Residency Diary

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

Lisa G. M. Friedman MA, MD

Thursday, July 2016

When I'm on call during the week, one of my resident responsibilities is to help out in the Acute Orthopaedic Clinic, better known as ACOR, where kids with acute problems—primarily fractures and postoperative concerns—can

be seen right away. The vast majority of unscheduled surgical procedures and admissions we see come from ACOR. On Thursday, I walked into an examining room and was confronted by luggage. Never a good sign.

Katy (names changed here and throughout), a preadolescent hockey player, had been complaining of steadily worsening hip pain for a couple of weeks. Finally, an outside provider took some x-rays and sent Katy to ACOR. The message Katy's family got—which included the instruction not to eat or drink—was ominous enough that the family packed some bags, unsure when they would be back home. The attending sat down with the girl and her family, and described a slipped capital femoral epiphysis (SCFE). Though I was sure she had given this talk many times before, I was impressed with how she took her time with the explanation. It was as though she was reading a beloved story to a child, taking her time to leave no

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A note from the Editor-in-Chief:

I am pleased to present to readers of Clinical Orthopaedics and Related Research® the next installment of "Residency Diary." Lisa G. M. Friedman MA, 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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word unsaid, no picture uncovered; she let the story unfold naturally.

With the family's concerns addressed and a plan in place, we took Katy to the OR after clinic. The attending took the customary spot next to Katy's hip. I stood next to her where I had a great view, and was well-positioned to help.

The attending explained to me how she liked to approach SCFEs, talking through how she liked to direct the guidewire. I listened and nodded intently.

And then the strangest thing happened. My attending took a small step to the side, a subtle one, but there was no question that she ceded the prime real estate at the hip to me.

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“Guide wire to Dr. Friedman.”

The scrub tech handed me the guide wire. My fingers locked on. My mind tried to race back. What did she say to do first? I thought. “So, I ... um ... just put ... here” I stammered, placing the guide wire on top of the skin of the hip. “X-ray?” I asked. Nothing happened. “X-ray?” I asked, a little louder. Still nothing. “Can I get an x-ray?” I demanded. The c-arm blinked to life. “Please?” I added.

The attending and I continued working through it. She talked me through the steps, and I did each one with all the awkwardness of a student learning a new skill. We finished, and Katy went home that night. The family never needed any of that luggage.

When I went to bed that night, I thought about Katy. She was probably asleep and probably pretty sore. I thought about her future and how different it might now be. I saw her returning to skating in a few months and playing high school hockey. I saw her hiking pain-free as an adult and telling her children stories of that one time when she was a child that she needed to go to the hospital for hip surgery. I smiled, knowing that I had played a role in a future so full of possibility. I looked into my own future and thought about a time when I would look back and tell stories about the SCFE, the first time I had done a case by myself.

Friday, July 2016

A week after the SCFE victory, I found myself in a simulation lab with the other residents and students. The task was pinning a supracondylar fracture and they gave us an elbow hiding under an amorphous goo representing soft tissue, which effectively obscured any bony landmarks and must have given the simulated child a BMI of at least 60.

For reasons that at not all that clear to me, I have always struggled with simulation activities. Whether role playing, practice tests, dress rehearsals, or simulation models, these exercises seem to scream “fake” and I have trouble performing. I must need the added adrenaline and hyper-focus that comes with knowing that something counts to help me get the job done. Of course I try hard, and want to do well, but in these settings something just seems missing.

True to form, the supracondylar lab proved challenging. One at a time, each resident came up and drove pins into the humerus as if they had been doing it all their life. My turn came and I approached the model. I touched my own elbow for the starting point I wanted and tried to find it beneath the gelatin on model. I thought I found it and stuck a K-wire in the spot and got ready to start to drill.

“Hey Lisa?” another resident spoke up.

“Yes?”

“Think about where you are starting.” I looked at him and looked down at the model. Our model had no fractures and while I thought I had found a good starting spot, I then angled the drill in exactly the wrong direction and was pointing it down the shaft of the ulna.

