

THE CASE I CAN'T FORGET

## If You Catch the Ball, We Win the Game. If You Drop It, We Lose

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As a transplant surgeon at California Pacific Medical Center in San Francisco, I cannot forget those cases where I faced forks in the road and had to decide whether the right direction lay in the well-charted direction of objective metrics or immeasurable feelings of intuition. I carry those cases with me still.

The decisionmaking process in transplant surgery starts with the selection committee, whose role is to determine whether to move forward with allocating a life-saving organ to a patient. This round table is a melting pot of different healthcare providers' expertise all coming together to try to make the right decision; and, on the top of everyone's mind is their fiduciary duty to give the patient a fair, objective shot at receiving an organ.

There is an additional fiduciary duty to the donor's family. Families have a right to know that the organ of their loved one will be placed in an environment to give the optimum chance for success and that the recipient will assume responsible care of it. For these reasons, as part of the selection process, members of the committee will raise questions from their professional perspectives. Social workers will look for compliance issues. If the problem is liver disease, certain disease entities need to address prior addictions; and the risk of recidivism. The hepatologist may report on the rate of recurrence of a former cancer. The dietician might confirm that the patient follows a nutritional eating plan. Evidence is also needed to show that the patient has the means to pay for monthly immunosuppression.

After the collective comments from around the table, there is a vote to determine whether this patient is going to be placed on the transplant list; and, if so, in what category. The list assignments are made according to the principle that the sickest patients are first in line for organ allocations. If listed as "active," the patient can be called in for transplantation at any time. If placed on "inactive" status, the patient is listed but not currently eligible.

It should be noted that, although selection committee deliberations are a common process among transplant centers, different criteria may have evolved within various institutions. If a patient is turned down by one committee, according to the United Network for Organ Sharing (UNOS) guidelines, they will be provided with a letter letting them know there are other centers where they may want to seek another opinion.

Decisions of the selection committee had always worked very well for me. Their prudent and carefully considered conclusions are a safe beacon of decisionmaking—and then I met Brian.<sup>1</sup> In medicine, there are those "AH HA" moments that shift the axis, after which nothing is quite the same. When Brian came in, he was about my age, he had been diagnosed with Hepatitis C years ago; and at that time, there was no cure. In an attempt to clear the virus, he had been enrolled in research trials; but they had not been successful. His disease had progressed to cirrhosis with complications stemming from portal hypertension causing him to retain fluid. He had encephalopathy and thus problems with concentration and memory.

The first fork in the road was when we took Brian's case to the selection committee with the "yes" or "no" question of whether he would be given a place on the transplant list. Despite the seriousness of his situation, Brian was otherwise reasonably healthy; and although the answer was "yes" to a place on the list, the committee deemed him "too healthy" to meet the "active" criteria and he was instead listed as "inactive."

Then, for reasons that in retrospect are hard to determine, perhaps an infection, Brian came into the intensive care unit (ICU) severely encephalopathic to the degree that he was essentially comatose. His pupils were almost fixed; and the situation was so dire that after he was put on a breathing machine, it was difficult to even tell if he was alive or brain dead.

In addition to our professional relationship, Brian and I connected on a personal level due to our mutual interest in sports. He was an avid sports fan and I joked with him about his baseball and football teams. Now, Brian was here in the ICU on a breathing machine. He remained there in critical condition for several weeks, until he eventually woke up. We treated him with antibiotics for a presumed peritoneal infection; but as would be expected, after this prolonged course of illness, he was extremely weak.

Medically, Brian was no longer the same person whom the selection committee had earlier listed as “inactive,” presenting the second fork in the road. At this moment, I was struck by the sobering realization that without the comforting support of a large collaborative group, it was going to fall on those of us who happened to be on-call that night to assume the responsibility of making the life or death decision as to whether or not to change this patient’s status to “active” and begin accepting potential life-saving liver organ offers.

Since that time, in the literature, there has been a great deal of research on the fragility of weak patients; and, we know that the more debilitated patients are, the more difficult it is for them to get through the kind of surgery Brian was facing. The bar we now set for operating is whether someone has an 85 percent chance of being alive in 5 years. There has also been an abundance of data to show that when patients have had multisystem failure, or if they do not have the minimal strength to get out of bed and walk, they do not do well. For some of my colleagues, testing the patient’s strength is as simple as an arbitrary handshake. If the handshake is strong, for them, it is a subjective assessment that they can judge “I think you’ll make it through the transplant.” Brian would not have measured up to any of these standards.

