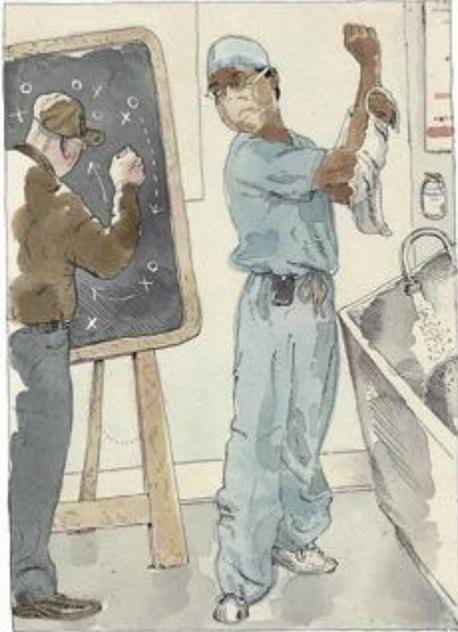


Personal Best-*New Yorker*

Top athletes and singers have coaches. Should you?

by [Atul Gawande](#) October 3, 2011



No matter how well trained people are, few can sustain their best performance on their own. That's where coaching comes in.

I've been a surgeon for eight years. For the past couple of them, my performance in the operating room has reached a plateau. I'd like to think it's a good thing—I've arrived at my professional peak. But mainly it seems as if I've just stopped getting better.

During the first two or three years in practice, your skills seem to improve almost daily. It's not about hand-eye coordination—you have that down halfway through your residency. As one of my professors once explained, doing surgery is no more physically difficult than writing in cursive. Surgical mastery is about familiarity and judgment. You learn the problems that can occur during a particular procedure or with a particular condition, and you learn how to either prevent or respond to those problems.

Say you've got a patient who needs surgery for appendicitis. These days, surgeons will typically do a laparoscopic appendectomy. You slide a small camera—a laparoscope—into the abdomen through a quarter-inch incision near the belly button, insert a long grasper through an incision beneath the waistline, and push a device for stapling and cutting through an incision in the left lower abdomen. Use the grasper to pick up the finger-size appendix, fire the stapler across its base and across the vessels feeding it, drop the severed organ into a plastic bag, and pull it out. Close up, and you're done. That's how you like it to go, anyway. But often it doesn't.

Even before you start, you need to make some judgments. Unusual anatomy, severe obesity, or internal scars from previous abdominal surgery could make it difficult to get the camera in safely; you don't want to poke it into a loop of intestine. You have to decide which camera-insertion method to use—there's a range of options—or whether to abandon the high-tech approach and do the operation the traditional way, with a wide-open incision that lets you see everything directly. If you do get your camera and instruments inside, you may have trouble grasping the appendix. Infection turns it into a fat, bloody, inflamed worm that sticks to everything around it—bowel, blood vessels, an ovary, the pelvic sidewall—and to free it you have to choose from a variety of tools and techniques. You can use a long cotton-tipped instrument to try to push the surrounding attachments away. You can use electrocautery, a hook, a pair of scissors, a sharp-tip dissector, a blunt-tip dissector, a right-angle dissector, or a suction device. You can adjust the operating table so that the patient's head is down and his feet are up, allowing gravity to pull the viscera in the right direction. Or you can just grab whatever part of the appendix is visible and pull really hard.

Once you have the little organ in view, you may find that appendicitis was the wrong diagnosis. It might be a tumor of the appendix, Crohn's disease, or an ovarian condition that happened to have inflamed the nearby appendix. Then you'd have to decide whether you need additional equipment or personnel—maybe it's time to enlist another surgeon.



Over time, you learn how to head off problems, and, when you can't, you arrive at solutions with less fumbling and more assurance. After eight years, I've performed more than two thousand operations. Three-quarters have involved my specialty, endocrine surgery—surgery for endocrine organs such as the thyroid, the parathyroid, and the adrenal glands. The rest have involved everything from simple biopsies to colon cancer. For my specialized cases, I've come to know most of the serious difficulties that could arise, and have worked out solutions. For the others, I've gained confidence in my ability to handle a wide range of situations, and to improvise when necessary.

As I went along, I compared my results against national data, and I began beating the averages. My rates of complications moved steadily lower and lower. And then, a couple of years ago, they didn't. It started to seem that the only direction things could go from here was the wrong one.

Maybe this is what happens when you turn forty-five. Surgery is, at least, a relatively late-peaking career. It's not like mathematics or baseball or pop music, where your best work is often behind you by the time you're thirty. Jobs that involve the complexities of people or nature seem to take the longest to master: the average age at which S. & P. 500 chief executive officers are hired is fifty-two, and the age of maximum productivity for geologists, one study estimated, is around fifty-four. Surgeons apparently fall somewhere between the extremes, requiring both physical stamina and the judgment that comes with experience. Apparently, I'd arrived at that middle point.

It wouldn't have been the first time I'd hit a plateau. I grew up in Ohio, and when I was in high school I hoped to become a serious tennis player. But I peaked at seventeen. That was the year that Danny Trevas and I climbed to the top tier for doubles in the Ohio Valley. I qualified to play singles in a couple of national tournaments, only to be smothered in the first round both times. The kids at that level were playing a different game than I was. At Stanford, where I went to college, the tennis team ranked No. 1 in the nation, and I had no chance of being picked. That meant spending the past twenty-five years trying to slow the steady decline of my game.

I still love getting out on the court on a warm summer day, swinging a racquet strung to fifty-six pounds of tension at a two-ounce felt-covered sphere, and trying for those increasingly elusive moments when my racquet feels like an extension of my arm, and my legs are putting me exactly where the ball is going to be. But I came to accept that I'd never be remotely as good as I was when I was seventeen. In the hope of not losing my game altogether, I play when I can. I often bring my racquet on trips, for instance, and look for time to squeeze in a match.

ILLUSTRATION: Barry Blitt