

Pull Up a Chair, Sit Down, and Listen

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One of our oldest tools may turn out to be one of our best: talking with patients. By getting to know patients' stories, and perhaps letting them know ours, we might be able to add a link to the chain of trust

—Elvin Geng, 2022

INTRODUCTION: THE CAREER DECISION TREE

When I was a medical student rotating on the various clinical services and thinking about career decisions, a common refrain from those offering advice on these decisions was that an early 'branch in the career decision tree' was deciding whether you liked caring for patients or liked doing procedures. I sensed that this advice was creating, or at least suggesting, a false or inaccurate choice. In fact, I even remember hearing that surgeons should not get too close to their patients in order to retain a sense of detachment. Somehow I just didn't see it that way.

One of my favorite teachers when I was on my rotation in obstetrics and gynecology, after pointing out how much I seemed to be enjoying delivering babies, some of which happened to have been delivered in the same room in which I myself was born, said "now think of your career choice in terms of what you want to see when you look out into your clinic waiting room. I look at my waiting room, and it's filled with beautiful young women. If you go into Surgery, your waiting room will be full of old folks missing a leg or two."

I found myself thinking that I wasn't so sure that those questions were the ones that I should be asking myself. It struck me that the 'first branch point' in the career decision tree might just as accurately be posed as asking yourself if you wanted to take care of, or be prepared to take care of, the sickest patients. Or, perhaps, that branch point might be asking yourself if you wanted to know something about almost everything in medicine. I realized that my answer to both of those questions was 'Yes.' And, it also dawned on me that students drawn in those directions might include those interested in a lot of fields in medicine, especially Internal Medicine and Surgery or, perhaps, high risk obstetrics or neonatal critical care. After further discussion with my

favorite advisors (including my own father, a Thoracic Surgeon), it occurred to me that, if one chose a more demanding field, especially one with a longer training trajectory, one would need to gain energy from both learning and practicing in one's chosen field. I eventually realized that I was, and always have been, someone who liked doing things, ranging from sports to crafts to building things and working on cars. [Tribble, *Mental Strategies of Surgeons, I & II*]



However, I also understood that I had chosen to enter medicine to work with and to try to help people. People that I would want to get to know, to connect with. [Tribble, *Talking to Strangers*]

I did eventually choose to pursue a career in Surgery and, not too long after starting my Surgery Residency, I accepted an offer to continue my training in Thoracic and Cardiovascular Surgery, all the while hoping that I could continue to be able to connect with my patients and their families. I had a hunch that I could balance those desires, to be good at and enjoy the technical aspects of my work and to also find ways to enjoy building relationships with the people for whom I would be caring.

The early years of training in Surgery were demanding, in an era in which there were no work hours restrictions and in which a call schedule of every other night call was the best schedule I would have for years. I found while working in the emergency room or on the Surgery wards at night, I was able to connect with my patients and their families. However, I also realized that I had to figure out how to make those connections both effectively and efficiently. Obviously, the basics include sitting down when feasible, asking about the patients about their families, where they lived, and what they liked to do. Gradually, I realized that the patients, at least most of them, also wanted to connect with us, their providers, developing at least some level of trust in us and our teams.

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However, I rarely had enough hours in the day to just sit and talk at length with my patients and their families. So, I realized I had to figure out how to control the conversations in ways that were good for both the patients and good for me and our teams. I eventually came up with what seemed to me to be the ‘just right question,’ which was “what do you want to do when you’re well again?” Everyone I have ever asked that question had an answer to that question. Sometimes the answers were quite simple, and sometimes they were considerably more elaborate, but they were always interesting and engaging.

Eventually, I had an additional epiphany, which was to ask the patients to bring me a picture of themselves doing whatever it was they had told me that they wanted to do after they recovered. And, eventually, it dawned on me to suggest that, whenever they found themselves becoming apprehensive about an upcoming operation or their current condition, they should put themselves into the scene of the picture that they were planning to create. I’d often remind them of the old saying that ‘if you look at the horizon, you’ll get there, but if you look at the ground you’ll fall.’ And, I’d point out that the more they put their mind towards thinking about the picture they were going to create, the easier it would become to ‘take themselves there.’ (I later learned from some of my yoga teachers that this strategy could be considered as having a mantra.)