So, here we were, on rounds, facing the second fork in the road; should we activate Brian for transplantation? The on-call team of myself as surgeon, a critical care physician, an ICU nurse practitioner, a hepatologist, a pharmacist, and the bedside nurse hemming and hawing as Brian’s life hung in the balance. In the end, we decided to change Brian’s status to “active,” start entertaining liver allograft offers on the assumption that he might be strong enough to make it through the operation if he was lucky enough to get the call. The on-call team of healthcare providers felt strongly that the transplant program had a commitment to Brian and wanted to honor that commitment while being conscious not to use an organ recklessly that could have saved another patient’s life.

A few days later, the phone rang with a liver allograft offer for Brian. In the interim, Brian had gotten sicker, and we were faced with the third fork in the road. We always err on the side of life, and it is very difficult to backtrack on decisions. Again, front and center on the team’s mind was the notion that this might be Brian’s only offer, but also to not perform a futile transplant, since if we pass on the offer for him the liver would be made available to save someone else’s life. We had the offer of a life-saving organ, what do we do with it?

I remember driving in to see Brian around midnight. I went over his clinical condition with him. His pressure was low and there were serious doubts in my mind as to whether he could make it through the operation; and here I was with an available organ in hand.

Looking back, I realize that, although it was impossible to fully know it at the time, it was one of those challenging moments in life that carries with it an exclamation point. Here was a man at a crossroad between life and death, and a decision had to be made whether, against the odds, to go ahead and chance a surgery or to make a judgment call that he cannot survive the operation and close off that option. Upper most was the thought: What if you take a chance, do the transplant and then you lose both the patient and the graft that could have helped save someone else?

Decisions, such as the one we faced that night with Brian, are so consequential that I sometimes wonder whether I chose the profession, or whether the profession chose me? I have had physicians tell me that they could never do transplants because they do not want those kinds of momentous decisions in their hands. I look at it differently, in that I have always thought of transplant as not just about me, but as a team sport. I do not use the term “sport” lightly. In order to achieve the goal, each member must blend

their individual roles and skills into one cohesive unit. It is the definition of the sum being greater than its parts. When I take a patient into the operating room, I am not alone; I have colleagues with me.

A clear example was that night when a decision had to be made regarding Brian. I phoned our anesthesiologist and asked if he would go to the ICU, meet the patient, and give me his opinion as to whether we should do the transplant or not. He went right in from home, saw Brian, and then objectively outlined all the risks. In his view, it came down to a flip of the coin whether Brian would make it or not. But, he said, "If you take care of doing the operation, I'll take care of the anesthesia. Do not worry about what I'm doing, worry about what you are doing. This will not be easy; but I'm ready to support whatever you decide."

His answer shows how the transplant team works. Although in the operating room, the surgeon is the captain of the ship and when something goes wrong, the responsibility is on your shoulders, you want to be working in tandem with a partner on the team who is performing interventions to sustain life, such as transfusing the patient, while you are losing blood. You want the entire team of physicians, nurses, physician assistants, perfusionists, and technicians to excel at their specialty so that you as the surgeon can focus on the job you need to do and do it the best that you can.

After speaking with the anesthesiologist, it was still weighing on me whether to proceed or not, so I went back to talk with Brian. There was no talk of numbers this time; the language was nonmedical, and it was on an entirely different plane. I told him that I was not sure whether we should go ahead with the operation. If he stayed as he was, he could live for perhaps a week or more; if we went forward with the surgery, he might be saying goodbye to his family tonight forever. To make sure it hit home, I turned to our shared sports imagery:

"There are two seconds left on the clock and we are 50 yards away from the end zone. We need a touchdown if we are going to win this game; and I'm not sure we can do it. If we go for it, you are the receiver. I am going to tell you to run this pattern and I'm going to throw that ball up there and you have to catch it. If you catch it we win the game; if you drop it we are going to lose."

I wanted to see how much fire he had to live; it is an unquantifiable gauge that can only be felt and not measured. We talked together and Brian said, "You know, Doc, I've been through a lot. You do your best, and I'm going to be there. I know you will throw the ball where it can be caught, and I will catch it. We will win." When I looked into his eyes, I could tell that this guy was not going to die easily. He was going to give me everything he had in the operating room even though he was going to be under anesthesia and unconscious.

