Commentary: Experience Fills the Void

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Central message: In these rare cases, we must rely on our personal experience when deciding if and when to transplant these complex patients.

Central Picture Legend: Jacob Klapper, MD

The world of evidence-based medicine (EBM); one where clinical decision-making is guided by factual evidence. Frequently encountered clinical questions are answered through generous budgets, motivated clinical research teams, and a shared common interest amongst the involved parties. In reality, the money is never enough, conflicting goals stand in the way of meaningful collaboration, and the bureaucracies of individual institutions stymie the process. Add to these facts the reality that the time it takes to answer these questions is often in years, and it becomes very easy to understand why so much of what we do occurs in the absence of good evidence.

Then of course there are those clinical questions you can never answer primarily because the uniqueness of the clinical situation does not allow for large scale investigation. The role of lung transplantation for acute respiratory distress syndrome exemplifies this. What we are thus left with is relying on the insights of the experts and that is why we continue to need manuscripts such as the one published by Hoetzecker.¹

There is certainly nothing in the next 250 words of this commentary that can offer more clarity on this subject. But I can emphasize from my own personal experience with these patients that selecting the best candidates for transplant are made through rigorous consensus. A shared mindset between the transplant and critical care teams about when to engage in the conversation regarding transplant must be cultivated. Healthy debates about whether the patient
in question can achieve lung recovery will occur, and both sides will offer evidence to support their contentions. And you know what? Neither side is wrong. In the end, the decisions that are and will continue to be made on these patients will rely on the intellectual rigor that makes our jobs so rewarding.

We are taking a gamble with these complex cases. Many have been hospitalized for months. They are deconditioned. They and their families have already dealt with profound levels of stress within the milieu of the ICU. Now, we must determine whether this patient, and their family, have the fortitude to overcome this next obstacle: transplant. I have no good advice on this matter and no revelations on how best to gauge an individual’s resilience. But I will say that one should trust their instincts if they or others are skeptical of the patient’s capacity to withstand this next stage. A good donor, operation, and postoperative care are no match for the patient that does not have the emotional wherewithal to complete their recovery.

In my opinion, the evidence for determining whether to transplant these patients does not reside within the pages of any journal, but rather in what we see and learn about each individual. Consequently, we must build a narrative around each and we must work together. We will save some and lose others but, in the end, we will acquire that most valuable of physician attributes: experience. For when the good evidence is lacking, experience fills the void.