I never had a patient who did not, eventually, take me up on my assignment. The plans for these pictures ranged from the mundane, like mowing the lawn or tending a garden, to the elaborate, such as planning a trip to a special place. My interest in what my patients’ dreams and aspirations were led at least some of them to be interested in me and my teams, as well. That made sense to me, given that they sensed that, if they were entrusting themselves or a loved one to us, they wanted to know more about us, to get a feel for whether they were willing to trust us with their care. [Tribble, Gimme 3 Steps]

Over the years, what I have learned is that it’s hard not to open up to someone who’ll pull up a stool or a chair to sit down and to listen and talk. The conversations that result are good for our patients, and they are good for us, their doctors and providers. [Tribble, Grandmother Rules]

A FELLOW SURGEON WITH A CHALLENGING CONDITION

Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine.

—Francis Peabody, *The Care of the Patient*, 1927

Sometimes trying to navigate the need to settle an apprehensive patient’s nerves can require some quick thinking and creativity. I was sitting in my office late one evening trying to catch up on paperwork when I saw a relatively young woman standing at the counter out in the anteroom of the office area that I shared with my partner. She was decked out in a cowboy hat, cowboy boots, and a jean jacket. I asked if I could help

her, thinking, perhaps, that she was one of the local artists that we sometimes employed to create art work for our articles. She said that she had come by “to drop off some information for Dr. Tribble, for a clinic appointment that’s scheduled for tomorrow.” I allowed as how that I was Dr. Tribble, and I immediately sensed that she’d been expecting someone with a little more gray hair than I had at the time. But, I figured I might as well get a head start on that visit and asked if she’d like to chat a bit right then and there. She accepted that offer and came into my office and sat down. Several things quickly became evident, including the fact that she was, herself, a head and neck surgeon and that she had a very unusual but dire condition. I also learned that she’d flown to Virginia from Montana that day and had come straight from the airport to the hospital to drop off those records, so that we’d have them for the clinic appointment the following day. After hearing just a bit about her quite challenging clinical situation, I also realized that we couldn’t, or shouldn’t, get further into the official clinic visit that evening. I asked her if she had eaten supper, and she acknowledged that she hadn’t eaten all day. I called my wife and asked if there was any food at the house, and she said that she had a chicken Caesar salad (my usual evening fare) there. I asked her if she could split it up and told her I was bringing someone over for dinner. I told my new patient that I thought it would be best if we put off talking more about what she might need to have done until the next day in the clinic. She agreed, and we talked that evening only about where she lived and what she liked to do when she wasn’t working, which included playing the clarinet in a local symphony and riding horses.

After seeing her the next day, I was even more concerned about the complexity of what she would need to have done, though I learned that she had been to a number of well-known centers around the country prior to coming to Virginia to see me. I was relieved to hear that news because I was certain that her initial impression of me as a somewhat disheveled, younger than expected, Nine Inch Nails fan would preclude her asking me to do the daunting and complex operation that she needed. She flew back to Montana the next day, and I thought that would be the end of the story. Alas, she called back the following week and said that she and her husband (who turned out to be a lawyer, much to my chagrin) wanted me to do her operation.

When I realized that there was not going to be a way to decline her request, I spent weeks preparing for her operation, which was probably the most time I had ever spent getting ready for a single operation. Somehow, perhaps through some divine intervention, she did well. When my resident and I decided that we would write up this very unusual case, we thought it appropriate to ask her if she would accept our offer to be a coauthor on her own case report. She accepted. [Kern et al, 1997]

Upon reflection, I suspect that this patient made the decision to ask us to do her operation, not because of a sense that we were any more expert in what needed to be done, but because, at some visceral level, she wanted someone to do her operation who seemed to be more interested in her as a person than as a ‘great case.’ I still thank our (hers and my)

lucky stars that her operation turned out well. She has regaled me, from time to time, with pictures of her horses and her ranch in Montana.

This patient's story reminded me that connecting with patients and their families is not something to be avoided in the pursuit of maintaining detachment, which many clinicians advocate, but is something to be sought after and cultivated. I believe that this sort of personal involvement is good for patients and it is good for us, their doctors and the teams that support them.

A WORLD RENOWNED BUSINESS MAN

Same way every day, as I know that anything other than that would, in your hands, not be as good.

