Residency Diary

Residency Diary: Big Lessons in Small Moments

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February 2017

I met Grace (names changed here and throughout) in the emergency department during my hand-surgery rotation. She was supratherapeutically anticoagulated on warfarin, and she had a red, swollen hand. We were concerned about the possibility of an abscess, but a bedside incision and

drainage instead revealed a large hematoma.

An elderly woman in her late 70s, Grace remained exceedingly pleasant throughout the procedure. She winced occasionally, but was otherwise appreciative, stating how grateful she was for my efforts and how lucky she felt to have so many people praying for and supporting her.

I grew up in a mixed-faith household in New Jersey. My parents raised me Jewish to share the identity with my Jewish family who lived close by in New York. I went to Hebrew school and became a Bat Mitzvah on my 13th birthday. But by high school, I was a confirmed existentialist, unable to fathom any religion as being the authority on “the truth.” I bought into Karl Marx’s interpretation of religion

as an opiate to the masses. I was like Nancy Reagan proselytizing during the war on drugs: “Just Say No.”

During medical school, any mention of religion made me uncomfortable. My discomfort went so far as to feel slighted when patients praised God for good outcomes—as if the medical team’s hard work was of little consequence. But after witnessing the full gamut of unfiltered human emotion—the joy in good outcomes to the tragedy and chaos with patients in crises—I found that my patients leaned on their faith to help make sense of whatever misfortune had befallen them and to understand the depths of what, at times, could seem so incomprehensible.

What surprised me most about my growth as a person and physician as I entered residency was the eagerness with which I tried to understand the viewpoint of my religious patients and engage my patients on this spiritual level even though I never had any interest in adopting these beliefs for myself.

I checked in on Grace a few hours after we finished irrigating and dressing her wound. Again, she professed her gratitude for my work.

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 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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"It's my pleasure," I said. "You're very lucky to have all those people praying for you. I think it makes a big difference." Who was this person? This doctor was unrecognizable from the Nietzsche-reading medical student who had graduated just 2 years ago.

Grace gave me a big smile, her body relaxing into her bed. She introduced me to her friend sitting next to her, a chaplain at another hospital.

"I think it's great that you have the man upstairs on speed dial," I joked. "You can just talk to your friend and she can get you straight through." The saccharine corniness of my joke hurt my ears.

Grace chuckled. "Hey, I never thought of that!"

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It was the kind of consult that a younger, less-experienced version of myself would have spent more time grumbling about. Now, less naïve and wiser to the workings of the modern healthcare system, I looked down at my pager and saw an opportunity: "ROUTINE INPATIENT COUNSULT. CHRONIC SHOULDER PAIN. OSTEOARTHRITIS?"

Just from the one-word suggestion, I could tell it would be unlikely for us to fix a patient's chronic shoulder pain in an inpatient stay. But I could

educate the patient on her pain and assist my colleagues if necessary. This was a better option than explaining that chronic shoulder pain in an elderly person was perhaps better served by the orthopaedic team in the clinic than the inpatient ward.

The patient, Ann, was petite, frail, and wheelchair-bound. She had a long history of shoulder pain, but as I suspected, her shoulder was not a problem that needed to be addressed acutely by an inpatient surgical team, particularly considering her overall health was in decline following a recent stroke. It was not just her shoulder; she hurt everywhere.

I told Ann there was not much to offer her except continuing therapy for pain management. After a brief discussion, I wished her well, but before leaving her room, I noticed tears in Ann's eyes. I wasn't sure what to do before kneeling beside her and placing my hand on her shoulder. The wheelchair swallowed Ann's tiny body, but I felt even smaller, just a bone doctor in training, wholly inadequate to address the problem of this patient's real suffering.

"I'm sorry you're in pain," I said. Ann's eyes looked up to meet mine. "What can I do to help?"

"You're helping me just by being here," she said.

"I can do that," I said.

Ann told me she was afraid that she would never get home. She told me she

grieved independence she had lost. She was lonely, she missed all the friends she made in her old way of life. She did not know what the future held and she was terrified. I offered no solutions, as I had none, but I knelt beside her, and I listened.

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The role of a surgical assistant is to anticipate the primary surgeon's next move. This is made difficult when I am perched on a step, clutching a deltoid retractor, and boxed out of view by the back of a shoulder. Unsure from that vantage point how to improve the exposure, I tried to stay very still. We were doing a reverse total shoulder arthroplasty for a woman who had so much bone loss on her glenoid that she required a custom-made implant—an atypical enough case that two attending surgeons worked on the patient together.

The surgeons took a standard deltopectoral approach, and though I could not see, I envisioned the layers through which we were going as the operation progressed. I resisted the urge to give names to the three sisters of the anterior humeral circumflex artery. Finally, we were down to the glenoid when the surgeon halted the operation. Without saying a word, one of the attendings tapped me on the back of the hand. With a look of boyish enthusiasm in his eyes, he

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beckoned me down from my perch. For the next few minutes, he pointed out the pertinent findings of bone loss on the MRI visible on the monitor across the room and showed me where they correlated to the shoulder of the patient in front of us. He invited me to look and to touch and he explained how the new technology fixed a problem that recently did not have a good solution. Satisfied I had an appreciation not just for the technicalities of the procedure, but for the scope of what we were attempting to do, my attending held my retractor as I returned to my perch and the operation continued.

I recognized the gleam in the attending's eyes. As an avid New York Yankees fan, when I was younger I lived and died with every pitch. I remember walking out from the concourse and taking in the manicured grass stretching out in front of me before my first game at Yankee Stadium. My emotions overcame me. My mother, confused, wondered whether I was happy. I finally managed between sobs, "I ... just ... can't ... believe ... that's really Derek Jeter!" There was a field in front of me filled with infinite possibility inhabited by my heroes.

As we mature, our dreams change. For my attending, the operating room was his playing field. For his patients, through his hard work and his commitment to patient care, he would be their hero. The passion with which he spoke came through in his eyes and in the kindness of his voice. He was working to create a world of infinite possibility. As I returned to my step and took up my retractors, I thought about how fortunate he was to have found this in his career. But even more so, I realized, how lucky I am, that he shared his secret with me.