



Residency Diary

Residency Diary: The Beginning of My Second Year: June and July 2016

Lisa G. M. Friedman MA, MD

Monday, June 2016

In mid-June, I started my second year at Gillette Children's Specialty Healthcare, a specialty hospital for children with disabilities and complex medical problems. One of the rotating residents let me know just how lucky I was to have Gillette in such close proximity. "We don't see any of this type of pathology at home!" he exclaimed.

Joshua (names changed here and throughout), a patient undergoing surgery for scoliosis, was a pretty

complex patient even by Gillette standards. He had syndromic scoliosis due to a chromosomal abnormality, resulting in multiple medical problems requiring priority treatment. His health problems not only delayed his spinal fusion, but also resulted in sacral agenesis, complicating the surgery we needed to perform.

On the day before Joshua's spinal fusion, I discussed his case with my attending, an experienced surgeon who commands my deep reverence. We had a general plan of what levels we wished to address, but given Joshua's unique anatomy, we could not be sure what spinal elements Joshua had or how strong they would be. Our plan was like getting a ship out of a windy



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A note from the Editor-in-Chief:

I am pleased to introduce readers of Clinical Orthopaedics and Related Research® to a new column, called "Residency Diary." Lisa G. M. Friedman MD, is a resident in the Orthopaedic Surgery Residency Program at the University of Minnesota Medical School Minneapolis, MN, USA. In this quarterly column, our readers have the chance to follow Dr. Friedman as she progresses through her residency, chronicling events and interactions that have made an impression on her.

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harbor, my attending reasoned. We would have to take care of the rest of the journey when we hit open water.

On the day of Joshua's surgery, I finished up some floor work as the operating room was being set up. The doors opened and in walked a woman holding a child in her arms. Though Joshua was a teenager, he looked about a third of his age, and he fit perfectly into his mother's arms. She carried him over to the operating room table and placed him down.

Joshua looked terrified. As I approached him, his face only grew more panicked. I turned around behind me looking for the object or ominous

Residency Diary

thing that could be tormenting him. I then realized it was me.

Not knowing what to do, I stepped back and allowed his mother to continue to comfort him, while the anesthesiologists allowed him to breathe his way off to sleep. An hour and a half of line placing and positioning later, we finally began. As we dissected, I could not shake the look on his face.

“Did you see the look of abject terror in his face as he was going to sleep?” I asked my attending.

“It makes you appreciate the amount of trust they put in you to be making the right decision,” he replied.

“Sure is humbling.”

We spent the next few hours dissecting muscle and shaping bone, bending minds and rods, and navigating rare and challenging anatomy. The spinal construct finally in place, we closed. In a moment we flipped what had been hours’ worth of the amazing pathology over and up woke Joshua, a small child, moving slowly at first and then steadily growing more animated. As Joshua lapsed in and out of a peaceful sleep, we moved him off the operating room table onto his bed. The roughest waters behind him, we pushed him down the long hallway to where his parents waited eagerly to receive him.

Saturday, June 2016

The hospital can be a lonely place on the weekend, especially when you are a brand new second-year resident with the troubles of an entire service suddenly ringing one’s pager. On my first weekend on call, I was paged to the bedside of Elizabeth, a teenage girl with Rett syndrome, a rare prenatal neurological disorder. She was here for a posterior spinal fusion for neuromuscular scoliosis. I had stumbled across Rett syndrome quite a bit in studying for various board exams, but I’d never cared for a patient with it. I remembered seeing Elizabeth during rounds with the attending. She looked uncomfortable, grimacing and moaning. We encouraged Dad to allow the nurse to give her as-needed pain medication, which he had been reticent to do for reasons none of us really understood. Thirty minutes later, with my attending already home, the nurse found me because Dad was concerned that Elizabeth was nonresponsive. The nurse didn’t seem too concerned.

“She’s not responsive?” I asked.

“Right.”

“Like ... coding?”

“Oh no. She’s totally stable.”

“Just not ... responding?” I asked again. Thirty minutes flying solo into

my first call was not the time to try to guess what people meant.

Entering the room, I found Elizabeth in her prior state of nonresponsiveness. Actually, she had stopped groaning, which struck me as an improvement in her status. Yet, her family and her nurse were concerned that Elizabeth was not being interactive and were looking up at me, her doctor of almost an hour, for some kind of an explanation.

I paused and thought carefully. In my head, I tried out, “What is her neurological baseline?” Too technical. “What can she do?” Too dehumanizing. I finally settled on, “How is she at home?”

“Not like this,” he said. “If you call her name, she’ll lock eyes onto you. And she’ll lock eyes onto the TV screen. She doesn’t just lie there.” I looked down at his daughter, just lying there. My ineptitude and insecurity on full display, I retreated into the role of the stereotypical orthopaedic resident.

Surgery? Went well. Bone? Fixed. Alignment? Straight. I consulted the pediatric service who ultimately attributed Elizabeth’s sleepiness to her slow metabolism of the narcotics. By the end of the day, Elizabeth was back to her old self, lying in the bed, locking her eyes onto the television screen.

