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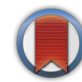
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Residency Diary

Residency Diary: My Second Year: September and October 2016

Lisa G. M. Friedman MA, MD

Tuesday, September 2016

As the summer rolled into September at Gillette (our pediatric specialty hospital), surgical volume dropped off considerably. Perhaps parents didn't want their kids undergoing major elective surgery at the start of the new school year. So for one week in early September, my surgery schedule consisted entirely of hardware removal procedures. Initially disappointed that I wouldn't observe some of the more-technical procedures that Gillette is known for, I quickly discovered that hardware removals are perfect opportunities for a developing second-year resident. They let me get my hands on the surgical instruments, and grow more comfortable using the various tools.

So on Tuesday morning, I sat, scalpel in hand, at the proximal femur of a young girl. The attending was at my side, directing me on how to make the approach down to the femoral plate we were trying to remove. Layer by layer, the attending helped me choose which instruments to use and how to approach each tissue plane until we were down to the plate. I easily removed the screws and scraped away some bony overgrowth around the plate so that the hardware came out without difficulty. Mission accomplished, it was time to close.

Lisa G. M. Friedman MA, MD

We reversed course now, retracing our steps and closing each layer we had come across. We lingered on the fascia, making sure the seal was watertight. We finished with a running monacryl suture, the two sides of the chasm coming together to kiss at the top of the gentle peak signifying the reconciliation of the opposing ends of the incision. We began to place steristrips across the wound when the leg began to ooze, dislodging some of the strips. I cut some more strips to replace the ones that had come loose and laid them on the incision, which held nicely.

"Those are too long," the attending pointed out. I examined the strips, which were poking out awkwardly

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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beyond the edges of the colinear strips on the incision. Indeed, I cut them longer than the ones the scrub tech had cut earlier.

As I replaced the steristrips with ones that were better sized, the attending explained that the incision is the only thing the patient sees. The patient often has little idea about the technical aspects that go on deep to the barrier of the skin. He takes it on good faith that the surgeon is doing her best work and doing what is in his best interest. The incision becomes the visual representation of the surgery we performed. As we finished applying the dressing, I stood with a surgeon who was capable of doing complex and creative pediatric surgery, but who had stayed until the very end of a hardware removal to ensure all the steristrips were cut to the same size.

There are no small operations.

Friday, September 2016

Back on call one Friday afternoon, I walked into Acute Orthopaedic Clinic (ACOR). The nurse quickly shuttled me into a room.

She told me I would want to see Addison (names changed here and throughout).

"She's operative," she said.

I walked into the room to see a young girl with her arm in a sling. She had slipped backwards when building a tent, landing hard on her outstretched arm.

A couple hours later, she was asleep in the operating room; I sat at the edge of the operating table, her fractured elbow resting comfortably in my gloves.

The c-arm blinked to life, revealing a Type 2 supracondylar fracture. With the attending's help, we reduced the fracture, and flexed the forearm up, holding the reduction in place.

We obtained a radiograph of Addison's arm), which superimposed perfectly in my mind over the picture of the model buried in amorphous goo in the surgical simulation lab I went to a few months ago [1].

The attending asked me where I wanted to start. I closed my eyes and crept my fingers along my own elbow in my mind until I found a familiar landmark from the earlier simulation lab. I felt along Addison's elbow with my fingers to find that spot on her arm.

"Laterally," I said.

The attending nodded and the scrub tech handed me a drill. I ventured forward with the pin, driving it into her humerus. The c-arm hummed and I looked up at the screen, disappointed that the pin did not travel in a straight trajectory as I had hoped.

"What's wrong with that pin placement?" The attending asked.

"Oh no," I thought. "Not again. Not now. Not when it counts." My mind spiraled back to the simulation lab that I found so difficult. My cheeks grew red beneath my mask. Beads of sweat rolled down the back of my neck. The flip-book of bad radiographs from my time in the simulation lab a few months earlier replayed in my mind.

"Take a deep breath and battle back," I thought.

