

## Medicine Versus Surgery

By Khanjan Shah

“This is surgery,” he said on the phone. I imagine a faceless man clothed in scrubs elbow-deep in intestines and bile. “I have a consult for you,” I replied banally. “The patient is a middle-aged male, he is located on ward 4A, and the question is management of acute cholecystitis.” This sentence flowed flawlessly; full of confidence after a year of well rehearsed consults. “I think he may be more appropriate on the surgical service,” I quickly continued. “We will see the patient, but his medical problems will be better managed on the medical service,” the nameless voice replied curtly prior to vanishing.

Many hours passed as the middle-aged man with surgical disease remained on ward 4A. I quietly surveyed his “medical problems:” insulin-dependent diabetes mellitus, hypertension, dyslipidemia, obesity, probable obstructive sleep apnea, etc. This list seemed quite ordinary to me; to be quite honest, I am now more surprised when patients have lesser than ten medical problems rather than greater. My brilliant medical management strategy was to continue his home medications at his home dosages and frequencies. Essentially, he was no more “challenging” medically on ward 4A than he was at home. The only difference is that he had developed acute gallstone cholecystitis in the interim.

In the evening, I checked the medical record for some semblance of a surgical plan. No such luck. I became infinitely more exasperated and thus decided to ask the patient if the surgeons had evaluated him. What I found was both profoundly revealing and unfortunately routine: my patient informed me he was to have surgery in the morning, he needed to be “NPO” at midnight, and he needed me to order some sort of antibiotics for the morning. In short, my middle-aged patient had just supplied the surgery team’s recommendations to his primary medical team.

From the dawn of our medical career, we are invited to participate in the age-old rivalry between medicine and surgery. “You do not have the personality of a surgeon,” a pediatric resident once told me, “you are too nice.” Several clerkships later, a general surgery resident said, “I could never be an internist. I need to be a doer.” This antagonism reaches its climax during residency, as medicine residents often feel like they are merely “babysitting” surgical patients. Conversely, surgical residents feel overwhelmed by the sheer volume of consultations generated by medicine.

In the midst of this battle, we often forget our primary responsibility: our patient. In this particular case, my patient was not just a middle-aged male with acute cholecystitis like I had lackadaisically implied. Rather, he was a father and husband, a building manager and part-time soccer coach, a pizza connoisseur and amateur rock star whose life was severely limited

by his abdominal pain. He was a man with limited knowledge on the cause of his suffering who was requesting our medical expertise. He knew nothing of my current battle with the surgical team, knew nothing of the age-old rivalry between our services. To him, we were all one service: the group of physicians who would cease his ailment.

I resurveyed his “medical problems” with a tabula rasa and realized potential for improvement. His glycemic control was suboptimal, his obesity was not addressed at recent outpatient appointments, and his “probable” sleep apnea needed to be objectively diagnosed. I spent the next half hour optimizing his medical regimen and ordering necessary outpatient testing rather than brooding over my battle.

As physicians, we have a responsibility to our patients to provide the highest quality and most effective care. And because medicine as a field is so vast, we are dependent on various specialties to improve our knowledge of certain pathologies through expert consultation. In the grueling realm of residency, patients sometimes become placeholders on an ever-enlarging list, a constant source of paperwork and nursing pages. But we must continuously remind ourselves that our patients see us – internists and surgeons alike – as their potential healers.

For our patients, we, too, must begin to see each other in the same group. We must dissolve our rivalry, clear our battlefield, and open our minds to improved inter-service communication. We must know each other by name and not by service or level, discuss our patients in person and not by anonymous phone calls and text pages, and blissfully own our patients instead of demanding transfers.

I visited the surgical team room that night to confirm the recommendations supplied by my patient. There sat surgery, more weary than my imagined illusion. He apologized for not calling earlier or leaving a timely note; I apologized for impulsively requesting a transfer. We discussed the timing of surgery, need for preoperative antibiotics, and optimization of chronic medical conditions.

I called many more surgical consults that month and whenever possible discussed each patient directly. And each time I would feel a wave of frustration (and thus begin preparing for battle), I would remember our patient on ward 4A - the amateur rock star discharged two days postoperatively cured of his disease.

To him, there was no medicine versus surgery. To him, there is simply medicine *and* surgery, together his healers.

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