

# **Total Hip Replacement: A Personal Perspective**

by Ben Goldfarb

## Acknowledgements

Here I sit, thinking about the immense cast of characters I should thank for making my hip replacement an unqualified success. I am not even aware of the names of some of the people who did their part from behind the scenes. My aging brain will attempt to recognize everybody and their contributions. I apologize for any I have omitted, in whose case my gratitude is implicit.

The first stop on my thank-you tour is obvious. Without the surgical team led by Dr. Peter Gearen of the University of Florida, there would have been no surgery. With Dr. Gearen, the residents, the surgical nurses, and other support people, I was in good hands straight through the operation and recovery. I have had so little pain that it is just short of a miracle. Linda Berry, my case manager, superbly coordinated the details from long before the scheduled surgery date, all the while stoically coping with my Type A behavior (her characterization, not mine). Terry Emma, the frog lady of Shands, who scheduled the surgery and handled the insurance issues, made me smile while she was taking my money, no mean trick.

The entire Shands Hospital experience was a positive one. I felt that both the medical and the non-medical personnel were well trained, hard working, and respectful. I would especially like to thank the nurses and aides of the seventh floor, who took excellent care of me. Charge nurse Jill Conley was always pleasant and always ready with solutions to problems before they occurred. There were many others who cared for me and cared about me, including Bobbie (surname unknown), Nate Bell, Darlene Brown, Sherry Chumack, Carmen Clayton, Vickie Guin, Evette Johnson, Tim Lee, Chris Northcott, Laurine Scott, Francene Smith, Mike Stagliano, and Theresa (CSO). The physical therapists who got me up and moving were Gene and Charlie (who is also an ordained minister), Chris Harrington, and Lisa Phillips. Immediately before surgery, my angel of mercy in the anesthesia prep area was Susan Smith.

In his pre-surgery visit, the information and demonstrations provided in my home by physical therapist Bruce Satterlund of ORHS proved invaluable. I would hope that any patient who has scheduled a total hip replacement would be as lucky as I was in obtaining such a skilled and knowledgeable briefing.

At Lucerne Hospital rehab, I enjoyed my brief acquaintances with my physical therapist Shahm (sorry if I've spelled it incorrectly), occupational therapist Donna, and post-release care coordinator Tracy.

Also deserving of recognition is my in-home physical therapist from the Visiting Nurses Association, Ann Mailey, who not only gave me a good workout program but also changed my compression stockings quite a few times.

Now, let me move on to special friends. Major thanks go to Margie Altman, who interrupted her busy schedule to fly down to Gainesville from her home in Louisville KY, just to be with me. Margie, herself a physician, stayed with me through the most critical period of the surgery and its aftermath. In her energetic and sincere manner, she was effective in ensuring that I was getting the best possible medical care. I could not have done this without her. Long time friends Joe and Judy Tamashasky deserve special credit for exhorting me to do something about my hip problem. It was obviously the right thing to do, and Penn State games will be less painful for all of us in the future. Nasir Madhany, my family doctor, was similarly instrumental in urging me to seek a surgeon. Bob Brigham was at his supportive, selfless best, providing both logistical and moral support. Without the caring and support of Bob and his late wife Dee during some of my darkest hours, I could not have ever reached the decision to fix the hip. R.D. Thrush was

an excellent chauffeur and carpenter. He drew the hazardous duty assignment of transporting me from Shands to Lucerne, and then home from Lucerne. Keri Caffrey, just back from a vacation in the Greek Islands, made several grocery trips and was the chauffeur for my six-week follow-up appointment at Shands. Tony Travaglini, whose own medical problems far transcend mine, went out of his way to make sure I had everything I needed. I value his friendship and camaraderie. It will not be long before Tony and I can hike some of those great Florida wilderness areas. My neighbors, Jeff and Elayne Wershil, not only helped out with chores, but also brought me an excellent pot of chicken soup—Jewish penicillin. On another occasion, it was chili. Dick Taylor provided the ankle weights that will be instrumental in bringing my operated leg to full strength. Carole Finnie had every intention of going out of her way to help but nature intervened quite pleasantly with the arrival of her first grandchild, in Seattle. Turn off your Scottish guilt, Carole! As you can glean from reading this, I was not neglected. Chrysanne Poole, whose cheerful and energetic phone calls and e-mails are always a treat, supplied words of encouragement. The multi-talented Laura Kittleson kept me in her prayers and her ICQ list through the surgery and into my recovery. Michelle Piccari, who plays a mean fiddle, sent me daisies and warm, caring thoughts. Betty Henry, my friend and barber for the past 25 years, deserves my thanks for giving me the best ever, surgery friendly, buzz cut. Betty, your fears that I will jump all over your case for ruining my hair are unfounded. Thanks also to David Weiner, who told me that Fluor Corporation might be building a new office building in Aliso Viejo, California, bringing back memories of all the hip pain I suffered in participating in the construction of the other six buildings. I would not have fought with him so much if I had had this operation before I engaged in that project. In addition, to special friend Evelyn Arnold, who really does think that everything in this country is “bigger and better” (well, it is!), thanks for chasing me down from the U.K. to give me your get well wishes.

Family support is always essential. I suppose I am guilty of not really letting my family know just how much pain I was suffering through the years leading up to the surgery. Accordingly, I am certain that my decision to have my hip replaced was confusing to some of them. Nevertheless, they gave me the support I expected, each in their own way. My mother, God bless her, would worry about me even if there were no reason to worry. She was very thankful that I made it through the surgery. She offered to help me in any way she could. However, with her being 80, it would have placed a severe strain on her. My brother, Joel, and my sister-in-law, Janet, supported me all the way, admonishing me to follow doctors’ orders and to not give the nurses a hard time. Their offspring, nephew Marc, amused me by sending me what was ostensibly a get-well card with all sorts of inappropriate inscriptions. My cousin, Paula Lawrence, who is the sister I never had, was very caring, loving, and concerned during the entire process. Her inquisitive nature kept me on my toes and her neo-liberalism kept me in stitches.

Modern medical science is wonderful. I have a new hip and a new lease on life. I have a great group of friends and a supportive family. Life is good. I thank you all for your help, support, caring, and love, and I hope that I can return the favor sometime soon.

## Introduction

This is an account of my total hip replacement and, to some extent, a guide to hip replacements in general. It does not purport to be an all-encompassing reference work. Call me lazy, but I felt that the time required to complete the necessary research and broaden the perspectives of this opus would delay its publication. Furthermore, there are many good books on the subject already in print. In Chapter II, I shall describe three of them that were quite helpful to me. This early effort of mine might be viewed either as a completed work or as a stepping-stone to a larger, more complete reference to be published later.

Getting back to why we are here, I began to write the book a little more than two weeks after having undergone total hip replacement surgery. By sharing my experiences with you, presumably another total hip replacement candidate, it is my hope that I can improve the outcome for you in some small way. While some patients will place blind faith in their medical practitioners, letting themselves be marched through the experience from beginning to end without active involvement in the plethora of associated decisions, it is the informed and involved patient who will derive the most benefit from reading this and the other books I will recommend. Based on my experiences and those of other authors, you will choose the best surgeon and hospital for you, you will form a partnership with the surgeon in setting a proper course for your hip replacement and recovery, and you will be able to proceed more confidently through the entire process. Knowledge is power. I urge you to set sufficient time aside for mental and physical preparation.

I mentioned earlier that this book would be based on my experiences rather than being a broad compendium of knowledge on the general subject of hip replacement surgery. Accordingly, it is necessary for you to understand my circumstances in order to evaluate the use of this book as a guide for your own hip replacement. I am a 54-year-old overweight male in generally good health who lives alone. My hip degeneration was caused by osteoarthritis (OA), which eventually caused the destruction of most of the cartilage in the joint. I am self-employed as a consultant in the computer field. I enjoy golf, hiking, nature photography, reading, writing, walking, attending sports events, and playing with my house and garden. To be accurate and honest, perhaps I should refer to some of these activities in the past tense because I have not derived much enjoyment from them for quite a while. However, it is my hope that I will soon be able to enjoy them once again, and do so painlessly! While I cannot predict that all of the information I present in this book will help others in different circumstances, I am certain there will be revelations applicable to everybody.

In Chapter I, I discuss events leading up to the decision for hip replacement, including early, more conservative treatments. In Chapter II I take the unusual step of recommending three books by other authors, which provide a more complete background on various medical and technical aspects of total hip replacement. Chapter III leads you through the process of selecting a surgeon, borrowing heavily from my personal experiences. Your choice of a surgeon will be one of the most important things you can do to ensure the success of your hip replacement operation. In Chapter IV, I discuss things you can do to prepare yourself mentally and physically for the surgery and things you can do to make your house more amenable to your return in a somewhat compromised state. Then, in Chapters V through VII, I take you through my surgical experience and my recovery period while still in the hospital. Chapter VIII describes my brief time in an in-patient rehabilitation facility. In Chapter IX, I come home and gradually resume my daily life, while doing physical therapy with a home visitor. I provide tips on how to deal with many common situations at home. Chapter X describes my successful follow-up visits with my surgeon and my rehab physician.

## Total Hip Replacement: A Personal Perspective

Whether you are reading this because you or someone in your family are contemplating total hip replacement or you have already undergone surgery, I think you will be enlightened and perhaps entertained by tuning in to my experiences. Please enjoy the book!

## Chapter I. Making the Decision

How does one arrive at the decision to commit to surgery that involves, stated bluntly, sawing off the top of one's femur and installing a metal replacement joint? This is not an easy decision. It can be said that total hip replacement surgery (the technical term is *total hip arthroplasty*) is a last ditch effort after all other measures to avert pain and disability have failed. Yet, I claim that by the time it is necessary, the decision is almost made automatically. By that time, the alternative is debilitating pain and physical impairment. Nobody likes surgery, but I can tell you that I have had absolutely no regrets that I have had it. I feel as if I have a new life in front of me.

Because you are reading this, you have probably arrived at the conclusion that total hip replacement surgery might loom in your future. You will identify with some of my early experiences with pain, treatment, and, of course, denial. What I wish to stress is that, although it is a weighty decision, eliminating the pain, suffering, compromised lifestyle, and, in some cases, heightened damage to the body, are worth the inconvenience of surgery.

Prior to surgery, I had developed a very bad limp. I had let it go too far. My back developed a curvature from compensation for the bad leg. My lifestyle was severely compromised. I looked upon people who could walk normally with great envy—including people much older than I am. I was old before my time, and I was constantly in pain. Thus, the decision was easy for me, albeit a long time in the making. Let us wind the clock back about ten years, to my first symptoms.

### The onset of pain

You feel a twinge of pain in your hip. It quickly goes away. A couple of months later, you feel another twinge. It might vanish quickly this time or it might stay with you for a while. Then perhaps you have a business trip and spend a day running through airports, scrunching your body into a fixed position for hours in a crowded airliner, standing in hotel and rental car check-in lines, and engaging in the myriad other body-punishing “features” of modern travel. The next day you are awash in pain from that hip. Then the pain departs for a while, and you quickly forget about it. Sometimes you are able to function completely normally without pain. Because of the insidious onset and because it is still tolerable, you probably will sum up the sporadic pain as an inevitable consequence of aging. You are in denial. The pain is a serious warning you should not ignore.