—Mr. C

I was asked to see, in consultation, a savvy and very successful business man, to talk to him and his wife about having an aortic valve replacement, which had been recommended by his cardiologist. Not only was I aware that this man could go anywhere in the world he wanted for his operation, I was also aware that he had already been seen in consultation for this operation at three of the most well-known cardiac surgery programs in the country, all three of which were also places with which the patient had connections of one sort or another. His wife, who I knew would accompany him to the clinic visit, was also from a very prominent family. When the referring cardiologist asked me to see this patient, I reminded him that my practice was filled with 'everyday people' from the mountains or countryside around Charlottesville. He continued to insist that I see his famous patient, and, seeing no way out, I agreed that I would see him.

On the day of his appointment, he and his wife came to my office. I reviewed the reasoning for the valve replacement, which, of course, he'd heard before. I described the operation, and I pointed out that an aortic valve replacement is, on average, one of the most straightforward operations that cardiac surgeons perform, adding, of course, that almost anything can happen with virtually any operation. The patient nodded in understanding. His wife then chimed in, saying "Now Curt, if he were to choose to have his operation here, you wouldn't allow any students or residents to be involved in his care, would you?" (I was aware that a similar stipulation had been agreed to, some years prior, for a fairly routine cancer operation that the patient had undergone.) I was ready. I turned to this obviously capable manager of money and people and said "Mr. C, if we were to do your operation here, would you want me to go about it the same way I would every day or in some different way?" He didn't even draw his next breath before replying, "Same way every day, as I know that anything other than that would, in your hands, not be as good." I turned to his wife and said, simply, "That is the just right answer." They departed, thanking us all for our time, and I heaved a sigh of relief, sure that I'd never hear from them again. To my surprise, a week later he called me and asked me to do his operation. Now there was

no room for backtracking, so we scheduled his operation at a time convenient for him.

On the appointed day, while we were well into the operation, Mr. C's cardiologist came in the room. I'd never seen him in the operating room before. He tapped me on the shoulder and said "I cannot believe you're helping Gene do this operation!" I said, "This is exactly what Mr. C asked me to do." My friend, astonished, said simply "I gotta hear this story later!" The operation went along just as planned and the patient did well. I later told my cardiology colleague of the conversation in my office. He then said, "hearing how you discussed the situation with Mr. C, I am not at all surprised that he agreed to the plan you offered him. That 'same way every day' concept obviously, and correctly, made sense to him."

Mr. C liked to have famous and / or interesting people come to his estate to give talks and, from that point on, he would insist that I come when I could. I was quite interested in most of these speakers and attended when I was able. I'd try to sneak into the theater at his estate where these addresses were delivered, hoping to keep a low profile. If Mr. C saw me, he'd interrupt the proceedings and say "I want to introduce the surgeon who saved my life." While I am the last person to want such public accolades, he meant what he said and wanted to thank me and my team for our care and for my honesty with him. That's what most of our patients can, and do, expect of us.

MR. D AND HIS RECIPE

There is a little witchdoctor operating in all physicians. Use that skill for the benefit of your patients.

—Clifton Meador, 2018

I was once referred a patient who needed a relatively routine cardiac operation, and I agreed to meet him and his long-term 'lady friend' in my office to discuss his situation. It turned out that his friend asked a very salient question as we finished up the usual discussion about the operation he needed and the potential complications associated with that operation. She mentioned that in addition to his smoking habit, which I had known about and which the patient and I had discussed, he also was an "every day drinker." I concluded that his habit was likely to put him at risk for having withdrawal symptoms after his operation. In relatively recent times, the 'approved protocol' for dealing with this situation is to 'load such a patient up' on benzodiazepines perioperatively. When I mentioned that strategy, the patient asked a pertinent set of questions, starting with asking me if that strategy would make his operation safer and enhance his recovery. I confessed that I was not at all sure of the answers to those questions. He asked me if there were alternatives to that approach, and I acknowledged that, in years past, we had routinely given patients such as him 'just enough' alcohol, to prevent withdrawal and that this approach had always worked out reasonably well, given that we could manage 'the dose' and the timing of what he'd be allowed to consume. The patient acknowledged that this approach seemed both

reasonable and appealing to him. We agreed that we'd make some version of this plan work.

We did perform the operation Mr. D needed, soon thereafter. The operation went along as planned, and I worked with his friend to carry out our plan to deal with his alcohol use. She would bring in some of his 'libation of choice,' which was vodka and orange juice. We worked together to 'manage the dose' in a way that kept him from suffering from withdrawal but that did not interfere with his recovery. His recovery, both in the hospital and at home, proceeded along a fairly normal trajectory.

