

# The Rural Surgeon and Ivory Towers

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It is snowing again. At 2 a.m., I get a call from the ER doctor: “I have a middle-aged man who just came in with a blood pressure of 40 and abdominal pain. Earlier today he had an elective computerized tomography (CT) (in a nearby town) which showed an 8-cm solid mass in the right lobe of the liver...his pain started a few hours later...I need your help.”

I put on my scrubs and jump into the pickup. In my mind I already see the liver adenoma or carcinoma, bleeding into the peritoneal cavity, and I know I will have to operate. I find the patient pale and sweating; his abdomen is distended and tender. The ultrasound technician is already scanning him: “lots of free fluid”...now, after a liter of Ringer’s Lactate his systolic pressure is 70. I tell the nurses “Get the OR team ready; we will have to open and pack and then ship to the University...get the chopper standby...and let me talk with the surgeon on call at the University...”.

A year ago, after many years of practice in urbane teaching hospitals, I arrived in this small rural hospital. Here, one of the many new skills I had to acquire was how to deal with the “Ivory Towers”. I had to change sides—from the receiving end to the referring one. And this proved to be rather distressing.

The University surgeon is on the line—a polite Mid-Western accent: “Yes? Doctor Jones speaking, I am the chief resident on call.”

I explain to him the situation.

“Well, let me talk first to my attending...I will call back with his decision and instructions...”, the resident says.

“My dear friend,” I say, “I am not calling you for instructions but to tell you that I am taking him to the OR, to achieve hemostasis and then I will ship him to you by chopper...”.

Silence. And then “How do you know that you will be able to stop the bleeding?”

“And how do you know that you will be able to stop it”, I reply. This resident is talking to me as if I were his resident. “I am going to pack, do you understand? Do you know the term...damage control?”

“Yes, I know what damage control is...let me talk with my attending...”. He hangs up, sounding insulted.

I look up and see that our OR girls arrived from home, standing against the wall, ready to take the patient to the OR. The ER physician reports: “BP 90...he is responding to fluids...”.

The phone rings, it is the nervous chief resident from the University: “My attending wants you to fly him immediately to us...it is only a 20-minute ...”.

Now they tell me what to do...

I look at the monitor at the nursing station: BP is 95... “Slow down the fluids...keep his BP at 90”, I tell the nurses...“How soon can we get the chopper?” To the University resident I say: “Please hold.”

Our nurse is on the other line with the chopper: “They are getting a weather report...they will call back in 5 minutes...”. I signal to the OR nurses to wait and go back to the patient. Ten minutes ago I have told the family that he is bleeding to death and that I will have to operate...and now I have to tell them that I am changing my mind...and what if he dies during the flight or on arrival...or what if he exanguinates once I open him and release the tamponade? The patient looks “happier” and is responsive; his pulse is slower and full.

“Doc, the chopper can be here in 10 minutes,” announces the nurse. OK, let us gamble: “Great. Bring in the chopper...”.

I pick up the phone to the University: “Are you still there? He has become stable and we are shipping him to you now.”

The chief resident sounds satisfied: "Good decision, we have angiography, you know, we can embolize him...". Of course, of course, but if he arrives dead...

I tell the OR girls to go home but they know better: "Doc, we better wait, fog is gathering...let us see whether they can land...".

The chopper arrives 30 minutes later and I drive home. As I undress in the darkness I hear my wife breathing heavily in her sleep and the chopper passing above us headed north towards the city.

I know that the patient landed safely on the other side...but typically—despite repeated enquiries, I was not able to learn how he was subsequently managed. Ivory Towers crave for our patients but are careless in providing follow-up and feedback.

Examples are abundant: like the obstructed, Type III paraesophageal hernia I shipped to cardiothoracic surgery in one of the University Hospitals around us. A day later I call the surgeon but was referred to his nurse practitioner. I ask for operative details. "It is in the mail," I am told. Two weeks later arrives the computer-generated printout: diagnosis, type of procedures—you have to spend long minutes to locate the dates of service at the bottom of the page. I e-mail the thoracic surgeon: "could you please send me a copy of the operative report—I want to learn from what you did."

"Of course," he promises, but the report never arrives.

Another perception among rural surgeons—and not only surgeons—is that the Ivory Towers "steal" patients away from us. You refer a patient with carcinoma of the breast to the University for a pre-operative oncologic consult and the lady ends being seen by their breast surgeon. What happens then is predictable—you will never see this patient again.

And while Ivory Tower doctors tend to ignore us, we cannot ignore them. When they discharge patients after the operation—sometimes too early—back to the community, we occasionally are presented with their complications. We have then to manage these complications with constant consultations with the Ivory Tower doctors for if something would turn wrong, we would be blamed for the poor outcome—not the operating surgeons.

That such breakdown in communication between rural and tertiary care centers is endemic is evident to me

from discussions with rural surgeons across the country. Not only do most of those who practice in academia not understand what it means to provide patient care in a small rural hospital, but also many of them—who receive referrals and patients from the surrounding communities—do not bother to familiarize themselves with the referring hospitals and their doctors.

Ivory doctors surely understand that by accepting our patients they are not doing us a favor; instead they are doing favor to the patients and to themselves. Indeed, their hospitals' administrators cherish the additional admissions which are also of value to their residents' case load—not to mention the additional income generated by the surgeons themselves. So why that arrogant attitude and the failure to communicate? Why not pick up the phone and call the referring surgeon: "thanks for the referral—your patient did well." Why leave us in darkness—often for many days—until the crumpled summary arrives in the mail. Why not do at least what the gastroenterologist, to whom I refer patients needing endoscopic retrograde cholangiopancreatography (ERCP), does: he immediately faxes to me his ERCP reports. But, then, he is a rare exception.

Ivory tower surgeons—I hope a few of them will be reading this—should understand that at least some of the rural surgeons are quite well-educated and capable. That they need to refer, or want to refer, does not always mean that they do not know what to do, or that they can not do it; to the contrary, it generally means they lack the facilities or backup to do that which they know should or has to be done. And sometimes, even if they could do the case, they refer because they simply cannot take the risk when the probability of complications is high. For those of us who practice in small communities, even one major complication may be too much for one's reputation, while complications in a big center or town are easily "diluted". Moreover, the common perception is that mortalities after an operation in a rural hospital are because "of the inexperienced surgeon or poor care", while if the patient dies in the Ivory Tower, then he dies despite "the best efforts of the excellent doctors in the great hospital."

It is difficult to eradicate such deep-rooted perceptions, but better communication between the "receiving" Ivory Tower surgeons and the "referring" rural surgeons is possible. Or is it?