



## The Society for Cardiovascular Angiography and Interventions

### SCAI President's Page

## The Cath Lab Crew: Your Second Family

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So far, my President's Pages have focused on several of the important issues facing the Society related to quality in the practice of invasive cardiology [1,2]. This month, I will deviate slightly from the quality focus, but will share some thoughts on a topic about which I am equally passionate – The Cath Lab Crew. It is my purpose to pay tribute to their frequently overlooked, but always crucial, role in the practice of invasive and interventional cardiology.

At various points during the past three decades, the amount of time I have spent with “the crew” in the cath lab has likely exceeded that spent with my wife and children, whom I love dearly. Many of you who are real “Cath-o-holics” can probably relate to this and likely understand why I have come to think of the nurses, technicians, aides, and others who comprise the cath lab crew as a second family. These dedicated, skilled, and talented individuals make an invaluable contribution to our delivery of high-quality patient care.

I don't want to get trapped in a corny metaphor, but every large ship has a captain and a crew. Sure, the captain is in charge and may issue the order to cast off, but the ship would never leave port if the crew didn't do their jobs. Over the years, I have had the



pleasure of being shipmates with several highly trained and motivated cath lab crews. The photograph at the top of this article includes some of the members of the cath lab crew at Scott & White, where I now work. My apologies to those who were busy doing cases in the other labs and could not be included. They, like the crews I worked alongside at the University of North Carolina and the University of Texas Southwestern Medical Center, often made my job easier, my cases go smoother, and frequently made the long days in the lab not only tolerable, but fun.

### Developing the Right Relationship

A great crew will come to know you as well as you know them, just like you hopefully know the members of your family. Will some wake-up “on the wrong side of the bed” or, as we say in Texas, “with a burr under their saddle” or at times go through the “terrible twos” that we have seen in our own children? The answer is clearly yes, but I'm sure any of your crew members would be quick to point out that these behaviors have also been observed in invasive cardiologists. If you have the right relationship with your crew, they will

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understand you, support you, and forgive you on those “bad days” and you should be willing to do the same for them. Just as you will, over time, become comfortable with the crew, they will become comfortable with you and, as a result, they can often anticipate your decisions.

How can you tell when your crew is really starting to feel comfortable with you? Before this can occur, they must feel completely comfortable with your technical skills and decision-making in the lab. If those pieces do not fall in place, they may never feel completely comfortable with you, especially when the patient's clinical situation begins to deteriorate in the lab. A big leap in developing your relationship occurs when your crew begins to feel comfortable making suggestions, taking initiative, and speaking up with their observations. If you have the proper attitude and mutual trust, this should not be perceived by you as a mutiny against the captain. This is **teamwork**, and it is my belief that such teamwork, where everyone is at ease and feels that their work is appreciated and respected, develops into the best possible situation for the patient. This usually starts with small suggestions from the crew like “I think the patient needs something extra for pain.” That may not always be the right thing for the patient, but whatever your judgment, respect their opinions and, if appropriate, provide a response as to why that might not be correct in the case. This will slowly progress to making more substantive suggestions about technical aspects of the procedure or important issues the patient may not have disclosed to you, but revealed during initial interactions with the crew. Not every member of the crew will fall into this category, but I have worked with several individuals who have spent every working day (and many nights) in cath labs for over 25 years. In a difficult case, who would ignore advice from some of the great names in the field of interventional cardiology? Similar to the “experts,” these crew members have “seen it all” and have a wealth of practical experience. In the midst of a challenging case that is going from bad to worse, it is difficult to keep an eye on every aspect of the situation. Having a good crew whom you trust and respect can be a life preserver for your patient. That mutual trust and respect comes only from developing the proper relationship with your crew.

### **The Crew Saves the Day**

In the early 1990s the new technique of directional atherectomy was just becoming available. I attended the training course and was ready to go, several patients were lined up, and our physician proctor was on-site. Since stents have come along, we don't do many

directional atherectomies, but those who remember this technique know that getting this large device down a coronary was much different than advancing a balloon and wasn't always tolerated for long periods. So, there we were, the 11 French guiding catheter was in place, the guidewire was across the stenosis, the cutter was being advanced into the left anterior descending for the first series of cuts and, of course, the control room was crowded with observers.

In this particular medical center, the cath lab was on the top floor of one of the older buildings in the hospital complex. Unknown to anyone in the cath lab, a new roof had been installed the previous weekend. Just as the procedure was starting, storm clouds were approaching (probably not a good sign, but there were no windows in the lab) and shortly thereafter a torrential downpour started. I'm sure the roofers thought they had everything water-tight, but that was not the case. What started as a few drops rapidly became a waterfall from the ceiling into the cath lab. With the cutter whirring in the background and the ST segments rapidly rising, disaster and embarrassment seemed imminent. To this day, I don't completely understand where all of the stuff came from so fast, but within a minute, there was the chief tech on a step ladder, with a roll of plastic sheeting and duct tape diverting the waterfall away from the patient, X-ray system, and sterile field. Because the crew thought fast, creatively, and with no input from me, no harm was done. Later, when the crisis had passed and the patient was doing well, we all had a good laugh — including the patient.

### **Breaking the Tension – Where is F.L.?**

If you have ever watched one of those “doctor shows” on television, you likely have seen depicted some of the practical jokes that occur among the medical staff. Few shows depicted this better than *M\*A\*S\*H*. What may seem somewhat inappropriate to those outside the medical profession does occur with some frequency. Dealing with the seriousness of human illness can be overwhelming, and these moments help to diffuse the tension that invariably builds. Sharing a lighter moment with your crew and laughing about it is important. Over the years, my crews have been known to play harmless practical jokes on me, I've often returned the favor, and sometimes we have even plotted together. Some of these had best not be repeated, but I cannot help but share a few that we still chuckle about today.

