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"On-Call" Follies (aka "The Un-Making of a Surgeon")

The 1970 very readable memoir by Dr. William Nolen about his surgical training, "The Making of a Surgeon" aptly chronicles the rigors of surgical "apprenticeship", in a way, the "rites of passage" we in surgery and its subspecialties have been forced to endure as the price to enter the "club". There are many references in Nolen's book to the horribly complicated and sick patients; matters of life and death decided by neophyte doctors in their 20's and early 30's; long hours, nights and weekends "on-call"; and the military-like chain of command in the maturation process toward becoming a "real" surgeon.

I am not aware of any books about the "unmaking" of a surgeon. However, I suspect the same factors that "make" a surgeon can wear on the individual, no matter how strong the character, and can among other things (inadequate compensation, stress, lack of balance in life, the publics' unrealistic expectations and their fear of death) can create the spiral toward retirement from the surgical/medical profession ("unmaking" of the surgeon) before one's time.

Let me share with you the essence of an especially wearying weekend "on-call" for me. We take rotating weekend call to cover other similar specialists' practice in the same geographic area. There is no <u>set</u> monetary compensation for doing this, and in fact, a lot of the care is "free". We cannot charge for phone calls (like our lawyer and accountant colleagues) from patients, hospitals, nurses or other doctors. People are free to pick up the phone and page us at will. Many are hoping we can practice good "telephone medicine" (an oxymoron of sorts) and make an intelligent decision on a patient we do not know and have never examined. This recent weekend, I probably fielded at least 50 calls. Most were legitimate in the sense there was a perceived problem, but often times, the caller divulged minimal helpful information--to the point where any decision making was more likely a guess on my part.

One of the calls, from the emergency room of an affiliated hospital was due to the inability to reach the urologist covering that particular hospital. At 11:30 PM on

Friday night, for a non-life threatening emergency (urinary bleeding almost certainly due to excessive use of anticoagulation), I was put in the position of "villain" for not immediately agreeing to assume the care for the "MIA" urologist. It required my talking to three different individuals (doctor, PA, charge nurse) in that ER to repeatedly explain what my role would be if the situation deteriorated and really warranted a urologic visit to the bedside of that patient.

Another problem Friday night [which occupied much of the weekend] was a colleague's patient, who went to an academic center for his kidney cancer surgery; but when he bled three weeks postoperatively from a vascular abnormality at the surgical site, he chose not to go back to the "downtown" hospital, but to come to our hospital. I and our interventional radiologist did a quite capable job of diagnosis and treatment. We see this phenomenon frequently, when we have to care for the complications created elsewhere and by the patient's personal choice to drive (or even fly) to an outside facility with (usually) an illusion that their care or outcome will be superior.

Several problems I cared for were "iatrogenic", i.e., in part created by healthcare providers themselves. One was the need to stent a ureter in a patient whose partially blocked kidney became more so after a gynecological procedure. Another was trauma to the urethra from inadvertent inflation of the urinary catheter retention balloon in the urethra (and not, as it should be, in the bladder); followed by a bleeding tear in the bladder after radiologic insertion of a tube into the bladder through the skin. That patient needed an urgent surgery to remove innumerable blood clots from the bladder, cauterize the area of injury, as well as to place an appropriate urethral catheter. [More about him below].

Another emergency was to place a ureteral stent on a lady without insurance who had developed pus in the kidney from an obstructing ureteral stone and was at risk for developing septic shock. Federal and state legislative "unfunded mandates" essentially force us to care for such patients without any guarantee of compensation

Calls come left and right from the emergency room about issues that could, in a more "civil" setting, be addressed the next day or perhaps in the office. Part of

this is really related to the patient: our society seems to have a low threshold for feeling their medical problem (1) is a true emergency (which if not immediately addressed, could cause death) and (2) can really be solved in that setting. Requests are made for us to see patients in the hospital for a consult, interrupting our busy schedule and adding to the cost of healthcare, when an outpatient office visit after discharge from the ER or hospital could suffice; or a simple phone conversation from doctor-to-doctor could clarify the issue.

It is finally Monday morning. I am “off” call for the other doctors; only “on-call” for my own patients. Monday is a typical hectic workday. Monday night, I fall asleep within a second of my head hitting the pillow. Off goes the cellphone/pager @ 4AM. An emergency? No, it was a hospital nurse calling for me to clarify an order (written during daylight hours, Monday morning 20 hours before!) about removal of a patient’s urinary catheter—that very patient who needed emergency surgery over the weekend for the “iatrogenic” problem started on the same hospital floor. After answering the call--and choosing to defer any commentary until I would see the patient early Tuesday morning--I lay half-awake, sleep deprived, another busy day on the horizon.

A glamorous profession, wouldn’t you agree?

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