The Most Important Lesson I've Learned This Year
The Under Utilization of a Non-Operative Approach (And Why We Can Forgive But Not Forget It)

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As I entered my chief year, I could nearly feel myself salivating at the prospect of finally having unhindered access to the "best" cases my attendings performed. After four years of enviously watching my more senior residents scrub in to, and over time take the lead on, cystectomies, central endophytic partial nephrectomies, bilateral staghorn PCNLs, and redo-redo urethroplasties, I was eager to have the opportunity to test my own surgical skills. I envisioned, through rose-colored glasses, a chief year where each case, despite its challenges, would come to some satisfactory conclusion, with me becoming a better surgeon for having participated in it.

Reality, as it usually does, turned out to be significantly less idealistic. I watched, first with shock, then horror, then dread, as we brought octogenarians, rife with life-threatening multi-system comorbidities, onto the operating table. I watched my patients aspirate on intubation – and then watched the fortunate ones slowly and painfully recover over weeks in the ICU. I watched my patients bleed postoperatively, sharing their family's fear as their multi-stented hearts strained with each precipitous drop in hemoglobin. I watched my patients eviscerate, ultimately shocked that their paper-thin fascia managed to hold together as long as it did over their super-morbidly obese abdomens.

I initially dealt with the dissonance between having a skill set to help these patients and the dawning realization that the solution to their "surgical problem" might hasten their demise in an internal, passive manner. Introspection turned to action the day we nearly operated on a highly comorbid nonagenarian with such severe dementia that she wavered in her desire to have surgery for a small renal mass all the way to the operating room. I am grateful to my anesthesia colleagues for their support of my verbal acknowledgement of the thought we all were having – in this situation, surgery is not the solution this woman needs.

I was angry initially; I felt that I, along with the patients, had been betrayed by those whom I entrusted to teach me, and whom they entrusted with their bodies and their lives. Those feelings softened over time, and I even dared to play devil's advocate with myself. I have been in clinic with these same archetypal patients – I have seen the fear in their eyes as we reviewed a CT scan and I explained that most likely, their renal lesion is cancer. I have heard the willpower in their voice, and believed them wholeheartedly, as they swore they would do whatever it took during the recovery process, so long as we gave them a chance for a cure or a life not riddled with infection or pain. I too hear that internal voice that says, "You trained for this."

I recently ran into a non-urologic surgeon I worked with during my intern year, who was often teased by her residents for "loving a good non-operative management." In my early years, I thought this statement was meant as ridicule, and perhaps to some it was. Looking back on the experiences of this past year, I now see the wisdom in her restraint. It is the more difficult path to tell certain patients that you choose to not operate on them; more difficult still is the requisite detailed discussion of why. We are fortunate as urologists to have clinical data to support selective active surveillance in two of our most commonly treated cancers. We benefit from having the option of nonsurgical ablative therapies

that are often far less invasive and risky in a population rife with comorbidities, albeit at slightly lower efficacy rates. As medicine continuously improves, our patients will continue to live longer and live through previously fatal conditions, rendering some of them ever more “risky” surgical candidates. We will always be a specialty that “cuts for stone,” amongst other things – may we be granted the wisdom to do so judiciously.