ISSN: 2754-8880
Published 00 11 0000

The Surgeon's Prayer: Rituals, Habits, and Superstitions Before the First Cut

The Rituals Surgeons Perform Before The First Incision

B Manzouri[1*]

[1]Consultant Ophthalmologist Queen's Hospital, BHRUT, Rom Valley Way, Romford RM7 0AG UK Orcid ID: https://orcid.org/0000-0002-4589-0831
[*]Correspondence author : Bita Manzouri Queen's Hospital, BHRUT, Rom Valley Way, Romford RM7 0AG UK. Email: bita.manzouri@nhs.net

ORIGINAL

Abstract

Introduction: Pre-operative rituals are common in many high-stakes professions, yet little is known about their prevalence or perceived role among surgeons. This exploratory study investigated the nature, origins, and significance of pre-operative rituals in contemporary surgical practice.

Methods: We distributed an anonymous cross-sectional online survey through international professional surgical networks using snowball sampling. The survey explored the prevalence, origins, purpose, and perceived importance of pre-operative rituals, together with their relationship to procedure complexity and operative performance.

Results: A total of 143 surgeons from multiple specialties and countries participated. Overall, 70% reported performing personal rituals or routines before surgery. Most rituals were established during training (58%) and were self-developed rather than learned from mentors (81%). Personal habit (30%) and psychological preparation (28%) were the most frequently cited reasons for ritual behaviour, whereas only 6% identified superstition as the primary basis. Rituals were generally unaffected by procedure complexity (70%), and most respondents reported little perceived impact on performance if unable to follow them (82%). Nevertheless, approximately two-thirds considered their rituals at least moderately important. Free-text responses consistently described rituals as enhancing focus, confidence, emotional regulation, and readiness for surgery.

Conclusions: Pre-operative rituals are common among surgeons and appear to function primarily as psychological strategies for preparing for high-stakes operative performance rather than as expressions of superstition. These findings highlight an under-recognised aspect of surgical practice and suggest that personal rituals may contribute to the cognitive and emotional preparation required for surgery.

Keywords

surgeon, surgery, ritual, superstition, performance psychology, human factors

OPEN ACCESS

Edited by
A.Hussain

Submitted *13 July. 2026*

Accepted *10 Sep. 2026*

Citation
B Manzouri.The Surgeon's Prayer: Rituals, Habits, And Superstitions Before The First Cut.Editorial article:BJOSS::2026:(6);196-203

Introduction

The operating theatre is, in many respects, the most controlled environment in modern medicine. Instruments are counted, protocols rehearsed, and complications anticipated through layers of systems designed to minimise uncertainty. Yet beneath the surgical cap and behind the scrub-room door, something far less empirical often takes place: the surgeon's ritual.

From the colorectal surgeon who wakes before dawn to walk the same route to hospital and pack the same breakfast (1), to the orthopaedic consultant who will not begin a list without a

particular piece of music playing (2)—pre-operative rituals among surgeons are widespread, varied, and, until recently, largely undiscussed in the peer-reviewed literature. The operating room may be governed by evidence-based medicine, but the surgeon who enters it is, first and foremost, human.

Rituals have accompanied medicine since its earliest incarnations. In ancient Egypt, priestly surgeons performed incantations over trepanned skulls and medieval barber-surgeons offered prayers before amputations. As medicine transitioned into a scientific discipline, such practices were expected to fade. And yet, as this survey demonstrates, they have not. Instead, they have been reframed—often as 'routines' or 'personal habits'—and quietly woven into the daily practice of some of the most technically trained individuals in healthcare.

Despite their prevalence, pre-operative surgical rituals have received relatively scant scholarly attention. The existing literature has focused predominantly on superstitions related to patient outcomes, such as whether operating on Friday the 13th portends harm (it does not) (3; 4), rather than on the personal, psychological practices of surgeons themselves. This study aimed to address that gap through a multispecialty, multinational survey distributed across the professional networks of the author. In doing so, it examines a dimension of surgical practice that is seldom discussed in the scientific literature. The operating theatre may be governed by evidence, protocol, and precision, but the surgeon who steps into it remains, first and foremost, human. Understanding the rituals that precede the first incision offers a window into the psychological preparation that underpins technical performance.

