

COMMENTARY

The Surgical History

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I'm spoiled. For all my physician friends who scurry between 15- and 20-minute appointment slots, and for all the concerns about safe inpatient provider censuses, I'm spoiled. I am a hospitalist who staffs our dedicated pre-operative medicine clinic. My patients are scheduled for 60-minute consults. I utilize the time performing a detailed review of known comorbid conditions, updating charts on patients who are often receiving their second episode of care ever at our institution, and including a very detailed cardiopulmonary review of systems to decide who meets the criteria for additional pre-op testing. I also provide pre-patient education and instructions. Sometimes I need more time for tasks such as arranging an urgent ECHO after hours for a frail immobile patient who lives six hours away in rural Oregon. Sometimes I need less time, and I fill a few minutes with pleasantries or get a patient on the road a few minutes early before rush hour hits. And sometimes having the full hour reaffirms why I need to slow down, ask, and listen.

On a particular Friday, my last patient of the day was a 96-year-old gentleman who was scheduled for TAVR (transcatheter aortic valve replacement). He had received the bulk of his care, including his primary care, at our institution. His electronic chart, so to speak, looked very complete—notes, EKG, imaging, and laboratories already all on file. There was even mention of a gunshot wound to his left thigh buried in the past medical history. However, one section of the chart was notably blank: the past surgical history tab.

He arrived with his two sons. We chatted. His last name led me to learn that he was originally from Poland. We confirmed that he was aware of the indications for his surgery and that he was indeed symptomatic from his previously documented severe aortic stenosis. We reviewed his recent upper respiratory infection as well as his allergies and medication list.

And then it was on to the past surgical history.

"Have you ever had surgery before?"

"Oh sure, I had my tonsils taken out in the 1960s," he replied.

"Have you ever had any other surgeries?"

"Oh yes, I had surgery on my left leg."

I was listening. And with that, and without me asking, he hiked up his left pants leg practically to the inguinal fold. His skinny leg showed signs of multiple deep scars on both sides of his thigh, medially and laterally.

"That's right! I saw in your chart that you were shot in the leg!"

"Gunshot wound doesn't quite describe it," he said.

Now I was really listening.

What had been recorded, transmitted, automatically imported into template notes, and established as a permanent part of his medical record as a "gunshot wound" was actually artillery fire from an airplane.

He was being transported from one concentration camp to another as part of a large German convoy that appeared to include military equipment. The Allies fired on it, and he was hit.

The wheels in my head started turning quickly, then furiously, then at

a breakneck speed as I was sat next to him with my jaw slack in stunned silence. All the teaching in elementary school about the Nazis and the Holocaust came rushing back, and I tried to fill in the gaps in the timeline from his injury to his recovery. Who? What? Where? How?

"Wait.... A Nazi surgeon didn't perform your surgery, or did he?" I asked.

"No. Another prisoner in the camp, who had been a doctor, performed the surgery."

"You didn't have anesthesia for this surgery, did you...?"

"No, no I didn't. I had ether for one of my follow-up surgeries, and I did fine with it!"

Now, not only was I listening, but my jaw had hit the floor floor. Every teaching point I make to my students and residents about the importance of "pertinent positives" and "pertinent negatives" was swirling around my head. This detail was seemingly unrelated but at the same time was immeasurably and critically vital to why this man was sitting next to me in an exam room awaiting heart surgery in a week.

I was in the presence of a true survivor.

I quickly gathered my thoughts and explained to his sons why I was asking these details, lest it appear that I was just being nosy. I explained that I ask every patient how he/she has fared with past surgery—and more specifically anesthesia—to gauge how he/she will do with the upcoming surgery. Without missing a beat, his son replied to me, "So he'll do fine with his heart surgery, right?"

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edges that it requires time. I am a full supporter of promoting curiosity in all medical providers, though I am also realistic that curiosity does indeed take *time*—time to talk, time to inquire, time to actively listen, and time to provide the patient a chance to share. These are the things that I agree are difficult to achieve in this time-crunched 21st century practice of medicine. I think we have to nurture the time-curiosity relationship—to use our existing

time with a patient to have our eyes, our ears, our full senses open to the humanity and human story of each of our patients. Sometimes a small fill-in-the-box “best practice” detail is small—but sometimes it opens the doorway to enriching the art of medicine and creates lasting patient connections.

This patient did indeed make it through his TAVR and was discharged home three days after surgery. His surgical history has been

updated in the electronic health record and is now being imported into templated notes by others. I hope it sparks future conversations. I already know it triggered at least one more meaningful patient-provider connection. Two days after his surgery, his anesthesiologist sent me this message: “He is an amazing man, and he did great! I felt honored to be able to care for him; we were all hoping he would do great.”

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