When I saw him back in my office a few weeks after discharge, I asked him how he was doing with both his overall recovery and, more specifically, with his use of tobacco (cigarettes) and his use of alcohol. He told me, and his friend corroborated his report, that he had not smoked another cigarette and that he had shifted from his fairly serious drinking habit to drinking one glass of what he called "heart healthy wine" with dinner each night.

About 10 years have elapsed since I last saw Mr. D in my office. He calls me (on my cell phone, the number for which I frequently have given to my patients) each year, on the anniversary of his operation, to say, each time, that he is doing well, having never smoked again and having stuck with his single glass of wine each night.

My reflections on this story, as they are for many of the patients I've cared for over the years, include:

- It is always worth trying to meet the patients where they are and to work with them individually to figure out a way to not only address their immediate cardiovascular issues but to also understand and work with them in the context of 'where they are in their lives' at the time.
- It is surprisingly easy to help many patients move towards healthier habits and lifestyles, if you listen, understand, and collaborate with them.
- Taking this sort of approach is good for them, and it's good for us, as well.

A MAN OF APPALACHIA

The worst mistakes involve not understanding people as well as you might.

—Warren Buffett

I once had a patient named Willard G. He had a lot of peripheral vascular disease that I managed with him over many years. He also had a lung cancer that we detected and that I removed at one point. As is my custom, I got to know him fairly well during our years together. I knew where he lived, outside of town at the base of the Blue Ridge Mountains. I learned that he was a fairly self-sufficient mountain man, growing much of his own food in his large gardens and hunting and fishing to supplement his food supply.

I was aware that his wife had died early in our time together. On one rather eye opening clinic visit, he arrived with a younger woman, who he introduced to me as his new

wife. It was apparent to me that this young woman was not all that 'mentally sharp.' I asked Mr. G. how he happened to have married this woman, sensing that this relationship was a bit out of the ordinary, even here on the edge of Appalachia. He told me that she 'needed a lot of care' and that her parents had died, sequentially, in the fairly recent past, prompting some of her remaining, though distant, relatives to ask him if he would be willing to marry her so that she could be 'provided for.' He allowed as how that had seemed like the 'neighborly' thing to do, and he did as these relatives had asked. Who was I to judge?

In addition to growing his own vegetables and fruits, Mr. G enjoyed telling me about how he could build or fix "most anything," reveling in detailed descriptions of the two shops he'd built on his property 'back in the hollow.' Having been a bit of an amateur mechanic and handyman myself, I enjoyed hearing about his tools and the projects he did with them.

After many years of operating on him for an abdominal aortic aneurysm, his lung cancer, and a myriad of peripheral vascular issues in both lower and upper extremities, it seemed that his vascular disease had 'cooled off' a bit, allowing us to enter a phase of 'health maintenance,' such as it was.

One day Mr. G came to my clinic for routine follow-up of all these conditions and prior operations, and one of my senior residents saw him first, in the usual rhythm of our clinic, which entailed the patients being seen and 'softened up' by the residents prior to my seeing them. This pattern was one that I had developed with the understanding that patients sensed that they need to be seen and talked to by some combination of us to have their visit feel as though it had taken an 'appropriate amount of time.' [Tribble, *The Well-Tempered Clinic*].

When it came time for Chuck, my resident, to present the patient to me, he, quite excitedly, announced that Mr. G likely had male breast cancer.

I asked Chuck if he had asked Mr. G if he happened to be taking some of the medications known to be associated with gynecomastia. He assured me that he had. I said "let's go talk to Mr. G about all this." When we settled into the room, I started by acknowledging that I knew that he had a machine shop and a wood working shop. He smiled at the question, saying "you know that I do, since you ask me about them frequently." I then asked him if he had a garden, and he pointed out that I knew that too, because he had occasionally brought me tomatoes and corn from his garden. I acknowledged that I did remember and had appreciated his thoughtfulness. I then noted that I was aware that the mountain folks in this region knew about marijuana that grew wild in the region, and I asked him if he had been able to cultivate some of that wild marijuana in his garden. He responded by saying "of course I do!"