The Anthropology of Ritual in High-Stakes Professions

Ritual behaviour in uncertain, high-stakes situations has been described across cultures and professions for centuries. Anthropologist Bronislaw Malinowski's influential 'anxiety-ritual' theory (5) emerged from his observations of Trobriand islanders, who relied little on ritual during lagoon fishing—an activity considered safe and predictable, dependent largely on skill and experience. In contrast, elaborate rituals were reserved for deep-sea fishing, where danger, unpredictability, and forces beyond human control were far greater. His work suggested that ritual tends to emerge at the intersection between expertise and uncertainty. Surgeons, despite years of rigorous training and technical mastery, practise daily at precisely this intersection.

Pearl Katz, an anthropologist at Johns Hopkins University, observed as early as 1981 that 'in modern operating rooms… rituals… occur as integral parts of surgical procedures' (6). More recently, a 2024 Medscape article on physician superstitions (1) reported that some surgeons believe rituals and superstitions are more prevalent in medicine than in virtually any other profession. One survey respondent, a colorectal surgeon in New York, described a preparatory ritual spanning nearly two hours: identical wake time, the same breakfast, the same route, the same greeting at the hospital entrance.

Superstition, Ritual, and Evidence

A distinction must be drawn at the outset between ritual and superstition, and between both of those and evidence-based routine. A surgeon who double-checks laterality before every procedure is engaged in best practice. A surgeon who refuses to operate on a ward numbered 13 is engaging in superstition. A surgeon who always ties their left boot before their right is performing a ritual. These categories overlap, but they are conceptually distinct.

The evidence on whether superstitions affect patient outcomes is, reassuringly, negative. A landmark analysis published in the Annals of Surgery in 2021 examined the records of 27,914 consecutive patients undergoing general, visceral, or vascular surgery, finding no association between moon phases, zodiac signs, or Friday the 13th and adverse outcomes (3). A subsequent population-based cohort study of 19,747 adults, published in the Annals of Surgery Open in 2024, similarly found no increase in death, readmission, or complications among patients who underwent one of 25 common surgical procedures on Friday the 13th compared to flanking

Fridays (4). Indeed, at Lehigh Valley Hospital in Pennsylvania, the second-floor operating suite designates what would be OR 13 as 'OR M'—a quiet institutional nod to the persistence of these beliefs (1).

What the evidence does suggest, however, is that rituals may offer genuine psychological benefit even when their direct mechanistic efficacy is nil. Psychosocial research has consistently shown that performing a ritual—even one the performer consciously acknowledges as symbolic—can reduce anxiety, enhance focus, and improve confidence in subsequent performance (7). It is this emotional dimension that forms the most plausible explanatory framework for pre-operative rituals in surgery.

Music, charms, and the theatre environment

Music in the operating theatre represents perhaps the most visible form of ritual in surgical practice. Surgeons frequently cite specific playlists as part of their pre-operative preparation. Others wear particular items of clothing—compression socks of a favoured colour, 'lucky' theatre shoes, or a specific cap—as talismanic preparations for the day ahead. One plastic surgeon, referenced in the published literature, wore Wonder Woman clogs to her most challenging cases, citing not magical protection but a sense of empowered identity (1). Beyond personal objects and routines, verbal superstitions are equally pervasive: the avoidance of the word 'quiet' on a busy shift lest fate be tempted, and the widespread belief in the 'black cloud' doctor—the colleague whose on-call shifts are believed to attract disproportionate numbers of complex cases—are amongst the most frequently cited examples of magical thinking in medical culture (8).

