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WHAT I HAVE LEARNED

Lessons from 50 years in orthopedic surgery

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Bob Neviaser is from the First Family of shoulder surgery in the United States. His father, Julius Neviaser, was an early pioneer in shoulder surgery. Bob was a founding member of the American Shoulder and Elbow Surgeons (ASES), and his brother, Tom Neviaser, is also an ASES member. Bob's son, Andy Neviaser, has also become a member of ASES.
Bob Neviaser studied at Princeton, where he played football and lacrosse, then went to Jefferson Medical College, and later did his orthopedic residency at the New York Orthopaedic Hospital. His orthopedic career is identified with George Washington University School of Medicine, where he spent his entire career and where he served as the chairman of orthopedics for 28 years. During that time, he trained hundreds of residents, which included 3 Kappa Delta awardees, 1 president of the American Orthopaedic Association, 2 department chairs (1 of whom was the first woman to chair a university orthopedic department), and the highest percentage of women in an orthopedic residency, as well as the highest percentage of graduates in academic orthopedics.
Bob Neviaser was president of ASES in 1992-1993 and president of the Western Trauma Association in 1985-1986. Among the honors he has received are the Unsung Hero Award from the Lacrosse Foundation, the Inaugural Lifetime Achievement Award from the Mid-Atlantic Shoulder and Elbow Society, and the Distinguished Clinician Educator Award from the American Orthopaedic Association, and he was named a Distinguished Alumnus of the New York Orthopaedic Hospital.
Bob Neviaser was editor-in-chief of the *Journal of Shoulder and Elbow Surgery* from 1997-2008, serving for 12 years, during which time he brought the journal into the 21st century and greatly upgraded the quality of the journal and its impact factor. On a personal note, Bob has been a trusted mentor to me and one to whom I still reach out when I have vexing problems related to the journal. I owe him a lot and have come to appreciate him as a man, as a scholar, and as a mentor.—*W.J.M.*

Reflecting on lessons learned during 50 years in orthopedic surgery requires some thought and some triage as well. A career over that time span has multiple phases, each of which presents its own lessons. As we gain experience, maturity, and hopefully, wisdom, we have changing perspectives on recurring issues. Therefore, recalling what we learned can be more complex and less obvious.

My own career has been spent entirely in academic orthopedic surgery. In my case, this involved not only education and research but also patient care. During the early years, clinically, I developed an appreciation that there are no absolutes. Orthopedics, like most of medicine, is not an exact science. There are many ways to treat the same condition that can result in consistently excellent outcomes. It is important to be open-minded and receptive to new techniques and ideas. Nevertheless, if you find something that succeeds consistently in your hands, it should take a great deal of convincing to make one change. Just because something is new does not necessarily mean that it is better. That does not mean that you should not try new approaches, but after given an adequate opportunity, if the outcomes cannot match the outcomes of what you had previously done, then there is no reason to continue with the newer approach, just because it is the latest hot topic. An example is the open Bankart repair for

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recurrent, traumatic anterior dislocation of the shoulder. We have reported virtually unmatched excellent outcomes using this procedure for initial operations (0.8% failure rate) as well as for revisions (0% failure rate) with 25 years' follow-up. Recognizing that others, in reporting results of arthroscopic Bankart or Latarjet procedures, cannot equal those outcomes, I found no reason to change what I do. On the other hand, as arthroscopic rotator cuff repairs evolved, I did find reasons to move away from strictly open repairs.

In the realm of research, I learned that it was important to review your approaches constantly and to share your thoughts with the broader orthopedic community. It is not enough to say that you believe something is true or that you know that what you are doing is the best way to do things. You need to document those opinions. You have to go back in a systematic fashion, recall your patients, and reassess their outcomes, and you may be surprised that they may be worse—or even better—than you thought they were. Either way, you should be willing to present your findings to your peers and stand up to the criticism. The best way to rebut your critics is to have the data to support your position. Just saying that you think your approach is better, without being able to substantiate it with data, will not carry the day.

Some years ago, the late Richard Smith of Massachusetts General Hospital and Harvard Medical School, president of the American Society for Surgery of the Hand, invited me to be a visiting professor. He introduced me as an iconoclast, a label that I am proud to wear. For me, challenging accepted dogma was often a motivation to do research. For many years, treating the long head of the biceps was frowned upon because it was allegedly a humeral head depressor. When we presented our outcomes of biceps tenodesis, we were roundly criticized and called ''biceps killers.'' This was the stimulus to do our electromyographic study of the biceps' function in patients with rotator cuff tears and show that the long head of the biceps was not a humeral head depressor. Other researchers confirmed our findings, and over time, much of the shoulder world came to agree that the biceps could be a pain generator and, when it was, needed treating.

From my 17 years in an editorial position with the *Journal of Shoulder and Elbow Surgery*—5 years as North American editor and 12 years as editor-in-chief—I learned that there are outstanding shoulder surgeons all over the world. They are innovative, talented, inquisitive, and research oriented. They want to share their information with the world. This editorial experience also showed me that the best of contributors to the *Journal of Shoulder and Elbow Surgery*, regardless of where they lived, were honest, always acknowledging their failures as well as their successes, and giving credit where credit was due by referencing the contributions of others and referencing the literature of the past. This trait is so important in establishing credibility.

From my experience with residents and students, as well as visitors who came to see what we were doing in shoulder surgery, I appreciated that, although I was the teacher, I could learn from them as well. Their questions forced me to become proficient in defending the ideas and principles that I was espousing. It reinforced my quest to challenge established dogma when I felt such dogma made no sense. I tried to impart that approach to all of my students and, hopefully, stimulated some of them to contribute to our understanding of this field.

I have always believed—and told my students and residents—that medicine, including orthopedic and shoulder surgery, is a lifelong learning process. The tremendous changes that have occurred over my career are almost too great to contemplate. We all need to continue to learn from one another and to share the fruits of our own experience for the benefit of those who come after. Before doing my orthopedic residency at the New York Orthopaedic Hospital of the Columbia University Presbyterian Medical Center, I spent 2 years in general surgery at the New York Hospital–Cornell Medical Center; that was how most of us fulfilled our 5-year requirement at the time. The New York Hospital had the motto ''Go and do thou likewise.'' I still think that is the way we should model our careers.

I also realized early on that our job, as educators, was not only to impart information to our students. This led to our philosophy of resident education to develop thinkers, not just doers. We wanted students to develop self-discipline and to gain a sound fundamental knowledge upon which to build over the rest of their careers. Of course, we wanted them to be inquisitive and challenge standard dogma that did not make sense, to pursue ideas that were different or new to see if they had merit, and to be able to stand up and defend themselves in the face of criticism.

Finally, and most importantly, I learned that, above all, family is the most important aspect of life. Like most of us, I have been dedicated to my professional life. I have made many good friends through my professional career and, hopefully, contributed to our understanding of the shoulder and upper extremity. Despite all of that, when I am gone, those who will care the most, remember me the most, and miss me the most are my wonderful wife of 52 years, our 4 great children—all successful in their own careers—and our 11 terrific grandchildren. I learned to make time for them, especially for important events in their lives, even if it meant changing my schedule to be able to do it. I know that many of my colleagues and residents believed me to be a family man. I hope that my family feels the same. It was certainly worth it to me. It is a valuable lesson that I hope all of those who read this will try to emulate.

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