

Editorial

Voices in Orthopaedics™...The Residency Programs: From the University of Washington- The Paradox of Healing

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During my (S.P.) first year in residency, I spent a month as the night float intern at Harborview Medical Center, managing an orthopedic service with an inpatient census that frequently reached the hundreds. When I was not responding to floor pages, it was expected that I would spend time in the emergency department (ED) assisting the second-year residents with new consults of varying acuity.

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The rotation functioned as somewhat of an apprenticeship in that way, learning from my seniors at odd hours of the night how to triage the onslaught of patients that the Pacific Northwest seemed to supply in endless numbers, gaining experience one procedure at a time on how to safely treat an ever-expanding range of injuries, both described and yet to be described in orthopaedic textbooks. As the

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end of my rotation approached, I could not escape the uncomfortable realization that stemmed from an understanding that any given procedure I saw or performed might just be my last before the baton was passed onto me, and it would be my turn to step into my role as a newly minted PGY-2.

Because of this, I carried with me a mental checklist of all the “minimums” I wanted to see and do before my watch as nightfloat concluded. Some of these procedures were basic: an ankle fracture reduction, a distal radius, or a joint challenge, for example. Others were more complex, such as a hip dislocation or a coaptation splint. By the time I returned to a diurnal schedule, however, I had still never witnessed a revision amputation.

July 5th soon arrived, and with it my first 24-hour shift as the consult resident. Sure enough, the first consult I fielded was a young man who had sustained a firework blast to the hand and required a two-digit revision amputation. I could not help but laugh at the irony before gathering my supplies and trudging down to the ED to perform the procedure on a human being for the first time. I’m not sure whether it was my youth that gave me away or if the patient sensed the hesitation in my voice, but at some point during the consent process, he asked, “How many of these have you done?” to which I replied, half-jokingly, “You wouldn’t believe me if I told you.”

Not all patients can tolerate such humor, and most scenarios demand more candor.

One of the unspoken “secrets” of residency training and practice is that there is always a first time we are called upon for a particular situation. Sometimes this involves a procedure, and others, a conversation. I (K.Z.) will never forget the first time I told a father his young son may be paralyzed for the rest of his life.

The patient was just 18 years old. He was involved in an automobile accident and sustained a high cervical spine facet dislocation which we colloquially refer to as “jumped facets”. It is an injury that makes all but perhaps the most confident spine surgeons’ shudder, and I was certainly not an exception. As I pulled up his CT scan, my heart fell. His neurologic prognosis was grim, and this injury was going to change the trajectory of his life.

I gave myself a moment to curse silently and then got to work. He needed an MRI and a prompt trip to the operating room—which meant a conversation with his family to obtain consent. Time was of the essence, and I had to move quickly. I found the social worker, and she brought me to his family. As we walked by the conference room—a spartan, empty-walled, fluorescently lit space littered with chairs and a table with a box of tissues in the center—I asked the social worker why the family wasn’t there. She informed me that his family didn’t quite fit in the usual rooms, a message she conveyed to me as she opened the door. I was greeted with the sight of at least twenty people who openly wore their fear and anticipation on their faces, and who quickly fell silent as they turned their gaze expectantly toward me.

There is no book, online training module, or simulation exercise that can prepare you for moments like this. The air felt thick, and time came to a standstill. I felt naked. I took a deep breath, introduced myself, and launched into the most compassionate delivery of this horrible news that I could muster. I must have gotten lost in the technical details, because it only took a minute before a middle-aged man leapt from his seat to interrupt me and almost shout, “is he going to walk again?” His voice was full of desperation, and his eyes welled with tears as I swallowed back my own. I instantly knew that this was his father. I gave him the unsatisfying answer that his son was in spinal shock so it was too early to tell, that he had a really bad injury, that he may be paralyzed for the rest of his life, and that he would have a long road of rehabilitation ahead of him if he does recover function. The tools I had learned for “delivering bad news” and “communicating under uncertainty” felt absurdly thin in that moment. I explained the plan, and he signed the papers wordlessly. My heart felt heavy, but the buzz of the pager on my hip meant that I would need to quickly reset for the next patient.

When I (S.P.) started PGY-2, I remember being struck by the noises that came out of the trauma bays. For the longest time, I carried with me this misconception that the noises were caused by the nature of my patient’s inciting injuries. The more time spent as a consult resident, though, the more I have come to realize how much we, as orthopaedists, are the very cause of the noises either through the delivery of bad news or by directly inflicting pain in our pursuit of preserving long-term function. In the hustle and bustle of the ED or operating room, with tasks accumulating and injuries to treat, it feels almost cruel that the most fledgling physicians are often the ones thrust into these situations, meeting our patients in moments where years of experience might feel like a cloak of armor shielding us during difficult conversations or providing ammunition that could be deployed to minimize suffering. I took this guilt home with me after many call shifts. Perhaps this is the hidden curriculum of residency: not only learning how to reduce a fracture or efficiently revise a finger amputation but learning how to earn the privilege of doing so.

We cannot eliminate the pain our patients experience, in fact, healing often demands it. I have observed, however, that we do have a say in how much preparation we have done to make that pain worthwhile. It might still mean that even as attending surgeons there will be instances in which we are called upon to perform a procedure for the very first time, but every textbook read, procedure rehearsed, difficult conversation practiced, and act of compassion performed is in its own way an effort to make ourselves worthy of the privilege that medicine affords us: the responsibility of minimizing the suffering we cause another person in the quest to make them whole.

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