In many people, this is how the pain of degenerative osteoarthritis of the hip joint presents itself. It happened to me this way, too. I, too, denied its existence for several years.

I would say that my first bout with hip pain came about ten years ago. It was merely annoying at that point. I felt that I could work around it, and I did. I put up with the pain, writing it off as one of the dubious joys of middle age. Sometimes the pain would hibernate for a while. Of course, it always returned, generally getting worse with each bout.

### Seeking medical advice

When it became clear that my pain would not be taking a leave of absence, I became more serious about exploring possible corrective measures. At first, my family doctor prescribed some mild non-steroidal anti-inflammatory drugs (NSAIDS). I believe the initial drug was ibuprofen. For a while, this kept the pain at bay. However, I wanted to learn more about the prognosis for my left hip, so I visited an Dr. S., an orthopedic surgeon who had helped me with a heel spur a few years earlier. Call him Dr. S. His X-

rays confirmed degenerative osteoarthritis of the left hip. I had complained to him that driving was painful because of having to frequently operate the clutch with my left leg. He responded that I would know when it was time to stop driving a car with a manual transmission and I would know when it was time to consider more serious measures. Of course, “more serious measures” meant surgery. In the meanwhile, he changed my NSAID prescription to something he liked better than ibuprofen, and it seemed to do the job—for a while.

A year or two later, I arranged to see a rheumatologist, Dr. F. After some manipulation and evaluation, she confirmed the presence of degenerative disease of the left hip. She felt that I should manage pain via NSAIDs and lose weight. She stated that I should live with the situation as long as possible before committing to surgery. She changed my prescription to yet another NSAID, this one called Ansaïd. It seemed to offer more relief from pain, but it was very hard on my stomach.

My family doctor, Dr. M, was an important factor in my decision making process. He supported me through times of severe frustration with the healthcare system. He also kept close tabs on my liver, which was necessary because I was taking huge doses of potentially damaging NSAIDs. The results of one such liver enzyme blood test in 1995 caused a major scare. My alkaline phosphatase was severely elevated, indicating any of several problem areas. A retest with fractions disclosed that the problem area was abnormal bone growth. This could indicate bone cancer. I went to the hospital for a bone scan after which I sweated it out for two days waiting for the results. Finally, the report came back: osteoarthritis of the left hip was the cause of the unusual bone activity. I was relieved, but somewhat concerned that the damage to my hip was accelerating.

### **Lifestyle changes**

It was depressing to think about it, but within a year or two after the onset of pain, my arthritic hip was starting to get in the way of my normal lifestyle. On the golf course, never a place where I was happy with my performance even without hip pain, I could no longer swing the club around completely. (An important part of a golf swing is the hip turn. My hips did not turn easily.) Walking 18 holes—even with the aid of a cart—would leave me aching and ready for the “19<sup>th</sup> hole,” where several rounds of beer would generally wash away the pain for a while. However, on the course, I was unpleasant and irascible.

Other, similar situations threatened my friendships. Walking with friends to sporting events or shopping would cause my hip joint to flare up to the point at which I could not participate in any conversations that took place. Instead, I concentrated on walking. Each step was painful. Slowing down was painful. Speeding up was painful. Stopping and starting were painful. Stepping off curbs was painful. Uneven surfaces were painful. Because every second step resulted in a sharp stab of pain, I appeared to be withdrawn and uncommunicative when I was actually concentrating on surmounting the pain. Simple things such as rising out of a chair after dining required an extreme mental effort. A few minutes before I actually stood up, I would have to start girding myself for the blast of pain I knew I would experience. While others were saying goodbye, discussing postprandial entertainment, or exchanging other amenities, I would be wincing, awash once again in pain and unable to speak for half a minute or so. When I did speak, I was irritable and belligerent. The overall assessment by many of my friends, though not openly stated, was that I was becoming a miserable, crotchety old man.

They were right, and I admit it. Pain was controlling my life. By early 1995, about seven years ago, it was clear that if I did not do something about it, I would degenerate into a reclusive cripple with no friends. To compound the problem, I was in the midst of a political conflict at the office, which did not help my mood at all. Some of the problems

there related to my realization that I was becoming a slave to my pain. I had become preoccupied and indecisive. Instead of dealing with the problem directly, I was letting the pain get the better of me. Furthermore, the same irritability and bellicosity that threatened my friendships also beleaguered my professional associations.

To be blunt, I sometimes compensated for my pain by making others miserable, too. Looking back, I suppose I was trying to share my pain with friends and business associates. That was a mistake. Nobody else can feel your pain. Few others can even *understand* your pain. I was expecting people to make accommodations for me even as I was alienating them with my pain-inspired bad behavior. This was obviously a no-win situation.

At other times, I hid my pain well. Still, it was clear to most of my friends and some of my more observant family members that something was wrong.

### Physical changes

As walking became more and more of a struggle, my exercise schedule quickly tailed off. I used to love to take long, brisk walks, but it had become far too painful to walk for exercise. Jogging was obviously out of the question. I have a Schwinn Airdyne exercise bike, which was always the easiest way for me to get an aerobic workout, rain or shine. For a while, I was able to surmount the hip pain that would sometimes flare up when using the bike. As time went on, if the pain was not debilitating during the actual workout, it would come with a vengeance the following day. After a while, I began to miss days. Thus, the backsliding began. One additional problem arose when I used the Airdyne. My left heel would bang against the frame of the bike while pedaling because of the deformity in my hip joint. The femoral head was rotated outward and pressing upward, causing my left foot to turn outward. When my heel started taking that beating, I knew that it was time to stop using the exercise bike completely.

Other changes in my physical stature and my gait began insidiously, but steadily grew worse with the passage of time. I was compensating for my bad leg by swaying when I walked. I could not carry a cup of coffee from the kitchen to my favorite chair without spilling a sizeable amount of coffee into the saucer or onto the floor. The worse the pain became, the more violently I would sway. Even with a cane, I had a Walter Brennan gait.

What is worse, I developed *scoliosis* (curvature of the spine) due to compensating for the bad leg in this exaggeratedly swaying manner. I first noticed this when zipping up my trousers. The top of the zipper would always point an inch to the left of my belly button. My belt buckle did not align with the buttons of my shirt. If I moved it to try to align it, the whole thing looked crooked. My thoracic vertebrae were going right while my lumbar vertebrae were going left. Subsequently, X-rays and an MRI confirmed this. I was like an old, swayback horse, ready for the glue factory!

I would be remiss if I did not mention that physical pain has an insidiously depressing effect on mental activities. After years and years of suffering chronic pain, you might not be consciously feeling the pain. You have “tuned it out.” Yet inside your brain, the act of tuning out is still a distraction. Thus, pain is at once fatiguing and mentally distracting. For this reason, my capacity for work involving concentration decreased remarkably during the lengthy crescendo of my hip pain. Increasingly at work I would subconsciously choose “no-brainer” tasks instead of complex problems, ignoring the tougher ones until my head cleared. It never did. My powers of concentration succumbed to limitations imposed by the pain. This effect was something I never thought about until after the surgery, when I felt the gradual return of my ability to concentrate. Although it might sound strange to couch it this way, absence of pain gave me one less major thing to



“think about.” Had I known how serious this effect was, I might have pressed the surgery issue much earlier *for that reason alone*.

Let me now leap forward to my initial consultation with the surgeon I would eventually select to perform the operation, Dr. G. He remarked that I probably had such a relatively high degree of resistance to pain that I did not know the extent to which the pain was affecting me. Had I remained unconvinced that I needed the hip replacement because of the deterioration of my lifestyle, he could have graphically demonstrated the effects of the pain by administering local anesthetic in the left hip joint, which would block the pain there for an hour or so. It was his conjecture that being free from the pain of a hip that was as far gone as mine would convince me that the surgery was greatly preferable to suffering in silence. I told him that it was not necessary, that I had resolved to have the surgery. Looking back, had I taken him up on the anesthetic, I might have asked him to operate on me immediately after the effects wore off!

### Conservative measures

Because surgery is a big deal with inherent risks and lofty expenses, doctors and insurance companies tend to recommend it only when all other measures have failed. The term *conservative measures* encompasses drug therapy, physical therapy, massage therapy, use of herbs and supplements, and alternative medicine—anything short of surgery. Unless it is an emergency, there is little chance that a scrupulous surgeon will commit to a total hip replacement operation unless the patient has employed at least some of these conservative measures. I describe a few of them below.

### NSAIDS

*Non-steroidal anti-inflammatory drugs* (NSAIDs) are likely to be your first course of conservative treatment. As I mentioned above, this was the first form of therapy for my hip pain. NSAIDs are available in over-the-counter and prescription varieties. There are approximately sixteen such drugs. Examples of over-the-counter formulations are Advil (ibuprofen), Alleve (naproxen), and Orudis KT (ketoprofen). There are many prescription strength NSAIDs, which are either merely increased dosages of NSAIDs available over the counter or higher potency formulations that are not available over the counter. NSAIDs exist in both brand name and generic varieties.

With the exception of two new drugs I will get to shortly, all of the NSAIDS have potentially serious side effects involving the stomach, liver, and kidneys. Taking large doses of these drugs over time can cause serious damage, including life threatening internal bleeding. In all cases, you should take them with food and a doctor should monitor you carefully at regular intervals. The two new drugs I mentioned earlier, which are supposedly easier on the stomach, are called *COX-2 Inhibitors*. At present, these are Celebrex and Vioxx. Perhaps because of the reduced side effects, they have gained considerable popularity among arthritis patients. However—and take this as completely subjective, anecdotal, layman’s testimony—I found that for me they provided significantly less pain relief than other NSAIDs I had taken. To be fair, please note that these two drugs were introduced late in the course of my hip degeneration, when the pain was severe. At an earlier point, they might have been more effective.\*

My progression through the NSAIDs over a seven-year course had included ibuprofen, Nalfon, Relafen, Ansaid (which was very hard on my stomach and might have been the cause of some hair loss), ketoprofen, Naprosyn, Celebrex, Vioxx, and Voltaren. The last

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\* At the time this is written, the COX-2 inhibitors mentioned here, Celebrex and Vioxx, have encountered some negative press because of a study that links them to an increased risk of heart attack compared with other NSAIDs. Some evidence has also been unearthed suggesting that these drugs might not have the reduced side-effects on the stomach that were originally claimed.

of the NSAIDS I tried and stayed on for the two or three years before surgery was a 1200 mg daily dose of Daypro. At the end, in the several months prior to surgery, nothing short of morphine would have helped.