Chuck and I excused ourselves from the clinic room, and I asked him in the hallway if he had considered the possibility that Mr. G's gynecomastia might have been caused by marijuana use. He acknowledged that this possibility hadn't even entered his mind, given that his presumption was that marijuana was not something an old mountain man would even have access to. Given that the resident had now come to realize that marijuana was not exclusively available to college kids

(and former college kids), he acknowledged that he would add that question to his workup of gynecomastia in an older man ‘from these parts’ from now on. That resident eventually ended up taking a job in Southwest Virginia, where, I am sure, he has encountered many more of the mountain men of Virginia in his practice over the years, and, I suspect, he has seen some more cases of gynecomastia induced by ‘home grown’ marijuana. And, I expect that this young surgeon has realized the value of getting to know one’s patients well, understanding their culture. Sometimes you just have to know your patients and know how to ask them the right questions.

THE COLLEGE PROFESSOR

Life isn't about how to survive the storm, but how to dance in the rain.

—Katie Lowe

I once had a patient referred to me for an aortic valve replacement. He was an older man who, it turned out, ran a small business selling Civil War memorabilia. His wife, S, who accompanied him to the clinic visit, assisted him in this business. She also taught English at a college in the region of Virginia in which they lived. As is my habit, I asked him what he wanted to do when he was well again, and he said, simply, that he enjoyed his work, finding and then selling these relics of the Civil War.

His operation was straightforward, and we had settled him into our intensive care unit after its completion. The following day, with the patients I had operated on the day before seeming quite stable, I headed to a meeting in a different part of the state. Later that day, my chief resident called to inform me that this patient had had an arrhythmia, which had caused a cardiac arrest, and that he and the ICU team had been unable to resuscitate him. As terrible as this news was to receive, I also hated that I was not there to talk to his wife. I told him to tell her, as I always do under such circumstances, that I would be eager to meet with her upon my return to talk to her about this unfortunate outcome. It turned out that S was an ‘early adopter’ of email and, given that she lived two hours away from Charlottesville, she suggested that we exchange emails, in lieu of a face to face meeting. I accepted her offer, and thus began a series of email exchanges that lasted for several years.

Of course, the initial emails were related to the circumstances of her husband’s death. I explained that one of the reasons we perform aortic valve replacements is that the hypertrophied left ventricle that always accompanies aortic stenosis is prone to arrhythmias which, if valve replacement is not done, will likely result in death from those arrhythmias. However, though not often discussed, the risk of those arrhythmias only gradually diminishes after the valve is replaced. S understood this concept, and, it seemed, was adjusting to her life without her husband. It has always been my practice to respond to any communication that a patient or a patient’s family member has with me, with an unwritten rule being that I would not let their communication with me be ‘the

last word.’ Said differently, if a patient or a patient’s family member had called, written, or emailed me, I would answer, no matter how many exchanges that might entail. [Tribble, Humane Letters, 2016]

Our emails continued and gradually shifted to S’s telling me about how she had gotten into walking for exercise and that she had decided to sell the Civil War memorabilia business to focus on her teaching at the college. While answering her emails did take some time, I didn’t mind participating in these exchanges, as I sensed that she really didn’t have anyone else to communicate with regularly, as she didn’t have many, if any, close family members nor neighbors.

Gradually, she did develop a friendship with a nearby farmer, who, it turned out, was a widower. She told me that she and this neighbor had begun walking together in hopes of improving their respective health conditions. I sensed from the ongoing exchanges that a significant friendship was developing between the two of them. After what turned out to be several years of exchanging emails, she startled me by asking for my permission to accept her neighbor’s proposal that they get married! I, of course, was thinking “Why ask me that question?!” Sensing that I was a bit perplexed by her question, she pointed out simply that, at this point in her life, I was the closest thing to a relative that she had and that she sensed that I would be an appropriate person to ask this question of. Given that the question was posed in an email, I had a chance to contemplate what an appropriate response would be. Of course, I considered the possibility that this arrangement wouldn’t work out and that I’d have been complicit in this debacle if that did, indeed, turn out to be what happened. I concluded, having gotten to know her, that this proposal was ‘more likely than not’ to turn out well for the protagonists. They did, indeed, get married and things seemed to work out well for all concerned, including the farmer’s extended family.

