

Peering over the Ether Screen

Are We the Last True Generalists?

By Karen S. Sibert, M.D., Associate Editor

I brought my patient from the OR back to the medical ICU and gave report to the nurse; made sure that the ventilator settings were appropriate and that the arterial line waveform was crisp. Upon confirming that the patient was stable (which was a relative term in the context of this very ill elderly man), I headed over to the ICU desk to finish the paperwork. The case had been a video-assisted lung decortication and evacuation of empyema, a two-hour procedure with moderate blood loss in a patient with a host of underlying medical problems. Sitting next to me at the ICU desk was a young medicine resident. Without preamble, he turned to me and inquired, “What was the indication for putting in an art line?” For a second I thought he was kidding, so I didn’t immediately reply. “No, really,” he said. “Was there an event or what?”

Once a mother, always a mother. I was amused to hear myself answering him with the soothing tone and simple words one uses with a sleepy child. “Well,” I said, “the event was thoracic surgery. They’re working near things like the heart. Only one lung is being ventilated during the operation, so you may want to check blood gases. And it’s nice to know what the blood pressure is all the time.”

Then I went back to the OR and left the medicine resident on his planet, where it seems you need to research the latest evidence-based guidelines to figure out if you should place an arterial line in a critically ill patient who’s having major surgery.

A few days later, an interesting case came along—a middle-aged woman with severe IHSS who needed a VATS lung biopsy to diagnose her pulmonary infiltrates. (In case you were wondering, I don’t get to look after a lot of healthy patients.) The cardiologists had arranged to come to the OR to do a trans-esophageal echo while she was under anesthesia. Once she was asleep and intubated, they moved in with the echo probe and the rest of the OR team stood by politely. The cardiology fellow—meaning well—said we were welcome to proceed with the surgery while they did their study. There was a pause, and an exchange of looks among the surgery team, and then someone explained that we would have to turn the patient to the lateral position for the surgery to take place. The cardiology fellow looked abashed.

The point of these cautionary tales is simply this: It can’t be good for there to be so much isolation between medicine and surgery that the left hand clearly

Peering Over the Ether Screen (cont'd)

has no idea what the right hand is doing. I feel sometimes like the ambassador shuttling between two continents that are poles apart, although I will say that my surgical colleagues seem to give a lot more credit to my diplomatic portfolio than my medical colleagues do. If I start to explain to a surgeon why it matters that his patient has a drug-eluting coronary artery stent, and why we shouldn't stop the patient's aspirin before his gastric bypass, his eyes may glaze over a bit but the chances are that he will go along with my recommendation. On the other hand, the internists are likely to demand "cardiac anesthesia" for any high-risk patient, apparently with little appreciation of the experience the rest of us have in caring for the myriad patients with cardiac disease who present for non-cardiac surgery.

When I was an intern (and yes, it was quite some time ago), my rotations were planned by the Yale Department of Anesthesiology to give me a balanced preparation for my future practice. Four months were spent on surgery and eight months on internal medicine with an emphasis on ICU care. If I had been interested in pediatrics, time would have been made for a rotation there as well. While no internship is a bed of roses, even at my most exhausted I could see the value of working on both the medical and surgical sides of patient care. The future internists may not have enjoyed scrubbing on a ruptured AAA very much, but at least by the end they understood what the case really involved and why it required invasive monitors.

Today, however, medical students graduate and move straight into either a medical or surgical track. The surgical residents tend to learn some medicine along the way as they take part in managing their patients' coexisting medical problems. The internal medicine residents, on the other hand, never have the opportunity to see what actually happens to their patients during surgery. They'll call for a VATS lung biopsy in a patient who is teetering on the brink of death, not seeming to realize that if they can't ventilate the patient on two lungs, I won't be able to ventilate with just one. It might be very instructive for medical residents to accompany their patients to the OR whenever surgery is needed. That experience might also improve the quality of the internal medicine "clearance"—we all have our favorite examples. One of mine was the VA cirrhosis patient with ascites and coagulopathy, who was considered by his medicine resident to be too sick for general anesthesia but just fine for a spinal.

There were a lot of advantages to the concept of the flexible internship, though I don't think we are likely to see it reappear. In the meantime, it looks as though a significant part of our job as anesthesiologists is to be the physicians who work at the intersection between the medical and surgical spheres. If we do it right, we are keeping up with new developments in internal medicine—and the constant appearance of new drugs—so that we can manage our

Peering Over the Ether Screen (cont'd)

patients' underlying diseases. At the same time, we see the latest in surgical techniques and gadgetry just by showing up for work. Since Dr. House, expert in everything, is just a fictional character, maybe it's the anesthesiologists who are the true generalists of the 21st century. We can take pride in that.



2009 Forrest E. Leffingwell Lecturer: Myer H. "Mike" Rosenthal, M.D. (third from left), surrounded by Drs. Ron Pearl, Linda Hertzberg, Michael Champeau, Christine Doyle, and R. Lawrence Sullivan, Jr.

**CMA Physician's
Confidential Assistance Line**

(650) 756-7787 or (213) 383-2691