These practices echo findings from sports psychology, where pre-performance routines are not only common but actively encouraged by performance coaches. Elite athletes from tennis to gymnastics employ fixed preparatory behaviours that serve as cues for attentional focus and emotional regulation. Few athletes have made pre-match ritual as visible as Rafael Nadal, whose famously precise court-side routine — arranging his water bottles just so, tugging his shirt, brushing his hair behind both ears in strict sequence — transforms the baseline into something approaching an altar. Surgery, for all its differences from competitive sport, shares the essential psychological architecture: a skilled performer, a defined task, and the outcome of a performance that matters enormously.

Methods

Study Design

A cross-sectional online survey was designed to characterise the nature and prevalence of pre-operative rituals among surgeons. The survey comprised nine questions covering the prevalence, duration, basis, purpose, procedural variability, cultural transmission, performance impact, and perceived importance of these practices, plus a free-text question on purpose and a grade/specialty demographic question.

Participants And Sampling

The survey was distributed via snowball sampling through the author's professional networks. Recipients were asked to forward the survey to colleagues across surgical specialties and grades. Respondents included surgeons at various career stages—from trainees to consultants—across a range of surgical disciplines including general surgery, orthopaedics, neurosurgery, vascular surgery, plastic and reconstructive surgery, cardiothoracic surgery, and others. Respondents were drawn from multiple countries across several continents, reflecting the international professional networks of the author.

A total of 143 responses were received. Individual questions had varying completion rates, as some were conditional on prior responses (e.g., questions about the nature of rituals were directed only at those who reported engaging in them).

Ethics

This survey was conducted as a professional insight project. Participation was voluntary and anonymous. No patient data were collected. Formal ethical review was not required under applicable institutional guidelines for anonymous practitioner surveys of this nature.

Statistical Analysis

Descriptive statistics were used to summarise responses to closed questions. Proportions are reported as percentages of responding participants. Free-text responses to Question 4 (purpose of rituals) were reviewed thematically to identify recurring categories of purpose cited by respondents. Given the snowball sampling methodology and self-selecting respondent pool, no inferential statistical testing was performed; the findings are presented as descriptive and hypothesis-generating.

Results

Overview of respondents

A total of 143 surgeons completed the survey in full or in part. Respondents spanned multiple surgical specialties and career grades, from foundation and core surgical trainees through to senior consultants and fellows. The geographical distribution included respondents from the United Kingdom, continental Europe, North America, the Middle East, South Asia, and Australasia, reflecting the multinational reach of the author's professional network.

Prevalence of pre-operative rituals (Q1): "Do you engage in any personal rituals, routines, or specific practices immediately prior to entering theatre or beginning surgery?"

The majority of respondents (100 respondents, 70%) reported engaging in personal rituals, routines, or specific practices immediately prior to entering theatre or beginning surgery. A substantial minority (43 respondents, 30%) reported no such practices. This finding—that more than half of a large, multidisciplinary cohort of surgeons acknowledge pre-operative ritual behaviour—is itself noteworthy, given the professional culture within surgery that tends to privilege empirical reasoning over superstition.

Duration and origin of practice (Q2): "How long have you been following these practices?"

Among those who reported engaging in rituals, the majority indicated that their practices had been established since training or residency (53 respondents, 58%). A smaller proportion reported adopting rituals later in their career (29 respondents, 32%). Very few indicated that their practices varied depending on the procedure (9 respondents, 10%). This finding suggests that pre-operative rituals are, for most surgeons, early and enduring formations of professional identity rather than adaptive responses developed to cope with specific cases or career pressures.

Basis of rituals (Q3): "What is the primary basis of these practices? (Select all that apply)."

Respondents were asked to identify the primary basis of their practices, with multiple selections permitted. Personal habit or routine (51 respondents, 30%) and psychological preparation (49 respondents, 28%) — defined in the survey as practices serving focus or stress reduction — were the most frequently endorsed categories, followed by religious belief (29 respondents, 17%) and professional training or tradition (17 respondents, 10%). Cultural tradition (7 respondent, 4%) and superstition (10 respondents, 6%) were the least commonly cited bases, suggesting that surgeons prefer to frame their behaviours in psychological rather than magical terms — a finding consistent with the broader medical literature on this subject. Notably, 5% of respondents (9) attributed their rituals to scientific or evidence-based reasoning.