I have been in an academic setting my entire career and thus have participated in the training of many cardiology fellows. For fellows who are interested in invasive cardiology, that first rotation in the cath lab is welcomed with great anticipation – the expression

“gung-ho” is often appropriate. To set the scene, it is usually Friday afternoon and the last case of a long week is approaching. Often this prank would start with one of the nurses or techs asking me, in the presence of the first-year fellow, if there were any “add-on” cases, emphasizing (with a twinkle in their eye) how they would all really, really appreciate the first-year fellow getting the patient evaluated and consented quickly so they would not have to stay late again. Sure enough, within about 30 minutes, he would appear on the scheduling board – the infamous F.L. I would use this person’s entire name, but in 2006 this could be a HIPPA violation even though no such patient ever existed. It was always the same name, F.L., and the more senior fellows knew it was time for this “rite of passage” just like the one they had endured when they were first-year fellows. Let the games begin. So . . .

“Where is the patient located?” the first-year would ask. “I’ll go see him right away.”

“I think he is up on 6 West, the cardiology floor,” someone would say.

As soon as the first-year left the lab, the betting would start – how long could we keep this going before they caught on? Predictably, several minutes later, the first-year fellow would either call on the phone or show up back in the lab saying they went to 6 West, but the patient wasn’t there. Someone would reply, “Oh, they just called back and F.L was moved to 5 East.”

So . . . off would go the first-year fellow for a second attempt to find the non-existent F.L. Again, we would all wait for the next contact from the first-year. This time, when F. L couldn’t be found, it was because he was getting sicker and had been moved to the CCU. “Why is this taking so long?” one of the techs would say to the increasingly frustrated first-year fellow.

Usually, after the third or fourth wild goose chase to the far ends of the hospital, the hapless first-year fellow would begin to get suspicious. “I called bed control, and there is nobody named F. L. in the hospital. Are you sure you got the name correct?” would be the question. Sometimes, F.L would just disappear from the scheduling board and the first-year would be told he had been discharged and the cath scheduled as an outpatient. Usually, the first-year would return from the hunt with a suspicious look on their face and someone in the lab would just bust out laughing. The charade was over – the truth would be told, and everyone would have a good laugh to end the week.

Sometimes, I was the victim. I have always emphasized to the cardiology fellows that they should have a thorough understanding of the patient’s clinical history before ever starting the procedure. The fellow and I would always review this before the procedure and decide how to approach the case. So . . . after hearing

about the case and meeting the patient, I looked up on the X-ray monitor and saw the typical radiographic signs of a prior median sternotomy (wire sutures) with several bypass graft markers. The fellow had just presented the case to me, making no mention of a prior bypass operation. I should have known something was up because there were more than the usual number of crew members just hanging around in the control room. I leaned over to the fellow, who by now was getting ready to numb the groin, and in a soft voice the patient could not hear asked him to explain the picture on the X-ray monitor. The fellow looked dumbfounded and started to apologize for the error. Just about the time we were getting ready to ask the patient when they had their bypass, one of the techs showed up at the foot of the table and held up a cardboard frame into which metal sutures and graft makers has been placed. Before we came in the room, the crew had put this on the patient’s chest and recorded a quick image that remained on the monitor. We had been duped, but it was worth the laugh.

Pranks like these, while silly, make for good memories and good friends. Likewise, we share bad days and cases that don’t go well. In those moments, the crew feels the same frustration and sorrow that you feel. While it is tempting to just walk away from a bad case, it is important to remember that it can also be a learning experience that can benefit everyone in the lab. If appropriate, talk about the case with your crew and this will further develop and strengthen you as a “family.”

### **Respect Everyone – They Have an Important Role**

Although you may have your closest relationships with the nurses and techs, there are many individuals who contribute to the job who are less well recognized. Perhaps this could be best illustrated with an anecdote from the past. During his term in office, former President Lyndon B. Johnson (LBJ) visited the massive National Aeronautics and Space Administration (NASA) facility outside Houston. Security requirements then were not as rigorous as they are now, so as he was walking around LBJ would frequently stop and shake the hand of many NASA employees. As the story goes, he was walking through one of the huge buildings when he started heading for a man wearing coveralls with the NASA emblem on the back. Many who saw this encounter suspect LBJ didn’t notice the man’s cart with cleaning supplies, broom, bucket, and mop just a few feet away. The President approached the man, vigorously shook his hand, and asked him what he did at NASA. To that question, the man

proudly replied, "Mr. President, I am helping to put a man on the moon." The point is very simple: There are many individuals who work in support of your efforts in the cath lab. Their job may seem trivial, but it is part of the entire patient care effort. I am sure saying "hello" or an occasional "thank you" would be much appreciated.

Saying thank-you *is* important, especially because it's all too easy to take for granted the good work our crews do. It is important to acknowledge and show respect for their shared investment in our joint mission of providing the highest quality care for our patients. Especially for physicians in the early stages of their careers, when there is still so much to learn, a crew of cath lab veterans makes all the difference. Personally, with nearly three decades behind me and relatively

few years to go before I hang up the lead, it still makes a difference. To all the cath lab crews everywhere – Thanks!

I invite your thoughts and ideas on this and other topics. Please send them to me at [president@scai.org](mailto:president@scai.org). I would be grateful to hear from you and will respond to every message.

## REFERENCES

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