A year or two later, S sent me a huge binder with every one of our emails printed out and secured in it. In her accompanying, heartfelt note, she said that my willingness to stay in touch with her had gotten her through a very dark period and that she would be forever grateful for my willingness to do that. I said simply that it had been the least I could do and that I hadn’t ever considered our exchanges to be a burden.

The last time I checked in with S, she was still teaching at the college and she was still walking with and married to her gentleman farmer....

MY MOUNTAIN VALLEY NEIGHBORS

Sometimes we need not say or do anything other than to be present, and momentarily silent, for our patients, their families, and ourselves.

—Ian Barbash, 2018

Many years ago, I was asked to see a woman, SR, with symptomatic left main coronary disease to consider her for a coronary artery bypass. It turned out that she was my neighbor. In fact, she had actually been born and grown up in the 100 year old house that my wife and I had bought 10 or 15 years earlier.

I told her referring doctor that I felt as though S was ‘like family to me,’ which was true, in that, after buying our old house, everyone in our valley had decided that the sale of the house, outside the family, was acceptable, in that they liked us and that they particularly liked the idea of having a doctor (me) and a nurse (my wife) in the valley. We had indeed, at times, served almost as ‘barefoot doctor and nurse’ (to borrow a phrase from the medical system in China decades ago) in responding to hypoglycemic episodes, untoward reactions to anti-depressants, diabetic foot ulcers, and a variety of other ailments. So, now that my help as a cardiothoracic surgeon was needed, the patient, her husband, and the other denizens of our valley, most of whom were related to each other, would hear nothing of my being reluctant to do her operation because of our close relationship with them. There was to be no way out for me but to accept their insistence that I perform her operation.

Besides our friend’s significant coronary disease, there were other concerning issues, including her age (she was in her mid 70’s), significant obesity, and a three pack a day smoking habit. However, in spite of these concerns, we proceeded to do the operation she needed, which was actually fairly straightforward. The operation went well, and after settling the patient into the intensive care unit (ICU) after her operation, I spoke to her husband, D, with whom I also had a very good relationship. As usual, in my postoperative meeting with him, I told him that his wife’s course from this point forward would likely be defined by her pulmonary status, her age, and her size. He acknowledged that he was, indeed, well aware of those issues.

A day or two after her operation, she had been extubated and was sitting in a chair in her ICU room, when the resident who had done her case with me was rounding on her and realized that she had had a cardiac arrest, which seemed to have been the result of a respiratory arrest (sometimes called ‘a Pickwickian arrest’). He pulled her from her chair and appropriately began a short cycle of chest compressions. She was reintubated and seemed to stabilize quickly.

When I was able to come up from the operating room and see her myself, I realized, not surprisingly, but to my chagrin, that her sternal wires seemed to have pulled through her osteoporotic sternum during the chest compressions. I knew immediately that we would need to reoperate on her and, with the help of our Plastic Surgery colleagues, reconstruct her sternal closure. Since we had a pair of lung transplants to do that night and since the operation to reclose her sternum was not urgent, we laid out the usual plan for such a situation, which was to keep her on a ventilator, paralyzed so that she could not cough or move, until we could get our teams together in the operation room in the next day or two to perform the necessary reclosure of her sternum.

That evening, knowing that I would likely be up most of the night with the impending transplants, I headed for home, in hopes of getting at least some sleep prior to the arrival of the donor lungs at our hospital. I was awakened by one of my residents, who I knew was headed out to procure the donor lungs, and his news was horrifying. While he was up in our ICU gathering his headlight and loupes for the lung

procurement, he looked in S’s room and realized that the bed, and even the floor, was covered in blood. The nurse caring for her had evidently stepped out of the room for a moment and had not realized that the patient had started bleeding. The folks who were there at the bedside were unable to resuscitate her. This type of bleeding is not uncommon after the events such as those of the prior day, which is why we keep such a patient intubated and paralyzed (so that they cannot cough, which can cause the unstable sternal edges to tear the right ventricle). I, of course, needed to notify her husband with the sad news that his wife had died. I knew that this notification could not be done with a phone call, not when they lived just up the valley from us.

So, at 4 o’clock in the morning, I walked down the gravel road to their house to deliver this awful news in person to S’s husband. It was a long walk, of course, though the actual distance was only about a quarter of a mile. I rang the doorbell, and D came to answer, sleepily opening the door. He, of course, knew that I did not come bearing good news. Anticipating what I had to say, he said, simply, “She’s gone, isn’t she?” I merely nodded and waited for him to speak. He gathered himself and said, simply, “We all knew that she wasn’t going to be the best patient.”