### Supplements

The FDA does not control food supplements as closely as it controls drugs. While manufacturers must nevertheless be careful with frivolous claims, the public can purchase these products without prescriptions and can use or abuse them as if they were food, rather than drugs. Manufacturers can provide anecdotal evidence of the effectiveness of the products and consumers who are convinced by the hype can use the supplements to their hearts' content. A huge dietary supplement industry has burgeoned in the past twenty years, as is evidenced by the growing number of "health food stores" appearing in shopping areas. Because of the size of the markets involved, it is not surprising that two major targets for such supplements are weight-loss and arthritis.

I am not saying that supplements are always bad or a waste of consumers' money. In fact, I have tried glucosamine/chondroitin and MSM. I have friends who swear by them. For me, the jury is out. I have seen no evidence of cartilage regeneration in my X-rays since taking glucosamine/chondroitin. I do not know whether it relieved any of my pain, either. The pain was all but overwhelming at the end. A small amount of relief would have been barely noticeable.

The best thing I can say about these supplements is that, like chicken soup, they might not provide a cure, but they couldn't hurt. However, be careful to keep up to date with current findings about food supplements you are contemplating taking. In recent years, many have been pulled from the market after harmful side effects were discovered. Moreover, it is essential that you apprise your doctor of any supplements you are taking.

### Physical Therapy

It is of great benefit to keep those joints moving, active, and the surrounding muscles, tendons, and ligaments strong and healthy. Any amount of exercise is quite helpful. After a while, however, you will find that your exercise capabilities have decreased. The pain is the culprit here. Keep at it as long as you can, though. Even when surgery is inevitable, keeping those muscles strong will be beneficial in speeding your recovery.

### "You'll know when it's time."

You have cycled through the NSAIDS, you have tried some physical therapy, you have seen orthopedists and rheumatologists, you have taken huge doses of glucosamine/chondroitin or MSM, maybe even tried bee stings or some of the other radical alternatives, but that hip pain seems to be getting worse and worse. In my case, it was bad enough to keep me awake at night. No position in bed was comfortable. The pain gnawed away at me night and day, day and night, *ad nauseum*. This was the point at which there was only one clear solution path.

The words of that first orthopedic surgeon, Dr. S, echoed in my pain-beleaguered brain: "You'll know when it's time." For me, it was time.

Of course, fate intervened. I had left my heartburn producing university job, becoming a self-employed consultant. In 1998-99, I landed a large consulting assignment that entailed commuting between Florida and California over a 15-month period. This project was rewarding both professionally and financially, but it nearly finished off my hip. When the project wound down and I returned to Florida full-time, my first order of business was to begin seriously pursuing surgery. As it turned out, it would take a year to get things going on the right track. After a false start or two, I was successful in finding

the right surgeon. I shall describe that search in Chapter III. Finally, in October 2000, I made the commitment to myself to arrange for the total hip replacement surgery.

In the next chapter, I will present brief synopses of books I had read for background on total hip replacements. I found them very helpful and informative. Read them if you have the time and the wherewithal. I urge you to get all the information you can. Forewarned is forearmed!

## Chapter II. Gathering Information

In the course of preparing myself for my hip replacement, I came across three excellent books, which I shall summarize in this chapter. Having been published within the past three or four years, they contain reasonably up-to-date information written for the nonprofessional. Each book provides a different perspective. My recommendation, if you have time, is to read all three (after reading my book, of course!). There is no such thing as being *too* prepared!

### ***Arthritis of the Hip and Knee***

Ronald J. Allen is a law professor who has undergone two hip replacement operations. Co-author Brander is the physician who directed Allen's physical therapy. The other co-author, S. David Stulberg, is his surgeon. The book is well organized, with Allen's patient's perspectives interspersed with technical information from the doctors. It is richly illustrated with photographs, X-rays, and drawings. This book is a rich source of information, incorporating perspectives of the patient, the surgeon, and the physical therapist in an easily readable, informative style.

Allen, Ronald J, Victoria Anne Brander, M.D., and S. David Stulberg, M.D., *Arthritis of the Hip & Knee: The Active Person's Guide to Taking Charge*, (Atlanta, Peachtree Publishers), ISBN 1-56145-149-5, 1998.

### ***A Patient's Guide to Knee and Hip Replacement***

Author Irwin Silber is a 67-year-old journalist who has undergone total replacement of both knees and one hip. His narrative is smooth and engaging, as one would expect from a journalist. I found the subject coverage very complete, even including recommendations for sex positions during convalescence. If you want a book written from the patient's perspective that is also well researched and accurate with respect to medical issues, this is the one to buy.

Silber, Irwin, *A Patient's Guide to Knee and Hip Replacement*, (New York: Fireside), ISBN 0-684-83920-2, 1999.

### ***All About Hip Replacement: A Patient's Guide***

This is a book written by a Dr. Richard Trahair, an Australian physician and hip replacement patient. In it, he provides his own as well as other patients' feelings about how they approached the decision to have hip surgery, their time in the hospital, and recuperating after the operation. The strength of this book lies in the variety of hip replacement experiences provided by the twelve very diverse "informants," who ranged from a university student in her twenties to a woman in her eighties, with a good, representative sampling of patients of other ages. It is a quick read, with a very good glossary.

Trahair, Richard, *All About Hip Replacement: A Patient's Guide*, (Melbourne, Australia: Oxford University Press), ISBN 0-19-554112-X, 1998.

All of these books provide details of the surgery and rehabilitation exercises, which are significant omissions in my book. While it is possible that at some future time I will add this information, I feel that it would be hard to compete. Thus, I reiterate my recommendation to read these books.

## Chapter III. Finding a Surgeon

Having made the decision to get a new hip, you are faced with the next and most important decision: who will perform the surgery and in which facility? In some cases, Medicare or private health insurance plans will limit your freedom of choice. Nevertheless, it is important to take advantage of as much flexibility as is available to you. The skill and experience of the surgeon has an important bearing on the favorable outcome of the surgery. Furthermore, a relaxed, comfortable, caring environment for the stressful time of surgery is of obvious benefit to the patient. In this chapter, I discuss the healthcare system and doctors, after which I describe my personal experiences in choosing a surgeon.

### The healthcare system

In the United States, healthcare options for most people relate to which type of medical insurance an individual has. For this reason, my experiences involving choice of physicians and facilities are likely to be different from others with a different type of insurance. In this pursuit, as in most others, money talks. If you are wealthy, you have absolute freedom of choice. You can either self-insure or buy an expensive, total indemnity, fee-for-service insurance policy that allows you to choose whichever practitioners and hospitals you want. Most of us, however, do not have that complete freedom. At some point, the insurance company, the Government, or the healthcare industry's subjugation to these entities will get in the way. If you are of qualifying age, you are eligible for government funded Medicare, which has certain limits and restrictions. Low-income families are eligible for Medicaid, which has other limits. Most people working for medium to large employers have a company sponsored health insurance plan, which is usually a PPO or HMO plan. PPO plans allow freedom to choose any doctor or hospital, but the insurance company bases the amount paid on a schedule of fees negotiated with "preferred providers." If you choose someone other than a preferred provider, you will pay much more out of pocket. Still, you have freedom of choice to the extent that your wallet will allow. With an HMO plan, the insurance company generally chooses the doctors and healthcare facilities for you. You have only limited choices. This is not good.

However, if you are fortunate enough to be employed where an open enrollment in a variety of different insurance plans are offered, you can probably switch plans at one specific time each year. This could allow you to choose a plan that enables you to use a specific provider that was not "in network" on your existing health insurance. You should consult your company benefits administrator to see whether this is a possibility for you.

This capitalistic medical care system, much the same as in the more socialistic schemes in England and Canada, has created a bifurcated market. A surgeon with excellent credentials is likely to be commanding fees at the top end of the scale, which would make it unlikely that you would find him or her on the approved list for the lower paying insurance plans. At the bottom end, you are likely to find the less experienced surgeons. The grass is not greener on the other side of the fence. Adam Smith was right; Karl Marx was wrong. You get what you pay for. Actually, for the masses in the U.K., for example, socialized medicine's bulk approach is replete with long waiting lists for total hip replacement surgery. I have heard that because of the disparity between supply and demand, people who are deemed unworthy of the surgery, for example the grossly obese, are completely denied a place on the waiting list. So much for the humanitarian side of medicine! The dismal science of economics has a firm grip on the health care industry.

I shall issue my disclaimer once again. If this was a well-researched book—which it may be someday if there is enough interest in fleshing it out—I would present information

about HMOs, PPOs, Medicare, Medicaid, etc., and offer differing perspectives corresponding to the vagaries of the various plans. In its present form, however, the book is a compendium of my personal experiences and observations. Some of the concepts may be applicable to patients in all health insurance situations, but others might apply only to those with insurance coverage similar to mine. I will avoid further editorializing about the way the bottom-line orientation of the health insurance and healthcare industries has transformed hospitals and many doctors over the past thirty years or so. I do not think any of us are happy with it; therefore, perhaps it is time for some grass-roots activism in this area.

### Doctors

Unless you are a member of an HMO, you will need to choose a doctor for any specialized medical procedures that cannot be performed by your family doctor, internist, or GP (now collectively referred to in 21<sup>st</sup> century insurance-speak as your PCP or Primary Care Physician). A highly trained orthopedic surgeon must perform total hip arthroplasty. In a perfect world, education and training of doctors would be consistent. Unfortunately, it is not. Furthermore, the surgeons you may be able to choose among will have a wide range of levels of experience in this procedure. Without any significant medical training, you are going to have to determine if this man or woman gets to cut you open saw, and drill your bones, and put you back together. How can you possibly accomplish this task?

The first thing you must do is lose your awe of doctors. They save lives and they work hard, but they are not miracle workers. Some might be geniuses, but the majority possess above-average intelligence. They are highly trained in their craft, but they are not God. This bluntness is necessary if we are to get anywhere here. Too many people will let a doctor sell them the Brooklyn Bridge just because “a doctor told me to do it, so it must be good for me.” Now, I am not suggesting that there are doctors who would deliberately suggest treatments that would harm a patient. What I am saying is that there is a tremendous range of skills and interpersonal sensitivities (a.k.a. bedside manner) among physicians. You obviously want a doctor who has the necessary technical skills. In this connection, you would hope that a medical degree, licensure, board certification, many years of experience, and continuing education requirements would guarantee a competent collection of such skills. That is, however, only half the battle. Importantly, no amount of testing or continuing education will correct a poor attitude toward patients. The doctor in whom you place your trust must be the complete package: technically competent yet highly communicative and, above all, humane. You and only you can be the judge.

Older generations of patients had been taught to place blind trust in the godlike powers of doctors. “If you do what the doctor says, everything will be alright.” The old school of thought did not provide for differences in competence among doctors. Am I suggesting that there are doctors who are incompetent and should not be practicing? Yes, this is certainly true in any profession. However, aside from the few who are completely incompetent, some doctors are better than others at what they do. We must reject the notions of the past if we are to obtain the best care for ourselves. It is reasonable to be at least as careful about selecting a doctor as one would be in selecting a house painter. Yet, too many of us still feel that a doctor is a doctor.

