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GUEST EDITOR'S PAGE

Lessons Learned

Are There New-School Methods for Teaching Old-School Values?

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With another academic year coming to a close, it is soon time to say goodbye to the graduating fellows. It is at times like this when I wonder whether I have taught the fellows the truly important lessons in decision making. For sure, the 40th anniversary celebrations of Dr. Gruentzig's first percutaneous transluminal coronary angioplasty (PTCA) prompted me to look back on my interventional cardiology career, a career spanning 38 years, and ask myself, what were the most important lessons I learned?—a seemingly difficult question, considering the multitude of advances and innovations that have occurred. Surprisingly, I keep coming back to a single truth. The most important thing I learned was when to say "no."

My clearest memories of seeing this lesson in action came from 2 giants in the field, Drs. John Simpson and Richard Schatz. I was present in the audience of a hundred plus eager want-to-be interventionalists in the early 1980s, at one of Dr. Simpson's first PTCA live demonstration courses. Every one of us was keen to learn how to perform coronary angioplasty from this trail-blazing innovator. We paid rapt attention to the cases performed and dreamed of offering this revolutionary therapy to our patients. But of the several cases performed that day, I only remember 1. It was a successful PTCA of a proximal left anterior descending artery. The lesion responded nicely to the balloon dilation, but as Dr. Simpson reviewed the post-procedure angiogram, he was not satisfied with the result. He and the moderator in the meeting room discussed his concerns in real time from the catheterization laboratory; he was not sure the final result was good enough. To everyone in the room, myself included, it certainly appeared to be adequate, but Dr. Simpson instead decided he had an outstanding heart surgeon available to provide a better result for this patient and proceeded to send him for coronary artery bypass surgery. The attendees were aghast. There was no emergency. There was no clinical problem. Where did Dr. Simpson find the courage, in the midst of all the enthusiasm for PTCA, to decide to do the "right" thing for this patient?

In retrospect, I do not know whether surgery was the right thing for that patient, but I have thought about his decision for more than 30 years. What Dr. Simpson taught me was that every day, for every procedure, I must do what is best for my patient, not what is best for me or my program. It made a lasting impression, and I deeply admire him for his courage to do what he thought was best for his patient and not make compromises to impress others.

More than 10 years later, I sat in an audience at an early Transcatheter Therapeutics course watching Dr. Richard Schatz demonstrate a new procedure, the use of a coronary stent. An audience of several hundred experienced interventionalists watched in great anticipation of a new technology that would greatly empower them to more safely perform angioplasty on increasingly complex patients. Dr. Schatz was in the catheterization laboratory, attempting to sequentially engage multiple guide catheters in the left coronary ostium in preparation for the stent delivery. One after another, the guide catheters failed the "push test" designed to confirm the stable platform necessary to deliver the bulky stent. Each attempt failed. Virtually everyone in the audience felt they had the skills necessary to engage that guide catheter and were anxious for Dr. Schatz to get on with this exciting procedure. But, after satisfying himself that none of the guide catheters met his criteria for safe stent delivery, he abandoned the procedure. The disappointment in the room was palpable. Where did he find the courage and discipline to prioritize the safety of his

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patient over the expectations of his peers in the audience? Perhaps he could have delivered the stent with a guiding catheter; we will never know. What was confirmed, again, for me that day was that the responsibility for the patient's well-being resides with the operator, the patient's doctor, not the crowd. Despite all the expectations and pressure to demonstrate this exciting procedure, he had the courage and conviction to say "not this time." This experience reinforced the lesson from Dr. Simpson's course that, despite outside pressure and influences, decisions made in the catheterization laboratory need to focus on the patient, not on any competing priorities.

In the current practice of medicine, many of us lament changes in how physicians are trained, the impact of limited work hours and other compromises we are forced to make in the training environment, and we perhaps wonder whether these young physicians have the same commitment to patient care as we did a generation ago? It is a fair question and requires we be honest about whether it is even feasible in the current era to use "old school" methods to prepare today's doctors for clinical practice. I think not.

Nonetheless, what must never change is the awareness of our responsibility to provide the very best care for our individual patients. For me, teaching trainees when to say "no" is critical to their education. They must learn that it is their responsibility to abandon an intended procedure or treatment plan when the best interests of their patients demand it. The courage and discipline to prioritize the patient's well-being over all else, in the face of competing interests, continues to be the most important lesson that I have learned.

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