Purpose of rituals (Q4): "What purpose do these rituals or routines serve for you?"

The free-text question on purpose yielded themes clustering around focus and mental preparedness, stress and anxiety management, confidence enhancement, and the establishment of

psychological readiness. Several respondents described their rituals as helping them to 'switch into' a surgical mindset, create a boundary between the pressures of daily clinical work and the focused demands of theatre, or simply as a source of comfort in a high-stakes environment. A smaller number mentioned team cohesion and the shared aspects of pre-operative routine as a collective settling mechanism. Others described a more explicitly spiritual dimension to their preparation, referring to prayer, trust in God, or placing the outcome of the operation in God's hands. For these respondents, religious faith formed part of their psychological preparation, providing reassurance and humility in the face of the inherent uncertainty and responsibility of surgery.

Variability with procedure complexity (Q5): "Do these practices change depending on the type or complexity of the procedure?"

The majority of the respondents to this question indicated that their practices did not change depending on the type or complexity of the procedure (100 respondents, 70%). This was a somewhat counterintuitive finding: one might expect more elaborate or intensive rituals before high-risk or technically demanding cases. However, the consistency of ritual across case types supports the interpretation of these practices as baseline psychological anchors—habitual behaviours that provide reliable states of readiness—rather than procedurally calibrated responses.

Transmission from mentors and culture (Q6): "Were any of these rituals learned from mentors, colleagues, or institutional culture?"

Contrary to what might be expected, the majority of the respondents to this question reported that their pre-operative practices had not been learned from mentors, colleagues, or institutional culture. Only 19% (19 respondents) indicated that their rituals had been transmitted through these channels, while the remaining 81% (79 respondents) identified their practices as self-generated. This is perhaps the most surprising finding of the survey, and it cuts against a widely held assumption about how professional behaviour propagates within surgical training environments.

Rather than being absorbed from senior colleagues or the ambient culture of the operating theatre, pre-operative rituals appear to be largely invented by individual surgeons—personal solutions to the emotional challenge of preparing for high-stakes work. This suggests that such behaviours arise from an intrinsic human need for psychological structure and control under uncertainty (5) rather than from explicit role modelling or institutional custom.

Impact of disrupted rituals (Q7): "If you are unable to follow these rituals or routines, do you feel your surgical performance is affected?"

Among the respondents, the majority reported feeling either 'not at all' (51 respondents, 52%) or only 'slightly' (30 respondents, 30%) affected in their perceived surgical performance when unable to follow their usual rituals or routines. A minority reported feeling 'moderately' affected (10 respondents, 10%), and a smaller number felt 'significantly' affected (8 respondents, 8%). This distribution is consistent with the view that these practices are primarily psychological supports rather than operationally critical prerequisites.

Perceived importance (Q8): "In your view, how important are these rituals to your surgical performance overall?"

Of the respondents to this question, 29% (30 respondents) rated their rituals as 'very important' to their surgical performance, making this the modal response. A further 23% (24 respondents) rated them as 'moderately important' and 9% (10 respondents) as 'essential', meaning that in total, approximately 61% of respondents ascribed at least moderate importance to their pre-operative practices. However, 26% (27 respondents) considered their rituals 'not important' and 13% (14 respondents) rated them as only 'mildly important'. Taken together, these figures reveal a nuanced picture: the majority of surgeons who engage in rituals do credit them with some degree of significance, yet a substantial minority—nearly four in ten—regard them as of little or no consequence to their performance. This internal inconsistency, in which practitioners maintain rituals they do not consider particularly important, is itself of psychological interest, suggesting that habitual behaviour persists independently of its perceived instrumental value.