Beyond the basic credentials, you will want a surgeon who specializes in hip and knee replacement, one who has performed the surgery many times, and with regularity. You do not want a generalist who does the occasional hip replacement. Nor do you want a new surgeon who has not yet performed several dozen hip replacements. Sure, they have to gain their experience somewhere, but they do not have to obtain it while operating on *you*! This is a complex operation; you have one chance to get it right. If a second surgery,

known as a *revision*, is necessary, it is much more difficult than the first. The experience level of the surgeon is the easiest thing to check, so do yourself a great favor and check it.

Getting back to the bedside manner, I do not deal well with arrogant doctors. They might be highly skilled otherwise, but if there is no way to cut through the smokescreen of arrogance, I can neither judge their competence nor communicate my needs effectively. A doctor of this personality type will tell me what he or she will do to me without allowing discussion or questions. He or she will not give details. Some of them will toss you a pamphlet about the surgery in question—usually published by a drug company or orthopedic appliance manufacturer—written in such generalized, eighth grade level baby talk that it inspires far more questions than it answers. By the time you get serious about evaluating doctors for performing a complex procedure such as a hip replacement, you should have done sufficient reading on the subject to render such pamphlets superfluous. You do not want or need the baby talk generalizations. You want interaction with the doctor and clarification of the fine points—the specifics of *your* case. You want answers to the medical and practical questions that have entered your mind as your study of the subject has progressed.

Assuming that you have found a doctor who is sincere, interested, and communicative, you must convince this rare individual that you have done a significant amount of background work on your own and you wish to discuss the finer points and concerns that have entered your mind. You will know that you have a good one if there is no hesitation to talk at an adult-to-adult level about your concerns. He or she will appreciate the work you have done on your own, which will allow more time for discussing specifics. You can be an informed consumer even if you do not want to invest time in studying hard-core medicine. If you do not understand something, the doctor should feel obligated to explain it thoroughly. It is a two-way street. Be full of questions. They are expected.

If a doctor insists on giving you baby talk or pontificating to you, even after you have expressed a preference to discuss your health on an adult level, find another doctor. You are eventually going to be subjecting yourself to considerable bodily trauma. For your own peace of mind, which is essential to a successful outcome, you need to place complete faith and trust in your surgeon. If you go into surgery feeling hostility toward a doctor who does not give you credit for your intelligence, you will be reducing your chances of a good result.

Similarly, if you encounter a surgeon who offers an opinion that does not seem to make sense or that bothers you in some way, seek additional opinions. Ah, the dreaded second opinion! Many patients fear seeking another opinion because it might offend the doctor. You would not hesitate to interview three contractors with different ideas about how to remodel your bathroom, and you would not worry about offending any of them by telling them that you would like to see what the others have to say. Why should remodeling your hip work any differently? The more opinions you obtain, the better versed you are and the better able you are to converge on a decision.

Take as much time as necessary to discuss the subject to your satisfaction with your surgeon at whatever level is most comfortable to you. The surgeon should adjust his or her level of communication to yours. On the other hand, do recognize that an orthopedic surgeon is a busy person. Do not burden him or her with extraneous small talk or gossip. Keep the conversation centered on the specific medical situation that brought you. Concise answers and a good, warm feeling about the professional you have chosen will reward your focus.

I have found many good, communicative doctors during my lifetime. For example, my relationship with my family doctor (PCP, if you must) has lasted over 20 years. On the other hand, I have had encounters with doctors with whom one appointment was too

many. (You will read about one of them in the forthcoming pages.) Fortunately, there have not been many in that category. It is my hope that it is possible for you to choose your doctor. I know that for some of you your choices will be limited by the type of insurance arrangement you have, but for those who have the freedom to choose, I hope you can find the best possible surgeon to conduct your journey through hip surgery—one in whom you can place your complete faith and trust.

### **Choosing a surgeon: personal experiences**

My quest for a surgeon began back in 1995, even before I had reached the point of no return for my hip. While I did not yet know whether the replacement surgery would be the ultimate solution, I thought I was being highly organized in preparing for all possible outcomes. I had done an on-line search on Medline using the keywords “total hip arthroplasty.” The search yielded many abstracts, which I began narrowing down. When I came across a paper written by a surgeon in my city, I ordered the full text.

#### **Dr. B: the elder statesman**

The paper was written by Dr. B, a prominent “hip man” in town, describing a technique in which the artificial joint was machined by a numerically controlled apparatus while the patient was on the operating table. A CT scan or MRI would provide the exact dimensions necessary for each particular patient. This appealed to my scientific curiosity, so I made an appointment with the good doctor to hear more about it and to have him evaluate my hip. Well, it turned out that the “while you wait” manufacturing process was not completely effective, either economically or medically. It was no longer in use. Dr. B looked at my X-rays, telling me that my bone structure was good and that a standard, off-the-shelf prosthesis would work fine. Upon hearing that I had previously discussed the hip with Dr. S, Dr. B asked me what he had to say. I told him he had said, “You’ll know when it is time.” Dr. B reiterated that notion. I asked him what scheduling surgery with him would entail. He then broke the news to me that he would be retiring from surgery at year-end. I teasingly accused him of deciding to retire on the spot after looking at my hip. He somewhat accepted the bait, offering that orthopedic surgery is a lot of hard work and it is a young man’s game. His young associates would be doing the surgery while he would be doing consulting. That was the last I saw of Dr. B.

I liked Dr. B. He was confident and secure; thus, he did not talk down to me as a patient. Obviously, bedside manner and straight talk are important to me. Some of my consultations, however, did not go similarly well. The next doctor I interviewed would turn me off completely.

#### **Dr. O: go away, kid!**

In the years after seeing Dr. B, I tore up whatever cartilage remained in my left hip. Fifteen months of grueling, cross-continental commuting and one large construction project later, I was anxious to resume the search for a surgeon. I was in pain day and night, and I was absolutely convinced that surgery was the only solution. The subsequent initial consultation with an orthopedic surgeon recommended to me by several different people, however, was to be a demoralizing setback. Please read on. I have included this failed doctor-patient relationship hoping that you can avoid a similar debacle.

Call this surgeon Dr. O. I made an appointment with him for an evaluation. After spending the usual time in the waiting room filling out forms and so forth, I waited and waited and was finally ushered to an examining room, where I waited some more. Eventually, Dr. O came in, asked me a few perfunctory questions, and did some leg manipulation to test my range of motion. He also looked at the soles of my shoes to discern their wear pattern. Knowing that I had recently suffered some painful back spasms, he asked me how I was able to tell whether the pain was coming from my back



or my hip. I told him that I had had many years of experience with both back spasms and hip pain, and that I could differentiate the pain between the two. I do not know whether he believed me or not.

He sent me back to X-ray. I had no doubt that upon seeing the films, the good doctor would conclude that total hip replacement surgery was indicated. The joint degeneration was such that it was already bone-on-bone when Dr. B did his X-rays—and that was prior to the coast-to-coast commuting grind. There was almost no cartilage left. That, plus the pain and lifestyle degeneration (which, by the way, Dr. O never even discussed) should have been enough to not only qualify me for surgery but also make it an urgent situation. The X-ray technician “posed” me for several shots, developed them, checked them, and told me I could go back to the examining room.

I got dressed and I was walking down the hall when Dr. O motioned me over to the X-ray viewer. He pointed out the problem, osteophytes that looked like the topography of the Himalayas, and told me that I had a lot of degeneration. He measured parts of the X-ray, noting that because of the cartilage loss, my left leg was about 10 mm shorter than the right. Then he told me that he would not recommend surgery because I was only 53 years old. *What did he just say?* He would recommend only conservative measures until I was 60, and then we would revisit the situation. I could not believe it! I told him that I had been in pain for at least seven years and had had quite enough of NSAIDS and other conservative measures, which were becoming increasingly ineffectual. However, he was unrelenting. Conservative measures. “Here, have you tried Voltaren? I’ll give you a prescription. And I’ll give you a 6 mm heel cushion for that shorter leg.” He advised that I should lose all my excess weight because it increases risk factors for surgery. I was well versed about the increased risk factors, and I was willing to accept them. Apparently, *he* was not. He continued the soliloquy by telling me that the first replacement joint might last 10-15 years, probably less, and the second surgery is more difficult. For that reason, he would not want to have to do the second [revision] surgery. I eventually told him not to be concerned about that—there was absolutely no chance that he would be doing it.

Dr. O told me he left me some pamphlets about arthritis and hip surgery on the chair in my examining room, which I should take with me on my way out. These were very cursory pamphlets about arthritis and hip surgery, comic book stuff, which further insulted my intelligence. If I had not made it clear that my reading on the subject had transcended baby books a long time ago, then Dr. O simply was not listening. As a parting shot, he told me, “...lose all that excess weight. I know it’s like Catch-22 to get some serious exercise when you have only one good leg, but there are ways. OK, so you know where we are if you need us.” I do not have a problem with doctors or well-meaning friends or family telling me that I need to lose weight. I know I am overweight to the extent that my health is compromised. However, here I felt that I was getting an ultimatum: “get down to your ideal weight for your height or I will not operate on you.” To add insult to injury, he wanted me to wait seven years. I left this encounter with great bitterness.

I am reasonably certain that Dr. O did not want to operate on me because of the additional risks associated with my being overweight. Whether this was merely a personal preference to operate only under ideal circumstances or a strong desire to avoid malpractice suits, he chose the “safe” way out. This seems to fit with the rest of his one-sided attitude. Of course, it is a free society and total hip arthroplasty is elective surgery. A surgeon is entitled to decide for himself whether to operate on any given patient for whatever reason he or she chooses. There are indeed doctors these days who will treat only healthy patients. However, I believe that it is essential for a surgeon to be open, honest, and communicative about such issues. We might agree to disagree, but the doctor must at least be forthcoming enough to tell me exactly why he or she does not wish to take on the case.

I had no intention of enduring excruciating pain and debilitation for seven more years. Had Dr. O's diatribe cowed me, as it would some patients, I might have accepted his word as gospel, suffering considerably more pain and possibly damaging my stomach, liver, or kidneys, after the trial and failure of additional conservative measures.

*Sayonara, Dr. O, big help that you were!*

#### **Dr. G: the search ends successfully**

After the Dr. O experience, I was somewhat disconcerted. My friends and my family doctor (Dr. M) were sympathetic and supportive, consoling me with the fact that there are many more orthopedic surgeons in the world, and others will have different attitudes about performing the surgery on me. Nevertheless, it took time to restore my faith in the medical community in general and orthopedic surgeons in particular. In spite of the assurances of my confidantes, was I going to run into the same attitude everywhere I went? Would I have to suffer that awful, debilitating pain for the rest of my life? I buried my head in the sand for a while, thinking about just what I would do.

