned from, viewed as part of the learning curve [18].
- **Judgmental Errors:** Incorrect decisions regarding treatment. They are more serious but tolerable if not malicious [18].
- **Normative Errors:** Failures in responsibility, honesty, or ethics (e.g., lying about a finding, failing to assess a patient). These are unforgivable because they violate the surgeon's code of honor [18].

Nevertheless, a surgical error dismantles the sensation of omnipotence by revealing human fallibility and fragility in the face of our biological complexity [7].

For the individual surgeon, however, the academic distinction fades when the result is a damaged life. The sensation of omnipotence is shattered, revealing the fragility of human competence against infinite biological complexity [7].

The emotional impact of medical errors has given rise to the concept of "Second Victim Syndrome" (SVS), coined by Albert Wu in 2000. While the patient is the first victim of the adverse event, the surgeon-who feels personally responsible and traumatized by having caused harm-becomes the second victim. Eighty percent of surgeons report feelings of guilt, anxiety, or shame following a major complication. Symptoms include flashbacks of the event, insomnia, doubts about one's own professional competence, and in severe cases, suicidal ideation [19].

This suffering is the definitive proof of humanity. A "God" would not feel guilt; neither would a psychopath. It is precisely the surgeon's capacity to feel moral responsibility and empathetic pain for the other that generates this syndrome. The surgeon's pain is the price of their ethics. If it did not hurt, they should not be a surgeon.

Burnout

Chronic exposure to the stress of life and death, combined with increasing administrative demands and a loss of autonomy, has led to a burnout epidemic in surgery. The statistics are alarming, with burnout rates exceeding 50% among general surgeons and residents [20].

This syndrome is characterized by three dimensions: emotional exhaustion, depersonalization, and low personal accomplishment. Depersonalization is particularly common as a defense mechanism to protect against Second Victim Syndrome (SVS). This cynical disconnection, although protective in the short term, erodes the essence of the medical calling. The surgeon who becomes a distant "God" may be technically competent, but is spiritually empty and professionally burned out. The recovery of humanity entails reconnecting with empathy, even if it means being vulnerable to pain [20].

Paradoxical Dichotomy

Understanding that the surgeon requires both the technical divinity necessary to operate and the inevitable emotional fragility of failure, where then does the figure of the surgeon reside? The answer lies not in one or the other, but in the integration of both. A surgeon who has felt the weight of error is more careful, more compassionate, and more communicative. The scar on the surgeon's mind reminds them of the sacred value of the life held in their hands [21,22].

Pedro Laín Entralgo argues that the doctor-patient relationship cannot be reduced to a mere technical interaction. It must be an "encounter" between two human beings, founded on philia (friendship). For Laín, the perfect medical act ("healing through words" and technique) requires recognizing the patient as an "other," a neighbor (proximus, the closest one). This vision transforms the surgical act: it is no longer just a mechanical repair performed by a god on an inert body, but an act of human solidarity in the face of the vulnerability of illness [23].

The human surgeon practices what Laín termed "loving objectification": viewing the patient's body with the objectivity necessary to operate (seeing the anatomy, the tumor), yet enveloped in a loving intention to help. This synthesis bridges the coldness of the technical "God" and the empathetic "humanity" of a friend [23].

Conclusion

The surgeon, caught in an existential dichotomy between technical divinity and biological mortality, must understand that there is no mutually exclusive choice; rather, an integration is essential. Precise technique and perfection in critical situations where the surgeon acts as the bridge between life and death by making irreversible decisions consolidate them in a state of divinity. However, these capabilities must not be exercised from a position of infallibility, but from the awareness that these skills allow them to connect with their human side, establishing a relationship of medical friendship with the patient that transcends mere mechanical repair [12,23].

This fusion allows the surgeon to practice a medicine that, despite utilizing instruments and decisions of almost divine power, remains rooted in the foundation of preventing human suffering. It is precisely within this biological vulnerability that the essence of the greatness of the surgeon's role is found [23].

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Use of Artificial Intelligence
No artificial intelligence technologies were used in the conduct of this research.

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