Surgeon as Hero

Jess H. Lonner, MD

In decades past the surgeon seems to have had an almost mythical ability and willingness to take on the most challenging and risky cases. While most of us have been touched by surgeons who are legendary in their own right, few have had the honor of training under or working beside such legendary surgeons, with names like DeBakey and Sabiston, among others, including luminaries in our own specialty of orthopedics. These surgeons were revered by the lay community as deities and admired by their peers because they were skilled, fearless, above-the-fray. They took on the most challenging cases, with little overt fear of failing. They were heroes.

"...sundry extraneous factors... put the 'hero-surgeon' at risk for extinction."

Today, we have equally skilled surgeons, particularly in our specialty. But while many of us have tremendous confidence in our surgical skill and competence, external forces present a set of pressures that are more prevalent (and perhaps unique) in this new millennium than in past decades. These pressures may confound our good intentions and impact our decisions. It's just natural that they should. Each of us has likely been affected on some level by these factors—medical risk, liability concerns, shrinking reimbursements (particularly with threatened Medicare cuts of 10% and payments that could be linked to performance and outcomes measures). I can think of but a few orthopedic surgeons who retain that unadulterated passion for the most complex and challenging cases despite all of those extraneous issues. I know many others, who for one reason or another, choose to refer the challenging, high-risk (and often low paying) cases to other surgeons, even though they still "love" the profession. For instance, despite escalating numbers of failed hip and knee arthroplasties, relatively few surgeons take on revisions, even if they have performed the primary procedure. Still fewer will accept revisions of arthroplasties that have been performed by other surgeons. Is it that they don't have the skills to take these on? In many cases, I suspect the answer is "no."

In our penchant for providing high-quality care for our patients, each of us will steer our patients toward a particular treatment depending on a variety of factors, including our personal experiences with the particular condition or disease, the various relevant nonsurgical and surgical alternatives, and surgical risk. Not all conditions are for all surgeons; hopefully, each of us has the insight to know when to refer the patient to another surgeon who may be better qualified. Moreover, not all conditions should be treated with surgery if the risks exceed the potential benefits. Clearly a balance must be struck. A risk-benefit analysis should be considered in all patients before the treatment is advocated. Idealistically, it would be my hope that our decisions are always made with the purest of intentions and that those other extraneous issues play a very minor role. But are they? Do they?

In an ideal world, those sundry extraneous factors wouldn't confound our recommendations regarding treatment, but they naturally do. These very distractions put the "hero-surgeon" at risk for extinction. This reality may trouble those idealistic surgeons who were drawn to the field by the romantic notion of healing the sickest patients, with the most complex and challenging problems, and by the cast of characters who were impacting the field when we were students, irrespective of the other "distractions." The fearless, but selfless and undaunted surgeon with a "never-say-never" attitude is being threatened! In fact, they are so uncommon in this day and age that the rare throwback surgeon is often dismissed as a "cowboy" (no offense to cowboys), even if they are using evidence-based medicine to support their decisions.

A recent personal experience has restored my faith in the purity and good intentions of some surgeons. My otherwise healthy 80-year-old

(Continued on page 504)

Dr. Lonner, this journal's Associate Editor for Adult Reconstruction, is Director, Knee Replacement Surgery, Pennsylvania Hospital, Philadelphia, Pennsylvania.

Am J Orthop. 2008;37(10):503-504. Copyright 2008, Quadrant HealthCom, Inc. All rights reserved.

 (*Continued from page 504)*

father was recently hospitalized with a challenging intestinal problem, related to sequelae of a partial colectomy and adjuvant therapy dating back 18 years and several more recent surgeries to treat adhesions and hernias. While my father had been having symptoms for quite some time, his stoic manner shielded all of us, except perhaps my mother, from the fact that for perhaps a year he was experiencing recurrent "mini"-small-bowel obstructions that were becoming more pronounced and more frequent, to the point where he could no longer keep food down.

Because the risks of further surgery were considerable, an initial, well-advised trial of nonoperative care (nasogastric decompression and diet modification) was undertaken, in the hope that the condition would improve and surgery would be avoided. Several weeks with total parenteral nutrition, nasogastric decompression, a battery of tests, and unspeakable boredom ensued. At this point, the surgeon caring for him proved to have the perfect blend of what my father needed—confidence, candor, and compassion. My father welcomed his frank delivery after 4 weeks in the hospital. After reviewing his limited progress and the studies that had been completed by then, the surgeon came in to his room one night, sat down at his bedside, and explained the options: live on baby food for the rest of your life or undergo risky surgery. For my father, the choice was clear.

The surgery was extremely complicated, lasting 7 hours. The recovery has been slow, but my father has been eating solid food now for a few weeks and was home in New York City 2 weeks after surgery to celebrate his 46th wedding anniversary with my mother. I think the meal was a poached egg, boiled chicken, and soup . . . a veritable feast. For my father and the rest of us, his 50-something-year-old surgeon is truly a "hero." The surgeon earned very little financially, despite performing lengthy, high-risk surgery that took him well into the evening and kept him from his own family. He took ownership of the case, assuming the care of another surgeon's highly challenging patient without wavering in his conviction regarding the best course of action. I suspect this surgery would not have been performed in some of the most modern societies around the world because of rationing based on age, risk, and diagnosis. I suspect many US surgeons would also have "punted" on this case because of those extraneous issues I mentioned earlier (risk, reward, etc). My father's surgeon had put the interests of his patient above all others, including his own (although I suspect that he would self-effacingly claim that his greatest joy is to see his patients get better).

"Each of us has likely been affected on some level by these factors—medical risk, liability concerns, shrinking reimbursements."

The bottom line is that my father's surgical care was provided by a competent, confident, and skilled surgeon who loves what he does and who also ministers to his patients with a level of patience and compassion that embodies the standards that Hippocrates urged nearly 2500 years ago. He is a throwback. He represents the purest in what motivated many of us to pursue a career in surgery, but which few of us realize in our own practices. Most of us take good care of our patients, we make a difference in their lives, and our patients appreciate what we do. But most of us are not heroic. He is a hero, just like some other great surgeons, like Drs. DeBakey and Sabiston, from years ago. ■