Residency Diary

Later in the day, Elizabeth went to get her postoperative radiographs. As I looked at her spine films, now instrumented, riddled with metal, I felt uneasy. Her large-magnitude curve was corrected and her pelvic obliquity improved. The surgical indications had been clear and by all technical measures, the surgery had been a success. And yet, I couldn't help but think, "What are we doing?"

I couldn't quite shake the image of Elizabeth lying in her bed, her big brown eyes looking right past me as I called her name. In this brave new world of medicine in which I was training, I sought to connect with and empower my patients. I wasn't sure where that left Elizabeth. I wondered if she had known about the big surgery she was going to have done. Did she think the postoperative pain and the risks of surgery were worth the long-term benefit of being able to sit more squarely in her wheelchair?

Perhaps I was so confused by her case because everything had gone perfectly well and yet I found myself in her room with her parents looking up to me for an explanation of why their child was not responding the way she should. I didn't have an answer. I probably never will. I don't know why girls get Rett's syndrome. I don't know how to make it better. I longed to be able to do more, making me draw the interventions we did offer into

question. I was unsure how to measure success in a child who had had so much taken away. And then it dawned on me, it wasn't for me to decide how Elizabeth should be.

I remember back in my intern year sitting in my mentor's office complaining about a number of the banal indignities of life as a resident.

"I have been stripped of my autonomy!" I declared.

He rightfully accused me of being overly dramatic before leaning in. "Remember, Lisa," he said. "This job is a privilege. Right?"

Throughout my career, I doubt I will ever lose the urge to fix and to cure. But I imagine there will be many times I will feel the uneasiness of a perfect spine radiograph and a persistently unresponsive child. The families and patients who enter into my care through the revolving door of the hospital let me in and share their most intimate fears and darkest days. And while it is a privilege to tell my patient's stories, in the end, their stories will also shape the story of my life.

Monday, July 2016

Every Monday, we hold our preoperative conference in which each resident chooses a case from the upcoming week to present and discuss with the group. Among residents, this conference is considered one of the

most valuable, not only because it ensures that we prep for cases well in advance, but also because it gives us a chance to ask questions of more experienced residents and staff. Our attendings help us to fill gaps in our knowledge and they give good suggestions for further reading. I'm grateful for the safe space for our inquiries.

Last Monday, one of my coresidents presented a case of a procedure for a young man with cerebral palsy and windswept hips. We discussed the plan for the child, and happy with our understanding of the subject, the attending decided to move on to another teaching point. As is not unusual for children at Gillette, this child had had numerous other procedures resulting in a multitude of imaging studies. The attending went back in the imaging archives to an AP pelvis radiograph and waited for someone to speak up with their impression.

"That hip is subluxed." I ventured.

"How do you know?" He asked.

"Well you see how that hip is nicely reduced on the left. The femoral head is in the acetabulum ..." I paused. He waited patiently for the deep orthopaedic wisdom I was about to drop on the conference "...Well, it's not on the right."

"Well, what more specifically could you say about the radiograph? Like, if you were calling me in the middle of

Residency Diary

the night. What precisely could you say about the radiograph that would let me know instantly that you know what you were talking about?”

“I don’t see why I couldn’t say that over the phone.” I said. The attending waited for someone who had something more useful to contribute to the conversation.

“Well, you can see Shenton’s line is broken on right,” Greg, our fourth-year medical student, added.

Shenton’s what? I turned to my right and Greg pointed out how the subluxed hip was causing a disruption between the medial edge of the femoral neck and the inferior edge of the superior pubic ramus. He finished his explanation and the discussion moved on.

I leaned over to Greg, “Nice job!” I whispered, and offered him a fist bump.

He pounded my fist, smiled sheepishly, and leaning in, whispered, “I’m sorry.”

This interaction stayed with me even after the conference ended. Greg was an excellent medical student. He

was punctual, respectful, hardworking, humble, and had a great attitude—all the attributes one could ask for in a student. Yet, we had engineered a medical educational system in which Greg felt reticent to speak up, and even when he did so—when he should be proud of his contribution—his first instinct was to apologize for it.

I remember my first medical school rotation as a third-year in general surgery. One of the residents gave us a PowerPoint presentation at orientation on how to be successful. She told us our only job was to make the resident look good. There was nothing about patient care or education. We were to be seen and not heard. We were to talk only when addressed directly. If an attending was quizzing a resident, we were not to answer the question. If the resident got the question wrong and we were asked, even if we know the correct answer, we were to get the question wrong on purpose or to say we did not know the answer, so as to not show up the resident. This was my introduction into clinical medical education. I suppose I should not be

surprised that a fourth-year medical student apologized.

As a medical student, the majority of my clinical education came at the hands of residents, a role many residents have minimal time, training, and desire to fulfill. Now, for the first time, I found myself with eager third and fourth-year medical students under my tutelage, and charged to make a difference in their education. It can be difficult to overcome the instinct to teach students the way I was taught, and make students suffer through an educational system in which maintaining the structure of the hierarchy is often placed above educating the next generation of doctors. Yet, I believe that no one should ever feel shame about the knowledge he has worked hard to acquire. If I can be a leader of my generation of resident-teachers in changing attitudes, and creating an environment in which education is primary and everyone is included in the team and their contribution is valued, it is not just the patients who will be healed.