

RAS

From residency to clinical ownership:

Reflections of a young thoracic surgeon

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Editor's note: *The following is the first of an ongoing series of articles written by members of the Resident and Associate Society of the American College of Surgeons (RAS-ACS). The series will provide a forum for the concerns and needs of residents and young surgeons in all surgical specialties.*

Upon embarking on my thoracic surgery career, I never thought that I would have innumerable sleepless nights until my friend and former attending said to me, "The problem with you guys is that you have no ownership of the patients." By "you guys," he meant the cardiothoracic surgery residents. At the time, I resented the comment. What did he mean by saying I had no ownership of my patients? After all, I had participated substantially in their operative care. Worse yet, who was the guy getting called at all hours of the night with patient updates ranging from the annoying to the troubling? Me! That's who. I took care of my patients.

It was not until I started as an attending thoracic surgeon in January 2007 that I began to fully understand the meaning behind the earlier admonition. I have learned that true ownership occurs at a much earlier phase than following an operation or procedure: It occurs from the moment I meet the patients and their families. (In actuality, the patients'

trust in me begins with the trust placed in me by the referring physicians.) The relationship that ultimately evolves brings with it a tremendous responsibility, and that responsibility starts to become truly evident when individually tailoring the best operative strategy within the context of the patient's clinical situation. The feeling of ownership is cemented before making any incision, simply by noticing my name on the patient's hospital identification card.

The surgical procedure itself is frequently the most familiar and relaxing part of the patient's care. I just do what I was trained to do. A healthy obsession for the postoperative well-being of my patient ensues almost immediately after the skin is closed. That obsession begins with wondering if I "did enough," and then it progresses to doing everything in my power to make sure my patient will do well. Fortunately, thus far, my patients have experienced an unremarkable postoperative course and, following discharge, despite their release from the inpatient setting, "out of sight, out of mind" is hardly the case. It is through the cumulative effect of these experiences that I truly understand what "ownership" means. The funny thing about this situation is that I would not want it any other way. I enjoy guiding my patients safely through their surgical journey.

My job satisfaction has evolved from the fact that I believe I was trained in a fundamentally sound manner. Of course, when I was in training, I had neither the insight nor the mind-set to ap-

preciate this fact. I remember one case in which I was the “first assist” on a redo sternotomy for an aortic valve and coronary artery bypass procedure. Standing on the left side of the table, I remember thinking, “This stinks. When am I going to get to do the operation?” The attending surgeon was a seasoned professional, but in the back of my mind, I was also thinking, “Isn’t he experienced enough to get me out of trouble if I were to get into it?” Little did I know that by doing the case himself, he was keeping me out of trouble.

I was too inexperienced at the time to realize that a redo sternotomy is a procedure that even a veteran cardiothoracic surgeon approaches with caution. As expected, the case was a difficult one. We got into torrential bleeding on the approach as a result of a vein graft that had crossed the midline. I remember thinking that we—especially the patient—were in a precarious situation. I was surprised (and happy) to see how the veteran surgeon calmly told our perfusionists that we were going on “pump sucker bypass.” After the turbulent takeoff, we settled into a pleasant cruising altitude, performed the operation, and ultimately landed the plane safely. The patient suffered no ill effects, and he was discharged following the usual postoperative course.

I walked out of the operating room that day, impressed by two things. The first thing that impressed me was that quick thinking and action by the surgeon orchestrating the operating room team (including surgical assistants, anesthesiologist, perfusionists, and nursing staff) literally saved a life. What I saw that day was truly a command performance. I was also impressed by the fact that I could learn so much by watching those who have gone before me. This concept was reinforced for me while preparing for my oral thoracic board examination—I easily answered a question about a hypothetical situation in which I encountered “horrific bleeding during a redo sternotomy.” That hypothetical question—like this one in which I was more intimately involved—brought me closer to understanding what ownership is really about.

My relatively new career as a general thoracic surgeon is exciting. I wish I could better pinpoint why I love what I do, but I can’t decide what it

is, except to say that cardiothoracic surgery is a great field. You take patients at death’s door and give them a second chance at life. The people who say that this current era is the worst time to begin a career in cardiothoracic surgery are absolutely incorrect. History has repeatedly demonstrated that the creative, resourceful, and successful individual can find new avenues when other roads are closed. Cardiothoracic surgery has tremendous opportunities in areas within the cardiac and thoracic disciplines.

I can tell you that if you choose a career in cardiothoracic surgery, you will be rewarded by having an opportunity to form wonderful relationships with your patients and to learn from some of the most talented and thoughtful physicians you will ever meet. I suppose you can also look forward to some sleepless nights, too, but to me, that is a price of ownership worth paying! [Q](#)

For additional information regarding the activities and benefits of the RAS-ACS, please contact Peg Haar, Administrator, Division of Member Services, 633 N. Saint Clair St., Chicago, IL 60611-3211; phone 312/202-5312; fax 312/202-5007; e-mail phaar@facs.org.

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