An inspiration came to me to check out the medical center at the University of Florida. I thought that it would be interesting to investigate what a large university medical center could do. I felt that they might be closer to the leading edge in research. Hospitals in Orlando, the area in which I live, had struck me as being short-staffed bastions of unfriendly people. I suppose hospitals are in that condition everywhere, but here the two big hospital entities were having a well-publicized bidding war for nurses, which seemed ludicrous. The net result could not possibly improve care levels for the patients. Therefore, I was ready and willing to consider alternatives outside the area. Accuse me of thinking that the grass was always greener on the other side of the fence, but Shands Hospital at the University of Florida had a good reputation, so why not see what was going on there. Gainesville, the location of the University of Florida, was only a two-hour drive from Orlando. The people there are a little less hurried—you can still do some pretty good fishing around that part of the state. I had a plan!

Of course, the hospital is only part of the equation. I would still have to find a surgeon who was compatible with me, one who could inspire me to place my faith and trust in him or her.

In October 2000, I obtained a referral to Dr. G, who has an excellent reputation as a hip man. He does only knee and hip replacements. He had been chief of staff there at Shands Hospital, and at the time I saw him, was chief of the orthopedic service. I was looking forward to meeting him, hoping that this would not be another wild goose chase. I drove up to Gainesville, anxious to resume my quest.

I arrived on time for my appointment at the Orthopedic Clinic. Most of the paperwork issues had been handled on the phone beforehand, so we could get right down to business. This efficiency pleasantly surprised me. Upon arrival, I was sent immediately to X-ray, where the usual films were taken, quickly developed, and given to me in a large envelope to take back to the clinic. Shortly after handing them to the receptionist, a nurse called my name, mispronouncing it as usual.

The nurse led me back to an examining room and told me to have a seat. Shortly thereafter, another nurse stopped by to review some things with me and to ask if I had brought the photograph of me, as instructed. I whipped out a nice, 5" x 7" glamour shot for the files. Eight months later, this photograph would enable Dr. G to impress me by commenting that I was then sporting a completely different haircut than I had when he last saw me.

Then I waited. And waited. And waited. The examining room door was open, so I amused myself by watching other patients in various stages of joint impairment or recovery. Listening to the inevitable hospital humor that nurses and doctors employ to reduce tension further amused me. I had essentially committed the day to this visit, so I had no reason to be impatient. I would go with the flow. Actually, I had not been waiting more than about 45 minutes when Dr. G walked in with my X-rays.

After the usual amenities, the soft-spoken Dr. G summed up my situation. “Your left hip is shot and your right one is a couple of years behind it.” Soft-spoken though he might have been, he had gotten directly to the point. He then proceeded to explain exactly what was happening with the hip joint, using the X-rays. The amazing thing was that without any beating around the bush, Dr. G was able to choose an appropriately high level for communications. Knowing that I had an engineering background, he explained the forces involved in the hip joint, both as nature intended it and as it had degenerated in my case, using vectors and the terminology of physics. This was an impressive move. Surely, he would have taken a completely different tack for an artist or a CPA. Tailoring the presentation to meet the needs of the audience is standard in most industrial settings, but I have heretofore never observed it pulled off with this degree of finesse in doctor to patient presentations. Either you get the standard baby talk or you are pontificated to, but how often do you meet a doctor who takes the time and effort—and has the talent—to discuss a proposed medical procedure in the lingua franca of *your* industry or profession? Not very often! Here, I had a consummate pitchman and his record of accomplishment stood behind his sales pitch.

Dr. G apprised me that there were three reasons to have the surgery: abatement of pain, reduction of potential further damage, and resumption of a more normal lifestyle. He felt that in my case, all three were important, but that the lifestyle changes were the most significant. Obviously, I needed exercise, too, and the hip was increasingly getting in the way of that. He believed that I had a high tolerance threshold for pain, and I could probably accommodate more pain than I was then experiencing. (Speaking for myself, I had my doubts about just how much more pain I could handle). The lifestyle changes were really impeding my ability to enjoy life. Dr. G was able to tell me exactly how I was withdrawing from various activities without my having told him anything. He said that it would be not a matter of *if* I would be having the surgery, but *when*. Moreover, he noted, it needed to be soon because of the risk of further dislocation of the joint or damage to the bone structure, which he demonstrated to me with the X-ray.

Obviously, I did not need much convincing as to the need for surgery, as it was a preconceived notion before I even sat down in the examining room. Nevertheless, as further icing on the cake, Dr. G showed me how the outward and upward rotation of the femoral head was creating unusual stresses on the pelvic bone, causing pockets of something akin to ulceration that would eventually weaken it. If the pelvic bone were to fracture because it was compromised in this manner, or if it otherwise required reinforcement, it would require a much more difficult operation. This was the reason that there was some urgency as to when the surgery was scheduled.

Dr. G offered one further, superfluous notion to his sales pitch. He could give me an injection of a local anesthetic in that left hip joint that would eliminate my pain for an hour or so. I would be quickly convinced. No need.

I had heard all that I needed to hear. Although Dr. G spent more time with me and answered further questions from me, I had made up my mind. I would schedule the surgery here and this was my surgeon.

One of the more important questions involved my being fat and having risk factors that were perhaps more significant than the average case. Recall that I thought that the main

reason Dr. O did not want to operate on me was the presence of those increased risk factors, not because of the nonsensical and arbitrary notion about needing to continue conservative treatment until I became 60. I felt that Dr. O did not handle that in a very forthright manner. On the other hand, Dr. G told me that my size makes surgery more difficult for both the surgeon and the patient, but that he had operated on people bigger than I am. He advised me that if I decided to go ahead with surgery, I should commit myself to “sweat” for an hour a day between then and the date of surgery, choosing a method that would be appropriate to not being able to use my left hip. Swimming or water aerobics would work. This would get me into better shape for both the surgery and the rehabilitation.

I left Gainesville that day feeling good about the surgery. I finally met a no-nonsense surgeon with a can-do attitude and a great record of accomplishment. After giving it a couple of weeks thought, talking with friends, preening my schedule, and doing a little more research, I would call the clinic to schedule the surgery. I had one significant business commitment on my calendar that I wished to provide for before I could schedule any downtime for myself. This project was scheduled for completion on March 31, 2001. Knowing the players involved, I allowed one extra month of slop-over time, which would take me to the end of April. Then, I decided that I would like to commit a month to myself for relaxation, socialization, and preparation for the surgery. This brought me up to June 2001. That would be the earliest I could schedule the surgery. Therefore, I did. June 7, 2001 was the date.

### An Unplanned Encounter with Dr. S

Recall that my first orthopedic evaluation relating to the hip problem was performed by Dr. S way back at the time of my earliest realization that something was wrong. I had eliminated Dr. S from consideration as the surgeon who would replace my hip for a couple of reasons. He had not acted very interested in discussing the surgery option with me back at that time, a time when I could have used more information. More importantly, he is a general orthopedic surgeon, doing a lot of arthroscopy and office treatments, whereas I wanted a specialist who does only hip and knee replacements.

In early 2001, my old heel spur had flared up on me, necessitating a visit to Dr. S to get an X-ray and be apprised of treatment options. During the examination, I told Dr. S that I would be having the total hip replacement in Gainesville, and it would be performed by Dr. G. He looked surprised and somewhat hurt, telling me that there was still time to change my mind. I told him that the issue was decided. Dr. S gave me a shot of cortisone for the heel pain and, while doing so, continued to proselytize me about using his services for the hip replacement. I continued to state that my decision was made and there was no going back. He finally gave up and joked that he would send me a postcard every week reminding me that he does that surgery, too.

Obviously, doctors have to market their services somehow, so I don't have a problem with Dr. S trying to get me to change my mind. However, this experience is illustrative of something you might encounter in your travails while choosing a surgeon. The decision should be yours (subject, of course, to the restrictions imposed upon you by your health insurance), and you must stick to your guns. It is your hip, not the doctor's, and you must consider it first and foremost. If you hurt somebody's feelings, that's life.

## Chapter IV. Things to Do Before Surgery

Depending on how soon your surgery appointment is, either you will have plenty of time to prepare or you will have to condense the myriad little details into a very short period. It helps to have others you can rely on to help accomplish some of the things in which you do not have to be personally involved. Taking a little time to sit down, making a list of the tasks, and scheduling them is a good idea. Try to get the most important and taxing things out of the way early so that issues of lesser importance do not bog you down. While many of the preparatory steps you take will be specific to your case, in this chapter I will discuss several universally applicable measures.

### Hospital pre-op education programs

In my reading, I had learned that the extent and quality of pre-operation education provided to patients ranged from nothing at all to multi-session courses. While I felt that I was fairly well versed in the particulars of the surgery, as well as the preparation for and recovery from the operation, I would still take advantage of any opportunities to amass additional knowledge of the subject.

Unfortunately, the hospital at which the surgery was to be performed was a two-hour drive from home. Furthermore, to my knowledge, they did not offer pre-operation education. I was beginning to feel as if I would skip this step when I stumbled across the solution. In the process of searching for rehab facilities, I found that one large, local healthcare organization offered an in-home consultation with a physical therapist. The consultation would cover familiarization with the operation and subsequent hospitalization, rehabilitation, and occupational therapy. The therapist would also perform a walk-through of the house to identify problem areas and help solve them. This sounded like a very valuable service and, what's more, it was free!\* How often can you get something for nothing in these days of bottom-line orientation in healthcare?

### Home visits by physical therapists

The idea of a visit to my house by a physical therapist trained and experienced in hip replacements was appealing. I quickly decided to take advantage of this service. I spoke with the therapist, Bruce, to schedule an in-home appointment. He advised me that it would be best if I did this at least two to three weeks in advance of the surgery so that I would have ample time to address needs that became apparent during his visit. Bruce had a busy schedule for the remaining three weeks before my surgery date, but he was able to commit to an appointment approximately two weeks in advance of my operation.

Bruce arrived at the appointed hour with a veritable plethora of gadgets, appliances, aids, and whatnot for show and tell. I grabbed some crutches, canes, walkers, grabbers, and stuff that I had either bought or been given, in order for Bruce to evaluate them for my use during my recovery. He asked me to take him to someplace where we could talk comfortably. We went to the living room and got right down to business.

The first thing was, of course, paperwork. Fortunately, this was relatively painless. The service was free, but I still needed to sign some forms whose purpose was to hold the hospital harmless for any consequential damage and account for Bruce's on-site time.

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\* The service is normally supplied at no charge by the healthcare organization for its own hip replacement patients. My surgery was to be done at another hospital out of the area, but the service was nevertheless given to me at no charge. I had told them that there was a good chance that I would use their facilities for rehab, but I had made no commitment.

Bruce asked me a number of questions about the operation, so as to tailor his presentation to the particular materials and techniques that would be used in my operation. In your consultation with your surgeon, you should have received most of this information. For example, you will know whether the prosthesis will be *cemented* or *cementless* and you will know the composition of the joint. The one question Bruce asked that threw me a curve was the surgical approach: *anterior* or *posterior*. My self-preparation in this area was deficient. I did not know. A call to the surgeon's office got me my answer: *posterior*. Bruce also asked what the bending restriction would be, knowing that each surgeon seems to have a different requirement. In my case, the restriction was to bend the joint no more than 70 degrees for the first two weeks and no more than 90 degrees thereafter. I was impressed that Bruce was able to tailor his presentation to take into account the vagaries of the particular surgeon.

