

**The Surgeon-Patient Relationship:
An Interview With Sheldon M. Feldman, MD**

By Judith A. Greenfield, PhD, RN

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The relationships patients have with their surgeons may be somewhat different from those they have with their primary-care physicians. On the one hand, ongoing relationships are able to form and mature over an extended period of time. On the other hand, short-term relationships are often influenced by a strong sense of alarm on the parts of patients who are facing surgery. What, then, can we expect from surgeon-patient relationships? We turned to Dr. Sheldon Feldman for some answers to this question. Formerly practicing as a general and vascular surgeon in Kingston, NY, Dr. Feldman now specializes in Breast Cancer surgery and serves as Chief of the Louis Venet Comprehensive Breast Service Unit at Beth Israel Medical Center in New York City. He is also on the faculty of Albert Einstein College of Medicine.

REVIEW: Please describe the role of the surgeon as you see it.

SF: In one sense the surgeon is a technician – someone who employs strong surgical techniques to performing procedures or consulting regarding procedures. They must have high-level skills. A lot of what they do is also non-surgical. They do traditional evaluations, clinical diagnoses, and biopsies. They also develop treatment plans and coordinate a multidisciplinary team that represents medical and surgical components of care. In my area, breast cancer, I see patients with serious breast problems. I review mammograms, ultrasounds, and biopsies. I also consult with others to assure accurate diagnoses so that, before the surgery, I can get enough information that will allow me to tailor the surgery to the specific problem. People often don't realize the importance of this. They sometimes want to move quickly. But, for instance, how a biopsy is done may make it harder to save the breast. So, often, my role is to make sure that the patient understands what's happening and what the choices are. The great amount of information out there makes this especially challenging. It's hard for breast cancer patients to know what's the best path.

I actually see myself as having three jobs. First, I have to have a high level of surgical skills. Second, I have to be an expert. In the case of breast cancer, this means knowing what there is to know about breast cancer and treatment options so that I use that to help my patients understand. In the case of general surgery, expertise is more focused on procedure and the technical aspects of recovery, possible complications, when they might be able to resume normal activities, and so on. This relates to my third job, which is to give clear expectations of what the experience will be like – to walk the patient through it.

REVIEW: Walking the patient through it takes time and patients may feel they don't have time. Do they?

SF: Breast cancer is never a medical emergency. It may be a psychological emergency but not medical. What I do is try to get them to understand enough about the disease so they can make a decision that's right for them. I push for them to learn what they can by meeting with others who've been through this experience. The greatest tragedy is if they make the decision without understanding and then say 'If I had only known I would have made a different decision.' At the same time, I don't like seeing procrastination – just enough time to get the facts. A second opinion is good but six opinions are not.

REVIEW: Is the same true of other cancer surgeries?

SF: Some cancers have symptoms. Breast cancer generally does not. When symptoms do occur, like coughing up blood with lung cancer or an obstructed colon with colon cancer, there is urgency. Patients should check with their doctors.

REVIEW: Is your view of the surgeon's role a commonly held one?

SF: Not as a rule, but medical students have better understandings of the importance of doctor-patient communication and know that poor communication is one of the causes of our malpractice crisis.

REVIEW: What can patients reasonably expect from surgeons before and after the surgery?

SF: *Before:* To make sure patients have a clear view of risks and benefits, expected recovery experiences. To address life issues, such as when they'll be able to return to work, and practical issues, such as what the breast will look like and types of incisions. *Immediately before:* To talk and be available to answer any last minute questions. I walk down the hall to the operating room with the patient. *After:* To give a clear explanation about how it went, what was found. Be clear about when and how pathology reports will be given to them. Tell what the policy is – for instance, are results given over the phone or only in the office? Waiting for reports is difficult. Information vacuum periods, where information is out there but patients just can't get it, are hard to deal with. Physician accessibility by phone or email – either directly or through their office staff – is critical.

REVIEW: What can surgeons reasonably expect of patients?

SF: To follow instructions after surgery and if they have problems, or doubts, to let the doctor or the office know.

REVIEW: What changes, on the parts of patients and surgeons, would you like to see?

SF: More open and honest communication on both sides.

REVIEW: What can patients do if they don't have a surgeon who communicates with them the way they want?

SF: Patients should be candid and advocate for themselves. If they are not getting the interaction they need they should let the doctor know. 'I feel I need more information.' If they can't establish trusting relationships, seek care elsewhere. I would.□

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