Discussion

The surgeon as ritual agent

The principal finding of this survey is that pre-operative rituals are common amongst surgeons, that they are rooted primarily in cognitive/emotional preparation and habit rather than superstition, and that they are largely established during the formative years of surgical training. Taken together, these findings paint a picture of the surgeon not merely as a technical operative unit but as a psychologically complex practitioner who, like elite athletes, military personnel, and performing artists, employs preparatory behaviour to achieve optimal functional states (9).

The reluctance of respondents to categorise their practices as 'superstition' is telling. As noted in the published literature, surgeons—as scientists by training—tend to resist this framing even when the behaviours in question are functionally indistinguishable from superstitious ritual (10). A surgeon who always listens to the same playlist before a Whipple procedure is performing a ritual; whether it is called a 'routine' or a 'superstition' may matter less than the psychological function it serves.

Psychological mechanisms

The psychological literature on ritual performance provides a plausible explanatory framework. Rituals are thought to reduce pre-performance anxiety by providing a sense of agency, predictability, and control in uncertain environments (9). For surgeons, who face the uncertainty of human anatomy and biology on a daily basis, this interpretive framework has particular resonance. Structured pre-operative behaviour may serve as a form of attentional focussing, signalling the transition from the ambient demands of clinical work to the concentrated requirements of operative surgery.

This is consistent with the responses to Q4 of the present survey, in which the most commonly described purposes of rituals were focus, mental preparedness, and stress reduction. It is also consistent with broader evidence on psychological preparedness in surgery: Wang and colleagues noted in a comprehensive review that preoperative anxiety carries physiological and psychological adverse effects, and that non-pharmacological, behavioural approaches to anxiety reduction are increasingly recognised as beneficial in surgical contexts (11).

The origins of surgical ritual: individual invention, not cultural inheritance

One of the most striking findings of this survey is that the vast majority of surgeons reported that their pre-operative rituals were not learned from mentors, colleagues, or institutional culture. Only 19% of respondents attributed their practices to these external sources. This challenges a natural assumption—that the rituals of the operating theatre, like its technical traditions, are passed down through the hierarchy of surgical training.

Instead, the data suggest that pre-operative rituals are predominantly self-generated: personal responses to the cognitive demands of surgical practice, constructed independently by each practitioner. This is consistent with the broader psychological literature on ritual formation, which holds that individuals spontaneously develop ritualistic behaviours in high-uncertainty, high-stakes contexts as a means of achieving cognitive control (5). The implication is not that surgical culture is irrelevant to how surgeons prepare for theatre, but that when it comes to these private preparatory practices, culture appears to be less influential than individual psychology.

This finding may also have implications for how we understand the limits of professional socialisation in surgery. Whilst the operating theatre clearly transmits a great deal—technical skills, hierarchy, norms of communication—the inner, pre-operative life of the surgeon appears to remain largely a private affair, shaped more by personal temperament and individual coping than by the influence of mentors and institutions.

Limitations

Several limitations of this study merit acknowledgement. The survey was distributed via snowball sampling through the professional networks of the author, introducing selection bias: respondents

were more likely to be connected to the academic and professional spheres of the author, and may not represent the global surgical workforce. The response to individual questions varied, reducing the completeness of the dataset for some domains. The absence of quantitative data on the specific content of rituals—that is, what surgeons actually do—represents a gap that qualitative follow-up research could address. Finally, the cross-sectional design precludes any inference about whether rituals are causally related to surgical performance or outcomes.

These limitations notwithstanding, this survey represents one of the first multispecialty, multinational explorations of pre-operative ritual behaviour among surgeons, and its findings provide a foundation for future, more detailed investigation.

Implications and future directions

The findings of this survey have implications for surgical training, team culture, and performance psychology. If rituals serve genuinely useful psychological functions—as the data suggest—then surgical educators and training programmes might consider how to support the development of healthy, functional pre-operative routines in trainees. This is particularly salient in the context of the growing literature on surgeon burnout, mental health, and performance under pressure.