He took me through what to expect on the day of the operation. With minor deviations, due to procedural differences between the hospitals involved, Bruce turned out to be right on the money. He told me that I would wake up in the recovery room with a large, wedge-shaped *abduction pillow* strapped between my legs, and that I would be wearing compression stockings to help keep down swelling and prevent blood clots in the deep veins of the legs. These accoutrements would become my bedtime companions for at least six weeks. I would have to sleep on my back with that big, bulky abduction pillow strapped in between my legs. Naturally, Bruce had brought along an abduction pillow for show and tell.

I expressed my concern that I had never found it easy to sleep on my back. In fact, I was a stomach sleeper. I would not be able to roll over onto my stomach because of the potential for dislocating the new joint in the process. This, of course, was the reason for using the abduction pillow. Bruce told me that I would get used to sleeping on my back. Of course, I did not believe him. However, he was right. After the first three or four days, it would turn out that I could sleep like a baby.

Next, it was practicing how I would be getting around after the surgery. My surgeon had not told me how much weight I would be able to bear with the operated leg during the first few weeks after surgery, so Bruce assumed it would be no weight at all. (It turned out to be 20-40 pounds, which is next to nothing.) The first exercise was getting out of the chair I was sitting in, for which I had to use my upper body and my good leg. Then Bruce showed me how to use a walker, which I practiced for a few minutes. We looked at several other chairs for potential use during recovery. Using the approved, post-surgery technique, I got into and out of them with varying degrees of difficulty. The most interesting chair was the big, leather LaZBoy recliner in the family room. It would almost suffice as-is, but Bruce recommended that I build a platform to elevate it by six inches or so to make it a bit easier to mount and dismount. I would eventually implement his recommendation, which would serve me well during my extended convalescence.

We visited the kitchen, where Bruce told me the occupational therapists at the rehab would show me how to organize things to avoid bending, stretching, and retracing steps.

My house has a stairway. This would be the toughest part of my hampered locomotion. Bruce acquainted me with one technique for going up and down, using a crutch in one hand and the stair rail in the other. I would learn other techniques in the rehab. If I would not be able to conquer the stairs, it would be necessary to rent a hospital bed for the first floor, so that I could sleep there. Being a stubborn person, I knew it would not happen that way. I would use my whole house and that would be that. Therefore, I struggled up the stairs. Later, I would learn other ways to accomplish the same thing.

Upstairs, Bruce looked at my bed, and pronounced it fit for rehab duty. It has a new, thick mattress, making it quite high, which makes it easier to get into and out of without

violating any bending restrictions. In the bathroom, he advised me that I would have to get a 3-in-1 commode<sup>†</sup> chair to provide a toilet of sufficient height. He also told me to get rid of the throw rugs, as they represented tripping hazards. Looking at the walk-in shower, Bruce recommended that I remove the glass doors and put up a shower curtain instead. This would enable me to step in forward instead of sideways. I would not need to install grab bars if I purchased a shower chair with high handholds.

A walk down to the other end of the long hall brought us to my office. Bruce gave me the go-ahead to sit in my office chair and work at my desk—but no leaning forward, which would violate the 90-degree limit.

We struggled back down the stairs (I had to do the one crutch thing again). One last thing Bruce wanted to walk me through was getting into and out of cars. Using my personal automobile, he showed me that by moving the passenger seat all the way back and lowering the back of the seat as far as it would go it was relatively easy to get into the car without violating any bending restrictions. This was to prove to be invaluable later on, obviating the need for non-emergency medical transport for my trip from the hospital to the rehab and for my trip from the rehab to home.

We were done, and I was still absorbing all the good information, for which I thanked Bruce. Even if I had been required to pay a couple of hundred dollars for his visit, I would have received much more than my money's worth. I have been talking up Bruce's services to medical practitioners and patients ever since. A program this good deserves to be better known.

### Shape yourself up

If you are overweight, you should seriously consider shedding some of the excess weight. I realize that exercising might be difficult at this point. Your hip pain might well deter you from doing much heavy exercising that would promote weight loss. Watching your diet and doing whatever exercising you can is better than doing nothing at all. You can certainly do aerobic exercises with your upper body. I did, even though I have arthritic shoulders. In addition, you can perform many good exercises in the swimming pool. Consult your local chapter of The Arthritis Foundation for a water exercise program in your area. When you lose weight and increase your conditioning level, you will be facilitating both your surgery and your recovery.

Even if you are not overweight, it makes sense to increase your aerobic endurance and your upper body strength. You will be using your arms, your shoulders, and your abdominal and chest muscles to support your body weight during your convalescence with a walker or crutches. Believe me, this is very fatiguing, particularly for larger people. The better conditioned you are, the easier it will be to get around after surgery.

One other thing you can do in this area is start doing the exercises that you will be doing after surgery. If you are fortunate enough to have had a visit by a physical therapist as I described above, he or she probably will have briefed you about these exercises and perhaps will have given you a pictorial instruction sheet. If not, you can find many of the exercises in the three books I recommended in Chapter II. Do them. You will strengthen the muscles you will need after surgery. Furthermore, you will have a head start on learning the exercises, which will make the post-surgery physical therapists' job much easier.

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<sup>†</sup> The "3-in-1" refers to its triple use as an over-the-toilet raised seat with handholds, a beside-the-bed stand-alone toilet, and a shower chair. You probably will not need to use it as a beside-the-bed toilet, and most probably will leave it in the bathroom to serve as a raised seat.

I lost about 15 pounds before surgery, and I worked on upper body strength. I should have done better with the weight loss. I also started doing as many of the post-surgery leg exercises as I could. My upper body strength training consisted only of push-ups, of which I did 45 per day. This caused pain in my arthritic shoulders from time to time, but it was something I had to do. I would like to think that these measures positively affected what eventually turned out to be an extremely rapid recovery.

### **Autologous blood donations**

Your surgeon will probably recommend that you give one or more units of your own blood in advance of the surgery. If it is necessary to have a transfusion, the risk of viral infection will be low, because it is your own blood. This is a very desirable thing to do, so make sure it is high on your list.

You will have to phone your local blood bank for an appointment, and your surgeon's office will supply the details the blood bank will need. There is a time limit for the useable period for whole blood: approximately 30 days. You will therefore need to consider this when scheduling appointments. Another thing to take into account is that appointments for blood donations need to be spaced sufficiently to allow regeneration of the blood lost. Expect to schedule appointments about two weeks apart.

Many people are concerned about being a human pincushion. At the very least, a fear of needles is normal. Alas, this fear will have to be surmounted long before you arrive at the hospital for surgery. Giving your own blood is too important to allow squeamishness to get in the way.

### **Handicapped parking permits**

After you finally regain the ability to drive, it will be difficult to get into and out of cars, and you might find it difficult to walk long distances. Thus, it is advisable to have your doctor or your surgeon authorize a handicapped-parking permit. Even if you are not doing the driving, other drivers who transport you can use this permit for your convenience. You can obtain applications through your state division of motor vehicles. In my state, for a very small fee and a short wait at the local county auto tag agency, the permit will be issued the same day as you bring in the application.

If you travel frequently, you might be able to obtain a second permit to use for rental cars you will be driving or on the cars of those who will be transporting you. You will need the original permit to park appropriately at your home airport.

### **Dental appointments**

It is *very* important that you complete all pending dental work in advance of your surgery. This is because of the possibility of the bloodstream carrying infections from the mouth to the new joint. Any such deep infections are a very serious matter and very difficult to treat. It is for this reason that, once your surgery has occurred, your surgeon will advise you to take antibiotics before and after any dental procedures you undergo *for the rest of your life*.

It was ironic that I, with all my professed organization skills, wound up with a dental dilemma immediately before my surgery. I had scheduled a checkup in May, believing that it would allow sufficient time before my June 7 surgery date to do any necessary work. I had not had a checkup that resulted in anything more than a cleaning for the past ten years, and I had no symptoms of dental problems. However, the May checkup revealed a cavity forming under an old crown, which meant that the old crown would have to be removed, the cavity excavated and filled, and a new crown cast and fitted. My dentist's office apprised me they could not complete the work before my surgery. It took



a few increasingly assertive phone calls on my part to make my point, which was like pulling teeth (pun intended), but I finally got them to cooperate. The dental work was completed on the day before my pre-op testing was to begin.

### **Rally friends and family and arrange logistics**

It seems obvious, but somebody will have to transport you to and from the hospital or the rehab. Someone will have to look after your bills and your mail. Somebody will have to pay the household help, if you have any. If you are married, your spouse will be able to do most of these things. However, if you are single, as I am, and live alone, this requires significantly more planning.

Do not forget to begin planning for what happens when you return home. The hospital and rehab time will pass quickly, and you will need to have means of getting groceries and other necessities delivered to you. If you are lucky, as I am, you will have plenty of volunteers, and you will not have to give this much thought.

If you are a social creature, you might want to have a few get-togethers for friends to celebrate your forthcoming surgery and to let them know you appreciate their expressed willingness to help. If you are not the party type, then perhaps a nice, elegant dinner with your spouse or significant other would be appropriate. A visit with the grandchildren might be a relaxing family outing worthy of consideration. This is a time when much thought and activity centers on *you*. Therefore, why not turn it around for a little while and focus on those who are important to you?

### **Financial Affairs**

I hate to plan for negative contingencies, but if you care about your family, you will want to make sure that your financial affairs are in order, just in case something undesirable happens during surgery. I should stress that life threatening complications of this surgery are increasingly rare, and I do not wish to scare you. Nevertheless, two documents that must be up to date are your Last Will and Testament and your Living Will. See your attorney or your estate planner far enough in advance of your surgery to allow for preparation and execution of any new documents or codicils to old ones. Discuss these with your loved ones to make them aware of your wishes about how to proceed if anything should happen to you.

### **Buy some slip-on shoes**

You will not be able to tie shoelaces for quite a while. Thus, it is a good idea to have a pair or two of slip-on shoes on hand for when you return from the hospital or the rehab facility. I found that sneakers with Velcro closures were good all-around shoes for use during the recovery period. You will have been given a long-handled shoehorn and a long-handled grabber device by the rehab. Used in tandem, these make easy work of putting shoes on.

### **Just before the big day**

If you are like me, you will find yourself with 98 things to do at the 11<sup>th</sup> hour. Now you know why I advised you to make a prioritized to-do list. At this point, the key is to relax, not to worry about the remaining tasks. You will probably have family and friends clamoring to help you (particularly if you have wine and dined them as I suggested), so this is the time to take them up on it. Do not feel guilty about taking it easy while they do the rough stuff. They care about you, and they know this is a stressful time for you.