Despite objective reasons to the contrary, I decided to go ahead and took Brian to the operating room. It was an incredibly difficult case; Brian lost a lot of blood, but the anesthesiologist did a wonderful job. Post op, Brian did well. The beauty of transplant surgery is that when you remove the engine that has been struggling and replace it with a new engine, a day or two later, the car runs like new. Brian looked like a new man and a few weeks later, he was walking the halls. I remember this case because it was not the intricate procedure that made an indelible impression, it was the subjective part of medicine that goes beyond science and truly defines medicine as an art. It is not always a matter of A therefore B. It taught me to trust my judgment and to trust my patient's instincts.

It is this nonobjective part of decisionmaking that I try to convey to selection committees. It is not all a numbers game; if it were, we could just put all the data into a computer, and it would spit out "the answer." Over the years, I continue to think of Brian, what I learned about the unquantifiable, yet essential, part of decisionmaking, and every case since has benefited from that realization.

Not every case defies the odds and not every Hail Mary pass wins the game. Recently, the team had a situation where a patient was so ill that his only chance at survival was to take him to the operating room for transplantation. He was unconscious. I did not have a chance to talk to him, so I had to make decisions for him. He was offered a liver allograft that was not able to be used where first allocated. The liver allograft was already hours old and would not be usable in any other recipient due to the timing. Basically, it would be discarded. There would be a cost to the program if the transplant failed—outcomes are extremely important to transplant centers. However, when you are at the bedside, representing the patient, you do everything for that patient. In this case, we made the decision that he had nothing to lose and we would proceed with hopefully a life-saving liver transplant.

In the operating room, there was a major complication at the beginning of the procedure while placing the central intravenous catheters. Here was the fork in the road: either to continue with the transplant or to

stop and take the patient back to the intensive care unit. We continued and after 6 hours, all looked promising and the patient was stable. Then, unexpectedly, as we were closing, the abdominal incision, and the patient had an arrest. Despite all our interventions, we were unable to resuscitate him and the patient died. It is always a matter of life and death; and despite the outcome, in retrospect, I still would have made the same decision to give this patient a chance at life with a successful transplant. By now in my career, I have matured enough to move past second guessing myself for decisions which have poor outcomes.

Looking back to Brian, and my other patients over the years, I have felt privileged to share those life and death situations with them. It is that indefinable relationship between physician and patient where, for me, the meaning of medicine starts and keeps me steady through the hard times and challenges. That relationship begins when the patient thinks, “I trust this person and I want him to operate on me,” and the surgeon thinks, “I will do a good job for you, I’m not perfect, but I’ll do my best.” Over the years, that is exactly what so many patients have said “Just do your best, Doc.” It is incredibly humbling to know they are trusting me to hold their life in my hands. What greater responsibility could there be than to take care of it and do my best.

These fork-in-the-road situations have brought home the cautionary tale of mechanically relying on the data and trying to quantify decisions. When things go wrong, it could allow you to abrogate responsibility and say “Well, I was just doing what the selection committee told me to do, it wasn’t my fault.” But the truth is, when the graph comes in, that patient is going to be somewhat different from when their case was discussed in the selection committee and it is up to the surgeon to decide whether to proceed or not. It is knowing *when* to operate that is more important than knowing how to operate. The technology, which is always evolving, helps you know how to do it better; but I contend that decisions require an intuition acquired through experience.

For example, the tenaciousness of some patient’s will to live is not measurable in objective terms; and it is hard to teach younger residents how to assess it. It is a feeling you get; but its subjectivity should not be a disqualifier. At the end of the day, the surgeon will have to make last minute decisions and those judgment calls are founded on more than numbers.

In these reflections, I have tried to open myself up for readers to let them look into the mind of a transplant surgeon and how we are not robots. The decisions we make may not be the right decisions; but I believe the proxy to make them is given by the patient. Around the Medical Center where I practice, I have a reputation as a “hard ass.” I agree; I am tough and uncompromising when it comes to what I want for my patients because I do not take their proxy lightly. I understand that my professional passion comes with a fire that others can find too raw to take. However, when colleagues, come and tell me, “I may not always agree with you, but if I ever need a transplant, I want you to be fighting for me,” I consider it the highest compliment.

### Note

1. Not the patient’s real name.