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NEW YORK CITY MARATHON

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## Surgical lifestyles

# Discovering life's "chapter two" after surgery

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Over the past 12 months, I have received two calls from surgical colleagues who had suffered major myocardial events that altered both their professional and private lives. One had to retire from practice and the other worries every day that any pain he feels is related to his heart and then to his demise.

With these two phone calls, I thought back to my own experience. I had open-heart surgery on July 17, 2002, after developing severe angina when running toward Central Park while training for a New York City marathon. An angiogram showed that I needed a quadruple bypass and the hardest decision for a surgeon to make is whether to have major surgery, especially knowing how complicated it can be, as surgical complications are always reviewed weekly for medical students, residents, and faculty alike.

At my hospital, the morbidity and mortality conference is held on Wednesday mornings. As chief of surgery, one of my most cherished duties is to preside over the conference, which dissects the complications and operative misadventures of the previous week. The conference has always been billed as one that gives surgeons hope so they can learn from the mistakes of their peers; but this conference also helps surgeons gain knowledge of their own limitations and an awareness of imperfections that come with failures big and small in the operating room. It is sometimes a sobering experience when otherwise healthy patients, because of chance, have had a bad outcome. It is a weekly reality check.

Left: Dr. Wallack running the 2004 New York City Marathon.

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With full knowledge of the almost infinite possibilities for failure, I gave consent for the intubation, incision, and invasion of my chest cavity to accomplish the one goal, which was to repair the “blocked coronaries” and allow me to survive. Speaking volumes about the confidence in the people who were brought together as a team, I gave permission for these men and women to hold my heart in their hands and gave up my control. Obviously, this is not easy for surgeons to do. We know too much. Just as at the weekly morbidity and mortality conference where I gently exposed the fallibility of the surgeons in my department, on the morning of the surgery I would expose my own humanity, frailty, and devout trust to those with whom I worked. I clearly understood all the risks but for the present time, the time of the surgery, there could be only one priority and that was to heal and then survive.

### ***Surgery from another perspective***

As I was rolled down the familiar halls of the operating rooms toward the cardiac suite, my mind was filled with the heavy weight of 19 years worth of memories of those conferences and the element of chance that creeps into all human endeavors. A swirl of facts and dull reminiscences came to light from years of being the operating surgeon in these same rooms. Moreover, the most incredible thought that occurred to me was that my surgeon was someone whom I had actively recruited to perform this procedure—but I had not intended for it to be performed on me.

Like some battles in war, battles in surgery are fought in tight places with fine, precise weapons. Sometimes there is no cavalry to call in times of overwhelming trouble. Not everything ends in typical Hollywood style, with the correctly colored wire on the bomb, about to detonate, cut with just one second to spare. Sometimes the good guys lose. I have seen it so many times in my own general surgery and oncology practice. I hoped and even prayed that this was not such a time. I did not want to be presented at the next morbidity and mortality conference, and I wanted to be an inspiration for my colleagues to show that there can be a “chapter two.”

I entered the cardiac operating room and it was here—in this cold, Spartan room with people who knew and understood the concept of the morbid-

ity and mortality conference—that I was forced to give up control of my future, my vitality, and perhaps my very life. If all went well, I would be represented by a number next week in the department statistics; if it didn’t go well, there would be no more than two pages describing the misadventure played out of the peculiar stage of thoracic and cardiac anatomy, which had ended either in a complication or, worse yet, a death—my death. These thoughts came to an abrupt end with the taunted amnesic properties of sedating drugs, merciful intubation, and intravenous paralytics.

### ***Awakening***

The awareness that comes with awakening from anesthesia is gradual, fuzzy, and surreal. I only imagined I would be in the cardiac intensive care unit moments before I was discharged to the floor, but I had been there for 12 hours. Most importantly, I did not remember being intubated. I saw my wife’s face and could see the love and the tremendous passion she had for wanting to help me to survive. My children’s eyes were wide open and they did not need to say a word, but I knew that, despite having spent many long hours away from them at many different hospitals in my lifetime as a surgeon, they loved me and wanted me to be in their lives.

I spent three days in the hospital and was discharged on the third postoperative day. Being a surgeon did not help because I knew too much and was constantly worried even at home about potential complications. But as the time passed, despite the success of the surgery, it became apparent that what was left behind, like the uncounted sponge, was a sense of impending doom, a foreboding of the immediate personal mortality that comes with a near miss. Even if cardiac surgery leaves a person alive, it is a near miss.

### ***Surviving a near-miss***

I am sure that sense of mortality is what my two surgical colleagues were feeling when I talked to them about their myocardial conditions. In the same way that a near-miss car accident might cause a person to drive more slowly, the memory of a near-death experience forces a reinvention of one’s life, a close examination of life passed and missed opportunities. The potential for future missed opportunities of similar magnitude, real

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or imagined, lead to an anxiety-depression that does cast a pall over every second of every day that follows the intervention. One might think, “There has to be a way to sort out the whole thing.” The passing of time to allow for mourning is only part of it.

There are battles that can be won with physical prowess, those that can be won with strategy and tactic, and those that can’t be won alone. The sternal wound was healed in weeks. The leg wound was healed in a month. But three years later, the other wounds still continue to heal. How does one overcome the fears and suspicions about the future, tunneling just under the surface? How does one, given past failures, which now seem so irrelevant, navigate the road that lay ahead? Just as the anatomic lesion blocking oxygen delivery distally to a consummate professional to bypass, the psychic lesion was amenable only to a similar, yet disparate professional—a point that all surgeons in distress must understand. However, I knew that, for the most part, there is no room in the collective wisdom of the American success story for weakness, especially weakness of mind.