### A low-maintenance haircut

I had a little fun with this one. I was thinking about the possibility of being out of commission for about six weeks, wondering what my hair and beard would look like after having been unattended to for that length of time. I had been having it trimmed every two weeks, and I knew that if waited for three it got shaggy (by my standards). Well, just because everything else was topsy-turvy and I was having fun, I told my barber of 25 years that I would do something radical. She balked at first, thinking that I would be angry with her if she did what I asked her to do. Nevertheless, I finally convinced her to give me that same, Susan Powter crew cut my old man told me to get rid of in 1958. I looked weird but the shock value was great and I did not even have to comb it. Neither did I have to worry about it getting too dirty in the hospital. I could use soap and water on it like everything else. I think I now know what women go through when they make a radical change in their hairstyles. It was somehow appropriate to make a major appearance change going into major surgery.

### Prepare your house

I advised you to have a physical therapist visit your house to identify problem areas that might impede your rehabilitation. It is now time to pay heed to the recommendations made by that therapist. Remove possible tripping hazards such as throw rugs, children's toys, and ground clutter. Rearrange things you will be using such that they are reachable without bending or stooping or reaching across your body. Make whatever modifications were recommended to living, sleeping, and bathroom areas.

In my case, the most onerous task was elevating my favorite LaZBoy recliner by about eight inches, to make it easier to get into and out of it. This took the better part of an afternoon of makeshift carpentry by a friend and me, but it was well worth the effort.

### Bring your own prescription drugs

It is about time to think about what to take to the hospital. Make sure that if you are taking any prescription drugs, particularly expensive ones, you pack these in the bag you will bring to the hospital. They must be in their original bottles, or the hospital pharmacy will not accept them. The reason for bringing your own medications is to save money. There is a high probability that you paid much less for each pill than the hospital pharmacy would charge you if it were to supply the same drugs. Make certain that you tell the hospital in advance to note your chart with the names and dosages of any drugs you intend to bring yourself. Occasionally, you might have to remind nurses that the notation is there, as was the case with me, because such notations often escape nurses' attention at changes of shifts.

### Pack light!

I guess this is obvious, but I was in somewhat of a quandary as to what sort of clothes to pack for the hospital, so I shall share this exciting revelation with you. Other than what you will wear when you arrive, you will probably need no more than one change of clothing—to wear when leaving the hospital. You will be wearing that lovely, fashionable, open-backed hospital gown for four or five days. No need for keeping up with *GQ* or *Vogue*. Bear in mind that you will have some possibly bulky dressings on your hip and thigh when you leave, so your departure clothing should be loose fitting and airy.

## Chapter V. The Eve of Surgery

I had arranged for a friend, Bob, to take me to hospital, a two-hour drive from where I live. The plan was to go through a day of pre-operation testing and qualification the day before the actual surgery. This is done as an outpatient. If I had lived closer to the hospital, I would have gone home afterward and returned in the morning for surgery. However, being a couple of hours from home, I decided to get a room in a local hotel for the night before surgery. Another friend, Margie, herself a physician, would arrive in time for dinner that evening and planned to stay with me for the first few days after surgery.

### Pre-op testing and consultations

The purpose of the pre-op testing is to ensure that the patient is healthy enough to undergo surgery. I was a bit worried because I had set all the wheels in motion, particularly with respect to friends who had changed their schedules to accommodate mine. In Margie's case, she had scheduled vacation time from her physician's job in order to be with me. She flew in from 1,000 miles away. Gross inconvenience to many friends would result from my disqualification. I was concerned because I had a sore throat and a bit of a fever earlier in the week. I was afraid that it might recur. Fortunately, my fears would turn out to be unfounded.

The first stop on Pre-Op Day was the orthopedic clinic at the hospital, where I checked in and was quickly sent to X-ray for more glamour shots. There, things slowed down a bit, as there were six or seven patients there in the waiting room. Time to go with the flow. There was no way I could speed things up if I wanted to.

Bob wanted to talk with some friends, but his cell phone would not work deep in the bowels of the hospital. Therefore, while I waited for the next available X-ray setup, Bob went outside to make his calls. Thus, we initiated our game of hide-and-seek, which would continue throughout the day.

After getting the X-rays, I was given a large envelope to take back to the orthopedic clinic. There, I handed the envelope to the receptionist, who told me to take a seat. It was not long before they called my name (mispronounced, as usual) and ushered to one of the examining rooms. Here I would meet with the case manager, the surgical residents, and the surgeon himself to discuss final details of the surgery, what I could expect, and what would be expected of me. I was given some antimicrobial soap and was told to scrub myself very thoroughly with the soap that night and again in the morning. Humorously, the container holding the liquid soap was a urinalysis specimen jar, which I had to carry with me the rest of the day, precipitating some funny looks.

Most of the remaining questions were mundane. For example, I asked once again about using my own prescription medications instead of getting them from the hospital pharmacy. The case manager told me that it would be noted on my chart and that my drugs would be examined by the pharmacist to ensure that the contents of the bottles were what the labels said they were. Dr. G asked me if I would want a private room, which he recommended, stating that the difference in price was very small, around \$25\*. I agreed, because that is a small price to pay for privacy.

I was given instruction in how to use an *incentive spirometer* (IS), which is a simple device that helps you take deep breaths to fill your lungs after surgery. One of these devices will be supplied to you after surgery, and you will be expected to use it to keep

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\*Dr. G was wrong. It turned out to be only \$5 per day. Such a deal! Be certain to ask about the availability and cost of a private room.

your lungs clear. It is quite an easy exercise, which if you perform diligently, will make you feel better quickly.

I was then sent to Central Testing for an EKG, blood tests, and a urinalysis. All went smoothly, and I was almost into the home stretch. It was at this point that I began to lose my fear that something would get in the way of the next day's surgery.

### Anesthesia counseling

The next stop was Pre-Op Anesthesia. I had checked in, presenting my credentials, and sat down in the waiting room. Bob found me there. He must have been quite an expert on the playgrounds of New Jersey, playing hide-and-seek 60 years ago! As we waited, the receptionist fielded a phone call. I overheard, "Yes, Mr. Goldfarb is here. OK, I'll send him." What now? I was told to return to the orthopedic clinic. It did not take much rumination to figure out why they wanted me. What could be more important than medical testing on the day before surgery? Money, of course!

### Show me the money!

Back downstairs at the orthopedic clinic, I saw the woman responsible for scheduling and wallet extractions. A large number of toy frogs of various materials and statures decorated her office. (I imagined that one of them would fling its tongue out at me and slurp up my wallet!) In conjunction with my insurance company, she had calculated that I needed to give her about \$2,000 for the surgeon's fees. I put it on my American Express card. I might as well get some miles for my misery! Moreover, if something went wrong with the surgery, I could dispute it with American Express. After it was clear that my card would not bounce, I was given a receipt and permitted to go back to see the anesthesia folks.

### General or epidural?

Back at pre-op anesthesia, I sat down with a person who asked many questions. I was used to being asked about allergies to drugs and which medical conditions I have by that time, having answered the same questions at least five times that morning. I did not blow my cork because even if it meant that there was scant communication among departments of the hospital, all this redundancy could only give me some additional assurance that they would get it right. My vital signs were taken once again, and blood oxygen saturation was measured. I was then taken to a room where an anesthesiologist would take over to finish this phase of the pre-op day.

This was the most significant time snag. It took close to an hour for the anesthesiologist to arrive. Bob was beginning to get a bit impatient. I did not blame him; I was beginning to get antsy, too. Finally, the doctor arrived. More questions about drug allergies and medical history. No problem.

The big question for me was whether I wanted an epidural or a general anesthetic. I am not a doctor, but I think I have a rudimentary understanding of the differences between the two methods of anesthesia. The epidural anesthetic, sometimes called a *spinal block*, involves inserting a tiny catheter into the area around the spinal cord in order to inject the anesthetic. This will block any feeling in the area from the waist down.

A *general anesthetic* affects the entire body. The heart, lungs, circulatory system, and nervous system are all shut down to some extent. When you receive a general anesthetic, you do not sleep *per se*. If it were merely sleep, the pain from the surgery would quickly wake you up. The system shutdown, coupled with a dose of morphine to ease the pain of surgery, enable you to get through the experience without jumping off the operating table and screaming in pain. However, because all your systems have been affected, it will take

a while after surgery for things to get back to normal. This effect is what is commonly referred to as an “anesthetic hangover.”

An epidural in itself does not cause you to sleep. However, it is usually used in conjunction with some sedatives. You will sleep lightly, but you will not remember the surgery. The epidural has one additional benefit. Because the epidural catheter is left inserted after surgery, pain control is simplified. A device called a PCA (*patient controlled analgesia*) allows the patient to self-dose measured amounts of pain medication. The device is regulated such that an overdose is impossible. In addition, with the epidural, recovery from anesthesia is quicker and there is much less of an anesthesia hangover.

Having prepared myself by doing the reading and self-education I have been pushing to you throughout this book, I would be ready with a decision after asking only a couple of questions on points that I thought needed clarification. My questions involved my experiences with Versed (pronounced ver-**sed**), a drug that is used as a sedative in conjunction with the epidural. I apprised the anesthesiologist that Versed had not produced the desired effect in two earlier encounters. The drug is supposed to sedate the patient and cause him or her to not remember what happened while it is in effect. My first encounter was an endoscopy, a procedure that involved pushing a fiber optic probe down my throat and into my stomach to look for ulcers and other problems. I was given Versed, but I remembered everything! The next procedure that called for Versed came about 10 years later. It was a colonoscopy, which involves pushing a similar probe into the other end. I apprised the doctor who performed that procedure of my seeming resistance to Versed, prompting him to adjust the dosage. “Give him nine of Versed,” he told the nurse. It didn’t work. I remembered the entire procedure, including how it felt when the doctor burned off two small polyps. I told the anesthesiologist that I did not want to have any similar memories of the hip replacement. I did not want to remember how it felt to have my bones sawed, drilled, and hammered.

The anesthesiologist thanked me for bringing this up. He further expressed appreciation for the extent of my preparation for this discussion. He assuaged my concerns by telling me that he would make a note the Versed problem and other drugs would be used in the operating room in conjunction with the Versed to ensure that I would not remember anything. That assurance was good enough for me. I decided to proceed with the epidural.

This experience reinforces the need for preparation, especially with respect to understanding your own physical condition and any problems you might have with particular drugs. Doctors are generally very good at what they do, but they are not psychic. It is *your* responsibility, not theirs, to ensure that all pertinent details of your health are known before you submit yourself to surgery. If you are not sure about something, ask questions. Above all, do not hesitate to volunteer information that you think might be important. You can never supply too much relevant information.

Anesthesiology being my last stop, I was finished for the day. I was relieved that nothing was found amiss that would cause my surgery to be cancelled or postponed. It was time to have a quick bite with Bob and send him on his way after dropping me off at the Sheraton.

### **A relaxing evening**

I had been told to call Ambulatory Surgery Scheduling that evening to get my appointment time for the next morning’s surgery. I had been admonished not to eat or drink after midnight, but to take any prescription drugs I required. Finally, I was told to get a good night’s sleep and remember to scrub myself as directed.