“Oh. Thanks.” I withdrew the drill and stood up with the K-wire and returned to feeling for the landmark on my elbow and the landmark on the model.

I found a good starting spot again and began to drill. When I got something that looked good on the AP image, I checked the lateral and it was off. I moved the pin until it was right in the lateral, only to discover my AP image was now unacceptable. Round and round I went, correcting the pin on the AP, ruining the lateral, correcting the lateral, and botching the AP.

After about 20 minutes of this, the attending finally said I could quit with one good pin, as I needed to give someone else a turn. Everyone else in the lab (even the medical students) got two or three pins in; my experience was like a golf video game in which stroke after stroke goes into the water until “+10 Give Up” flashes on the screen. When I coached little league back in medical school, I gave each kid ten hits during batting practice. But there was always one kid who just

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couldn't hit. And as I would throw pitch after pitch after pitch, the expectation would move from 10 hits, to 10 bits of contact, to 10 swings, to 10 more pitches. Except as I butchered the model, driving pin after pin into the wrong spot, there was no option for me to not learn how to do this. At the end of the session, the attending gave a short talk about the process of gaining competence and mastery and how we were all closer to becoming competent. It was hard to hear him over the deafening sound of my own pouting.

I had dinner with my mom that night and told her about how the lab went.

"Can you practice?" she asked.

"Sure." I said. "Should we start with your right arm or your left?" Her smile dropped. She offered no more helpful advice after that.

Saturday, August 2016

On Saturday, I rounded on Cameron. Cameron, an adolescent with congenital scoliosis, had just undergone his last of several spine procedures. He is a small boy with a high-pitched voice, appearing several years younger than his actual age. However, what he lacked in physical prowess from time spent having and recovering from major surgery, he made up with his large, dynamic personality and quick intellect.

I so enjoyed spending time with Cameron that I set my alarm early, carving precious minutes from my already severely deficient sleep schedule. I even saved Cameron for last on rounds so that I could spend any extra time visiting with him.

Cameron was a character. I had to be careful not to laugh, though, because his comedy stemmed from a mixture of extreme earnestness and heightened postoperative anxiety.

On the morning after surgery, I asked Cameron about his pain control. "This place is a scam!" he exclaimed, and then referring to his patient-controlled analgesia, "They promised me I would be allowed to press the button, but they stole the button from me!"

Trying hard to stifle a smile, I persisted, "but how is your pain?"

"Oh, it's not bad." he finally admitted.

Throughout his hospital course, Cameron was slow to mobilize. As a bright kid, he tended to analyze every situation, and came to the conclusion that he had major spine surgery. It hurt to move. Moving was therefore a bad thing. Cameron and I had many early morning conversations in which I explained to him why he should get out of bed, and he explained in animated ways why my logic was faulty.

So far, on my time on the pediatric orthopaedic service, I've learned that the typical postoperative pattern is that kids

may struggle for a few days after surgery and then all of a sudden they wake up and suddenly emerge as the child that the parents recognize as their own. This finally happened with Cameron on Wednesday. I expected him to be nervous about the idea of going home, so I forayed into the subject lightly.

"Cameron! I'm so proud of you—it looks like you've done all of the things we look for patients to accomplish before we start thinking about getting them home."

"Oh, I need to go home right now," he said. "I have a very busy social calendar I need to attend to."

"Do you have a board meeting you need to get to?" I teased.

"No, there is no board meeting" he responded. "I am behind on my Facebook. And they are expecting me on World of Warcraft."

Realizing it was time to say goodbye, I told him how much I enjoyed getting to know him and that I was proud of him for all the hard work he put in to be ready to go home. As I got ready to leave, I asked him if there was anything I could do for him to make him more comfortable.

Without moving his eyes from his computer screen he said, "Yeah, are you going to get me my phone or is that other nurse going to get it?"

Sometimes our patients make a bigger impact on us than we leave on them.