If a person is to be successful, he or she must be strong. Yet, when that person is abruptly taken by a devastating event, part of the coping mechanism is systemic distress, and that can only be overcome with the help from loved ones and professionals. Surgeons, as a rule, don’t like to consult other professionals, but in my opinion, a life-altering event dictates such circumstances.

### ***Ways of healing***

If one issue had strengthened for me since the incision, sternal sawing, and vein harvest, it was the conviction that no one is alone. No army commander would go into battle against overwhelming odds without backup. No one intentionally goes into harm’s way alone. Those who go willingly, go with their teams of trusted associates at their side, protecting them and moving them toward the common goals. In my case, it was my wife, my mother, my children, my brother, select friends and colleagues, certain professionals, and a higher being who formed that small platoon to help me fight and claim chapter two of my life.

Sometimes the ways of healing are not explained in surgical texts, are not accounted for in the body

of knowledge that we lovingly and carefully pass to those eager to follow in our footsteps. Sometimes the truths are deeper and veiled and cannot be dissected like the saphenous vein. In those cases, the lingering effects of disease are not manifested in decreased, bursting strength; reduced exercise tolerance; and reaccumulating extraluminal foam cells. Long after those complex biochemical properties have been successfully modified, the real lingering effects are located in a different part of the anatomy. These effects—such as fear of the possibility of those chaotic and intricate variables once again coalescing in clinical disease; the pain that the incision on one’s chest caused in another person; or the blame leveled even at oneself for having become ill, causing a person to doubt his or her previous lifestyle choices—are so unacceptably slow to improve. Without attention to these issues, too, there is no meaningful survival and these questions provide the foundation for survival in chapter two.

The selflessness that we regard so highly in our fellow surgeons is what separates those practitioners who should not be in surgery from the practitioners who should. But that laudable characteristic of self-sacrifice is a weapon with two edges. If a similar value were placed on the wisdom necessary to balance one’s life, our successors might learn from our mistakes the way we expect them to learn from our complications. In the weekly conferences, our colleagues might ask for help of all kinds before the fates deal them an unwinnable hand.

I would like to break the cycle of what we could call “altruistic self-destruction” that we as surgeons enter into with pride and that we try to instill and sometimes inflict on those who seek to join us. This approach is not a softening of our mental outlook on ourselves but a “shoring up” of these cracks in the bulwark. In the 21st century, there can be left no room in the American construct for willful blindness from trouble. For me, the new paradigm was to adjust my life to the workplace so I could live and continue to work. For me, it meant to live more with ease, eat well, rest, enjoy family, exercise, get proper medical care, listen to my body, and shut out those who didn’t understand my experience and could not relate to it. It may not be a path for success, but it should allow a person to live.

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### ***Choosing and facing a new challenge***

One of the most important parts of my rebirth took place just two weeks after my open-heart surgery when, at home, I read Lance Armstrong's book, *It Is Not About the Bike*. I knew then what I had to do to prove to myself that I was ready to engage in life again, that I was not to be a victim, and that I would return to perform my job and be involved with my family and friends. How does one return from such devastation? Can there truly be a second chapter? What scale of victory can possibly overcome such a fantastic and devastating defeat?

For me, my illness was "not about the marathon." I had run in four New York marathons and numerous shorter road races to "maintain my health" and "keep my vessels open" before my surgery. Therefore, the pinnacle of my ability to control my own destiny lay in 26.2 miles of concrete and steel bridges, aged in the lore of those who completed such races before, and wizened with the sweat and blood of countless generations of those who yearly seek to memorialize an ancient sea battle with a personal triumph. Before this, the marathon was a simple milestone. It was an achievement, make no mistake, that confirmed membership in an elite fraternity that counted those who had sustained a personal victory over adversity and physical and mental limitations; it was proof-positive that the human body was capable of extraordinary feats if the mind so allowed it.

But in 2004, the marathon had the power to be more than just that hallowed parade of those out to test mind and body. It was more than a roll call of heroes, in a traditional Greek tragic sense, in which I again sought membership. In 2004, two years after my surgery, running the marathon marked my return from the dead and indicated that I had reclaimed my life. It was a return from the darkness to the light. The realization was that life could continue, that youth might be regained, and that possibly I had dodged a rather lethal bullet. Gone was the deadly fear of death, of living life unfinished, of bargaining for one more day. Gone were the haunting thoughts of personal and professional frailties, and along with the physical and mental victory, the operating room became comfortable again. Shrinking into the background against the Verrazano Bridge on Staten Island

were the thoughts that my life and career would be a tragic footnote in a greater story, which had as its centerpiece something else. The whole affair was starting to look like a speed bump and not a dead end.

The personal journey, which started my career now spanning to four decades, is turning to a new chapter. I believe what I learned, though personal, is important for the discipline of surgery as a whole. If others, as my two colleagues whose major myocardial events prompted me to write this article, can grasp an understanding of what this experience was like for me, perhaps my hard-fought lessons will be of some use other than just an inspirational story of "man runs marathon after heart surgery" on page 16 of the newspaper. Maybe it will cause others to move to chapter two with assuredness so involvement in our careers and in our life can be sustained and maintained. Ω

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Dr. Wallack encourages surgeons to send their comments regarding this article via e-mail to [itsthesarg@aol.com](mailto:itsthesarg@aol.com).

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