I waited to let him ‘control the conversation.’ He told me that he needed to call her son (a son from a prior marriage), and, after calling her son, he surprised me by saying that the son was on his way to the house and asking me if I would stay there with him until her son arrived. Knowing that it would be a while before I was needed at the hospital, I, of course, agreed to stay with him.

D said that he’d make some coffee, which I appreciated. Then he announced that the two of us would sit on the front porch of his mountain house to drink some coffee, smoke some cigarettes, watch the sunrise, and wait for S’s son to arrive, with D smoking and with me drinking coffee, of course. While this plan was most certainly not the way I had anticipated spending the hours prior to starting the transplants, there was, of course, no declining his offer. I



couldn't help thinking of the ironic juxtaposition of talking about losing one patient just prior to performing two lifesaving lung transplants, with the cycle of life and death playing out in real time. I was able to stay with D on the porch as the sun began to rise and until S's son arrived, while, though sad, was moving and uplifting, as all in the family were effusive in thanking me for our having given the matriarch of their clan "a chance."

About a month after S's death, D knocked on our door. He was carrying a painting of our house, which one of his wife's cousins had painted and which had hung in their house for years. D told us that he was sure that his wife would have wanted us to have it. We gratefully accepted his gift.

Some years later, I received an unexpected call from our neurological intensive care unit. They were calling, at the request of D's family, to ask me to come up and meet with them because D had suffered a devastating neurological event. I asked why they wanted me to meet with them, and their answer surprised me. They said that they were sure that D trusted me to help make decisions about his care as much as anyone in his extended family. I had to surmise that D had felt that I had treated him and his wife like the family that they claimed we had become to them. I, of course, honored that request, and while it turned out that the clinical situation was fairly straightforward, D's somewhat distant family assured me that they did not want to make the necessary end of life decisions without my input, which they said they were certain that he would have trusted.

I recall this poignant story as an example of how the old admonition that physicians should not become too close to their patients is not always an accurate one and may, under certain circumstances, not even be feasible. To have declined the family's insistence that I be S's surgeon would not have been acceptable to them. I do not think that I, or anyone on my team, treated her or her family any differently than any other similar patient. And, I believe that the family felt that I had cared for her, and her family, just as they had expected. In summary, while the admonition that surgeons should not operate on their own family members is a good one, sometimes you just cannot decline a family's request that you accept their insistence that you perform that operation for them or for a family member.

As time went on, I do recall these events with a sense that I and my team had done our best with the cards we were dealt and with a sense that the family would not have had it any other way.

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

—Maya Angelou

SUMMARY

One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.
—Francis Peabody, 1927

As I have noted, there are thoughtful physicians who have suggested that one may have to temper their connection with their patients (and their patients' families) to maintain objectivity. While there is surely some truth to this admonition, finding the 'just right' balance of caring and objectivity can be challenging.

I suppose I was taught, in the 'hidden curriculum' to which we are all exposed, especially when we are younger, that I should at least temper my connections with my patients for two main reasons:

- I wouldn't be as objective about their care as would be optimal
- I would likely be unable to practice long and hard in a challenging, difficult discipline because I would be burdened, maybe even debilitated, by the inevitable sad outcomes that everyone in medicine, especially those working in areas of high complexity and risk, must deal with, one way or another, from time to time.

I do not believe that remaining aloof is the right approach, at least not for me. I can be objective 'in the moment' when steely resolve is necessary. But, I can experience, and manage, the sadness and grief of an outcome that was not what anyone wanted, regardless of whether the outcome might have seemed (or, later, been deemed) inevitable or whether I suspect that I would find, later, upon review, things that might have been done differently... [Tribble, Practical Minded Obsession]

Sometimes these memories affect me emotionally. Sometimes they guide and benefit me. Over time I have learned to live and practice with these memories.

—Robert Johnstone, 2021

In summary, I eventually came to realize that the advice to remain detached was incorrect, at least for me. However, I will admit that my own understanding of these issues and my strategies for dealing with them evolved significantly over time, with significant help from many mentors, including my medical mentors, as well as my patients and their families. To put this differently, I have learned that lending an ear can be as important as lending a hand. [I Call That A Bargain]

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