I looked up at Addison's radiograph on the c-arm in front of me. Unlike the models in the lab, Addison had a fracture, centering the imaging, granting the action purpose. Unlike before, suddenly I knew exactly what I was aiming at.

"That pin is too posterior," I said. The attending nodded. I pulled it out and drove it back with a more anterior trajectory. We checked the radiograph again.

"What do you think?" The attending asked.

I furrowed my brow. I couldn't find anything wrong with it. It looked it good. The thought echoed around my head until finally it escaped and became truth.

"It looks good."

The attending agreed. I drove the next pin in and it looked good, too. And with that, the operation was over. Redemption.

As a former athlete, I've experienced yelling out in pure joy, throwing my helmet in the air, dog-piling on teammates after a victory. But I was a professional now. The attending

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thanked me and congratulated me on a job well done. I tipped my head slightly and thanked him for his help. As soon as he left the room, the corners of a huge grin crept around the edges of my surgical mask.

Tuesday, October 2016

Though Gillette, the pediatric hospital, and Regions, the urban Level 1 trauma center, are physically connected, they might as well sit miles apart. The volume, pace, and workload at Regions turned way up. And unlike at Gillette, where a second-year resident takes home call, possibly answers a few questions overnight, and occasionally comes in to assess a patient, at Regions, we are in-house, serving as the orthopaedic trauma resident on call.

In this environment, it is not difficult to get absorbed in the seemingly endless amounts of work. There are patients to round on, notes to write, operating rooms to get to, consults to staff, clinic patients to see, orders to enter, phone calls to make, and the need to keep it all straight, get it done on time, and make sure it all is well documented.

As the sun rose on a busy call shift, and with the lists of tasks mounting to complete before the 6:20 am fracture conference (where the judgement on my overnight work would be rendered), it was easy to turn the patients in front of me as impediments to efficiency, rather than folks who needed my help. And so in the middle of the night, I walked into the room of Constance, a 94-year-old woman who had been transferred to our hospital with a complex periprothestic distal femur fracture.

My pager went off. It was the floor. I would call it back in a few minutes. I asked Constance what happened. She told me her story of woe. A long story. After 20 minutes of storytelling, the gist was she had stood up, gotten dizzy, and fell, striking her leg on a davenport. I wasn't sure what a davenport was, but I wasn't about to ask. Probably a piece of furniture. She had laid on the floor for 8 hours, her home was too rural to be serviced by any of the medical life alert companies. I started to get antsy. My pager continued its rhythmic beeping. I continued to go through the patient interview, asking her—well, yelling, she was terribly deaf—questions about her knee pain. She would answer with more long stories that (after some time) I discovered had nothing to do with my questions. I needed an exit strategy.

My Great Aunt Verna passed away when I was in college; she was the last of my relatives in the generation older than my parents. She too, had a habit of answering questions in long-winding story, so excited was she to share the happenings of her life. She told the story of how she went fishing with her husband Joe and accidentally caught a seagull instead of a fish so many times that we started to call Aunt Verna's stories "seagull stories." It wasn't important that we had heard the stories before, it was the telling, the sharing, the being together that was important. A pastime before the digital age.

As Constance continued to share her stories, I began to see my great aunt in Constance's face. I missed her—it was a long time since I had heard any seagull stories. The mountain of work could wait. In front of me was a determined woman, asking for my help. She was someone else's Great Aunt Verna.

And so I sat and asked Constance about her medical history and learned that she fed a bunch of outdoor kittens at her property and was worried about how they would get their food. I too, had fostered cats in medical school, and my love for cats is well known among my peers. She smiled as I told her about my cats. I asked her about her social history and she told me about her faith and her fiery determination to stay independent, even at age 94. Finally, we got to the end of the interview, as I had travelled with her through the twist and turns of her story, and gathered the information that I needed.

I readied myself to leave, asking Constance if she needed anything

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before I left. She said she was a little cold. I went over to the cupboard and took out a few blankets. I pulled the blankets over her and tucked her in for the night. She thanked me as I left and wished me good night.

I returned to the demands of modern surgical training, but for a few minutes, I had found a way to reach through and care for the patient. She wasn't an impediment, she was the only thing that mattered.

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