Future research might usefully employ qualitative methods to elicit the specific content of surgical rituals across specialties, grades, and cultures. Mixed-methods approaches combining survey data with ethnographic observation and performance measurement could begin to address the empirically important question of whether, and through what mechanisms, pre-operative rituals influence intraoperative performance and patient outcomes.

Conclusion

Pre-operative rituals are alive and well in the operating theatres of the world. Just under two-thirds of the surgeons surveyed in this multispecialty, multinational study reported engaging in personal routines or practices before surgery, the majority of which were established during training, transmitted through mentorship, and grounded in psychological preparation rather than superstition. Most surgeons report little operational disruption when these rituals are disturbed, yet three-quarters of respondents regarded them as at least mildly important to their practice.

These findings invite us to take seriously the human dimensions of surgical performance—not because Wonder Woman clogs confer demonstrable operative advantage, or because an identical breakfast enhances technical precision, but because the surgeons who perform these rituals believe, on some level, that they help. In a profession where confidence, focus, and mental readiness may be the difference between a good operative day and a poor one, that belief may not be entirely without merit.

What, then, are we to make of the rituals surgeons carry with them into the operating room — the particular order of scrubbing, the preferred arrangement of instruments, the habitual silence before the first incision? They may appear, to the uninitiated observer, as superstition dressed in sterile gowns. But they are something altogether more purposeful: the mechanisms by which a surgeon crosses a threshold, leaving behind the ordinary world of corridors and human fallibility and entering a space that demands something close to perfection. Ritual may not directly alter surgical outcomes. But it may alter the surgeon — sharpening focus, reinforcing identity, and helping create the composure upon which good surgery so often depends. Surgery may aspire to perfect rationality. Surgeons, fortunately, remain human.

Conflict Of Interest

Author declare no conflict of interest and no funding for this study.

References

[1] Kita J. Why do so many doctors embrace superstitions and rituals? Medscape. 2024. Available from: https://www.medscape.com/viewarticle/why-do-so-many-doctors-embrace-superstitions-and-rituals-2024a100060b.

[2] Royal College of Surgeons of England. Rituals in surgery. Bulletin of the Royal College of Surgeons of England. 2025;107:14.

[3] Schuld J, Slotta JE, Schuld S, et al. Popular belief meets surgical reality: impact of lunar phases, Friday the 13th and zodiac signs on emergency operations and intraoperative blood loss. World Journal of Surgery. 2011;35:1945-9.

[4] Scarborough JE, Bennett KM, Pappas TN, et al. Friday the 13th and postoperative outcomes after common surgical procedures. Annals of Surgery Open. 2024;5:e465. Available from: https://pubmed.ncbi.nlm.nih.gov/38883950/.

[5] Malinowski B. Magic, Science and Religion and Other Essays. Glencoe, IL: Free Press; 1948. Available from: https://monoskop.org/images/4/41/Malinowski_Bronislaw_Magic_Science_and_Religion_and_Other_Essays_1948.pdf.

[6] Katz P. Ritual in the operating room. Ethnology. 1981;20:335-50.

[7] KevinMD com. The secret superstitions of surgeons: how rituals impact surgical success; 2024. Available from: https://kevinmd.com/2024/02/the-secret-superstitions-of-surgeons-how-rituals-impact-surgical-success.html.

[8] Med Independent. Superstitious surgeons, “black clouds”, and the “Q word” – when hokum and science collide; 2023. Available from: https://www.medindependent.ie/.

[9] Fong C. Surgery and superstition. Substack; 2023. Available from: https://carmenfong.substack.com/p/surgery-and-superstition.

[10] Nwachukwu A, El Ahmadieh TY. Rituals and superstitions in neurosurgery. Surgical Neurology International. 2025;16:93.

[11] Wang Y, Tang J, Li M, et al. Non-pharmacologic approaches in preoperative anxiety: a comprehensive review. Frontiers in Public Health. 2022;10:854673.