A Cute Appendix and Other Ruminations

Text by Dr Jared Ng and Dr Lo Hong Yee

The grid iron incision for open appendicectomy, first described by Dr Charles McBurney in 1894,[1] is fast fading into history. Once a rite of passage for the surgical trainee, it was often the first real abdominal operation a young surgeon performed. For decades, generations of surgeons gained their early confidence by mastering this familiar cut.

But the field has changed. Laparoscopic appendicectomy has become the standard in most hospitals. Unlike open cholecystectomy, which still has a place in certain complex gallbladder cases, the grid iron incision is nearly obsolete. In difficult appendicitis cases where laparoscopy fails, many surgeons now prefer a midline incision for better access and flexibility.

Evolution of surgical techniques

This evolution has improved patient care in clear ways. Smaller incisions mean faster recovery, less pain and fewer wound-related complications.[2] The long hospital stays and large scars that were once part of appendicitis management have been replaced by day surgeries and nearly invisible marks.

Yet, progress comes with trade-offs. The familiar scar in the right lower abdomen once served as a visible clue to a patient's surgical history. Today, these signs are subtler. We must look carefully for the small, well-healed puncture marks – a reminder that medicine often moves forward quietly.

However, surgery has never been only about tools or techniques. It is about relationships – between patient and surgeon, between teacher and trainee, and between our sense of competence and our tolerance for uncertainty. Each operation, no matter how routine, carries a chance of success or failure. And when complications happen, no amount of technical progress can protect us from the burden of responsibility. There is a "little cemetery" that every surgeon carries with them.[3] A place where they visit in quieter moments, to reflect and to temper, to remember and to learn.

When complications happen

In the OT, the weight of our work is measured not just by what we remove or repair but by the lives we touch.

I (Dr Lo) once treated an 88-year-old man for acute cholecystitis. He was independent and in good health before he fell ill. After antibiotics, we planned an interval laparoscopic cholecystectomy. The surgery itself was smooth and unremarkable. Two weeks later, he returned with fever and sepsis; imaging showed a large biloma collection. Despite repeated drainage, antibiotics and many days in intensive care, he developed one complication after another. After two months in hospital, he died.

Over those weeks, I got to know his family well. They were gracious and patient, even as the setbacks piled up. When he passed, they thanked me for trying my best. Their kindness somehow made the guilt sharper. I kept questioning whether I had made the right decision to operate or whether I should have done anything differently. I doubted my judgement and my hands.

In moments like these, many of us visit the "little cemetery" within. It is the place in our minds where we keep the memories of patients we could not save. No amount of experience makes that burden lighter. These memories are not just about failure. They also teach us humility. They remind us to hold ourselves to the highest standards, far beyond what is expected by law or policy.

The invisible scars of psychiatry

If surgery leaves visible scars, the wounds in psychiatry are often hidden. The outcomes are harder to measure, and the harm less visible. Yet the weight of caring can be just as heavy.

Some years ago, I (Dr Ng) cared for an elderly man who struggled with depression. He had made some progress in treatment. He seemed to be improving, and there were plans made for the future. Then one afternoon, I received a call from his son – he had taken his own life.

I asked for permission to attend the wake. I prepared myself to face anger and blame. Instead, the family greeted me with warmth. They thanked me for looking after him. I felt relief that they

did not hold me responsible, which was mixed with guilt that I could not prevent what happened.

Suicide prevention has become a central focus in mental health care in Singapore. This is a necessary and positive shift, but it also brings new pressures. Patients sometimes feel afraid to speak honestly about suicidal thoughts because they fear involuntary measures or being sent to hospital. Families feel they must stay constantly alert, watching for signs of decline. This atmosphere of vigilance can strain relationships and add stress to already fragile situations.

As psychiatrists, we walk a narrow path. We are bound to act when risk is high. But we must also create space for patients to share their distress without fear of overreaction. Sometimes, we have to choose between preserving trust and taking protective action. Even when our decisions are justified, they can damage the therapeutic relationship.

In our efforts to prevent death, we must not forget our purpose is also to help people live fully. Safety is essential, but so are dignity and autonomy.

The second victim

Whether in surgery or psychiatry, when a patient dies or suffers harm, the clinician is often the second victim. The concept of the "second victim" describes the emotional impact on healthcare professionals involved in adverse events. It may feel callous to talk about the impact on the doctor when it is the patient and their family who are suffering physically, but the emotional trauma faced by the healer is not insignificant.[4]

Tan HK and colleagues have done important work summarising studies on this phenomenon and examining its impact in Asian contexts, including in Singapore.[5,6] Their research challenges the comforting belief that those who remain in the profession simply grow stronger. In reality, many continue to struggle with guilt, shame and self-doubt. Some develop maladaptive coping patterns. Others leave the profession altogether.

Their findings also highlight that the medical culture in Asia often expects stoicism and composure. We are taught to compartmentalise, to keep going and to appear unaffected. Over time, this silence takes its toll. It can erode confidence, increase burnout and harm patient care.

In many hospitals, there is still an unspoken belief that seeking help is a sign of weakness. This idea is outdated and unhelpful. Emotional health is not separate from professional competence – it is part of it.

A call for change

We dedicate our lives to healing others. But the price can be high. We need to build a culture where asking for support is accepted, even encouraged.

In some places, peer support programmes have made a difference. After critical incidents, structured debriefings and confidential counselling can help clinicians process their experiences. Some hospitals in Singapore have also introduced peer support initiatives, though many clinicians remain unaware of them or feel hesitant to access help.

More can certainly be done. Institutions in Singapore can normalise discussions on emotional impact. Leaders can model openness by sharing their own struggles. Medical training can include preparation for coping with complications and loss, not only the technical aspects of care.

To colleagues in medicine, surgery and mental health: you are not alone. Struggling does not mean you are any less skilled or committed. You are human; you have limits, and that does not diminish your worth.

To policymakers and healthcare leaders: invest in systems that make it easier for clinicians to seek help without fear of judgement. Psychological support, mentoring and protected time for reflection are not luxuries; they are essential parts of a safe healthcare system.

In acknowledging our vulnerability, we affirm our humanity. As we move past outdated surgical techniques, let us also set aside the idea that clinicians must carry these burdens alone. The future of medicine depends not only on skill and innovation but on our ability to care for ourselves as we care for our patients. ◆

References

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