## Total Hip Replacement: A Personal Perspective

Margie arrived on schedule, shortly after Bob dropped me off at the Sheraton. We laughed, relaxed, caught up with old times, and had a mundane room service dinner. The toilet in the “luxury suite” provided some postprandial entertainment by threatening to overflow. I felt that this was a good omen—business as usual.

Soon, it was time to sleep. I took my extra-long shower with the antimicrobial soap in the specimen jar. Then, surprisingly, I got a good night’s sleep.

## Chapter VI. The Day of Surgery

The day finally arrived. Everything thus far had gone like clockwork and I was ready to dive right into the main event. Interestingly enough, the total hip replacement surgery is considered “ambulatory surgery”—I would be walking in, but definitely not walking out! I dressed in some minimal clothing, well aware that I would be spending most of my next four or five days wearing very fashionable, open-backed hospital gowns. We were at the Sheraton, only five minutes away from the hospital, so we dawdled a bit, checked out, and then headed over.

### Waiting to be called

As instructed, I proceeded to an area called “Ambulatory Surgery,” signed in, sat down, and began to wait. And wait. And wait. After waiting an hour and a half, both Margie and I were getting antsy. She decided to ask about what was going on. The receptionist informed her that I had been scheduled for the second surgery in Theatre #4, in which my surgeon had just finished his first operation of the day. He was in the surgeon’s lounge and I would be called shortly. “Shortly” turned out to be almost immediately!

Bingo! Time to rock and roll! Things started moving fast. I was given a packet of information and told to report to general surgery prep on the second floor. It was finally happening and there was no turning back.

With Margie in tow, I entered the elevator and pressed the “2” button. Was I apprehensive at all? No. But why? I know that many brave people have a very deep fear of surgery. There is nothing shameful or weak about that fear. In fact, I think it is probably more consistent with normal adult behavior to be fearful of surgery than not. One is losing control, leaving one’s body in the hands of strangers. I kept thinking, “Am I nuts? I’m not scared at all.” Well, in thinking about it afterward, I decided that my lack of fear was attributable to three distinct notions. First, this would be a great adventure. I had had surgery some 17 years beforehand and I had been intrigued by all the equipment and operating room activity. I was anxious to see the differences between that earlier surgery and this one. Second, I had developed a great amount of faith and trust in the surgeon and the hospital. Feeling that I was in good, experienced hands, there was no reason to worry. Lastly, to quench what is usually the greatest fear associated with major surgery, I rationalized that if I were to die I would slip quietly and obliviously into the night, never knowing that I left this earth.

OK, so I would probably concur with the assessment that I am totally nuts.

### General preparation

After that brief bit of soul searching in the elevator, it was back to the preparation. The general preparation area was small, with four beds, a tiny bathroom/dressing room, a waiting room with four or five chairs, and a reception desk. I handed my information to the receptionist, who gave me a gown and a plastic bag, directed me toward the dressing room, and told me to change into the gown and put my clothing and other effects into the plastic bag.

I can never figure out how to tie those ridiculous gowns in the back. As incompetent as I am, it usually takes me five minutes just to snap the sleeves together. Who came up with that design? I guess it was an attempt at fulfilling the two contradictory goals of simultaneously maximizing modesty and access. Cursing softly at first, and then not so softly, I finally called for Margie to help me tie the thing. (Mind you, I knew it would be

coming off, so I had to rhetorically question the need to be so diligent about tying the back.)

Once securely gowned, I was given a bed of my own—a gurney, really. A nice, non-patronizing nurse named Susan very quickly and professionally hooked up my I.V. tube, fitted my designer shower cap, and then did something quite important. With a black ballpoint pen, she wrote “**NO!**” on my right hip, the one that was not supposed to be replaced. I was at once amused and impressed—reassured that the proper hip would be the one replaced.

Next, my anesthesiologist arrived with the epidural catheter and the associated equipment. Its insertion was painless. I was prepped and ready to roll.

Margie asked Susan if she thought it would be possible for her to obtain permission from the surgeon to observe the surgery. Even though Margie is a doctor, it is the hospital's policy to prohibit friends and family of the surgical patient from the operating room. This made sense to me. I imagine that people can become emotional and irrational when things are appearing to go wrong—or even if everything was proceeding normally, given the hectic atmosphere of the O.R.

My gurney was rolling. I felt bad that Margie would have nothing to do but wait instead of watching my operation, but I could not do anything about that. Therefore, as I passed under a big red sign stating “**NO VISITORS PAST THIS POINT,**” I said, “Thanks, Margeroo. See you on the flip side!”

## The operating room

I quickly determined that I was in the operating room when I saw the gigantic lighting equipment overhead. From this point, events happened too quickly for me to get a good look around at all the equipment and people. I was moved from the gurney to the table. The presence of human hands on my body at this point was comforting—unexpectedly so, because these were the hands of strangers. I interpreted the touches as kind, caring, and gentle, which related back, I suppose, to my trust and confidence in the surgical team. The anesthesiologist placed a clear mask over my face, instructing me to take a couple of deep breaths. That was the last thing I remembered from the operating room.

Zzzzzzzzzzzzzzzzzzzz.

### While I lay sleeping

Based on my reading the surgeon's reports in the aftermath and piecing together other information, I can tell you what happened before and during the surgery even though I was not mentally aware of a single thing that went on. (Obviously, the Versed or whatever other drug they gave me worked very well.)

I suppose that because I am bearded, it was necessary to slop Betadine disinfectant all over my face. My beard must have been suspected of harboring every form of microbe, virus, cootie, and fungus known to medical science. In the aftermath of surgery, I discovered direct evidence that the Betadine bath occurred. I have a digital photo, courtesy of Dr. Margie the Photographer, showing my Betadined face, and I was still picking Betadine out of my moustache days later.

Also worthy of note are the intubations that happened while I was too oblivious to object. Obviously, the anesthesiologist wanted to be able to closely monitor and assist with breathing, so there were tubes in the nose and throat. Further down, it would have been a major disruption to the surgical procedure if I were to have asked at some point during the operation whether I could go to the bathroom to relieve myself. A Foley catheter was



inserted to eliminate the need to get up and go to the bathroom. I found evidence of the anesthesiologist's other tools of the trade in the aftermath of surgery. For example, a couple of days later I discovered a single, stray EKG contact that had obviously eluded the removal team's capture.

In a properly researched book, I would give you specifics of the surgery. I merely provide a general outline of the procedure here, as those details are quite readily available elsewhere, particularly in the three books I have recommended in an earlier chapter.

After the patient is anesthetized and properly positioned on the operating table, an incision is made along the side of the thigh, from mid-thigh to well atop the hip. The surgeon works through layers of muscle and fat to expose the hip joint, which is then dislocated. The femoral head is sawn off and the socket area (acetabulum) is smoothed out in preparation for receiving the new socket. The femur is drilled out to enable the insertion of the prosthesis with the ball part of the new joint. The new joint parts are hammered into place and fitted together. (Cement, similar to Super Glue, is applied to secure the various components to bone if the joint is of the cemented variety, which mine was not. Traditionally, cemented joints are used in older patients.) Drains are inserted, if necessary. Then the wound is closed with either standard sutures or surgical staples. The whole procedure generally requires an hour and a half to two hours\*.

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\* Mine required closer to four hours. In Dr. G's words to Margie, "Not only was his muscle tissue very dense, but also his fat was very dense!" Everything on me is dense.

## Chapter VII. The Hospital Stay

In spite of its categorization as “ambulatory surgery,” I was not asked to go home immediately after the operation. I found myself in a semi-drugged state, in the recovery area. There, well-trained nurses closely monitor patients’ vital signs. Effects of anesthesia are wearing off, patients are breathing on their own, and tubes are being removed here and there. There is a high level of activity, yet it is smooth and confident. I got the feeling that these people knew what they were doing and did their jobs very well. After all, I woke up and everything seemed to be functional.

### **I feel great!**

I rapidly shook off the fog of anesthesia. Having opted for the epidural anesthetic, this was easier for me than if I had had general anesthesia. The first things I recall were my name being called and a tube being wrestled from my nose. I could hear my friend Margie talking to Nurse Wade. When I became fully aware of where I was and all the surrounding implications, I was immediately anxious to know how an artificial hip joint would feel. Without thinking too much about particulars, I took inventory. I felt great. There was no pain from surgery and the great, gnawing pain of the bad joint was gone, too! This was going to be great!

My throat was sore and my mouth was dry, both effects of the endotracheal tube that is placed in there by the anesthesiologist to assist with breathing during surgery. Recovery room personnel will have ice chips available to suck on, which will temporarily alleviate the soreness and dryness. I took advantage of that as often as I felt I needed to. When one’s comfort is involved, it pays to be assertive. Recovery room personnel are there to get you through the rough spots as comfortably as possible. They will usually go out of their way to help you.

The sore throat and residual anesthesia notwithstanding, I already felt that much had been accomplished. I had cleared all the obstacles in my path leading up to surgery. The surgery had been completed uneventfully. There was no pain from either the bad joint or the surgery, and there was no feeling of a foreign object inside me. I knew, of course, that the surgery was the easy part—I just lay there passively while the surgical team did all the work—and that rehab would be grueling, lengthy, and difficult. Nevertheless, there was a clearly visible light at the end of the tunnel.

### **Not so fast, Buddy!**

As I further regained my capabilities for acute reasoning, I told myself to temper my euphoria about the lack of pain. After all, the epidural catheter was still installed, thereby effectively blocking any pain I might have had. Still, it was great to be devoid of that deep, ugly, overriding pain I had suffered for years and years. Self-administered epidurals are not a possibility or there would be broad-scale addiction by pain sufferers!

Anyway, I lay there in the recovery room, gradually coming back up to speed, chatting off and on with Margie and Nurse Wade. I was stable for a few hours, so what was the holdup? It turned out that a bed was not yet available. I wanted to get into a room so I could get some sleep. Hospitals must play a continual juggling act with beds. Patients come, patients leave, patients move from one area to another. There never seem to be enough beds to go around. I had been waiting for a room for four hours. One problem, I suppose, was that I had requested a private room, one of which would not be available for another few hours. I agreed to be moved to a semi-private room temporarily until my private room became available, even though this would mean being transferred from stretcher to bed one extra time—and the last thing I wanted at that point was to be moved around a lot.

Coming out of surgery, one lies amidst a tangle of tubes, wires, and various other devices. You will have at least one intravenous (IV) connection, and possibly a spare. Your epidural catheter will still be in place, if you opted for the epidural anesthetic. If you have been given a “pain button,” known as *patient controlled analgesia* (PCA), it will be dangling somewhere. There might be drains coming from your surgical incision. A *Foley catheter* will have been inserted into your bladder and connected via a tube to a reservoir beneath the stretcher. You will have an oxygen cannula in your nose. You might have a blood pressure/pulse monitor attached to you, as well as a blood oxygen concentration sensor clipped to one of your fingers. Having had a hip replacement, you will have a couple of other mechanical devices specific to this type of surgery. One will be a pair of inflatable leggings, secured by Velcro straps, which are attached to a compressed air supply and a sequencer that alternately inflates and deflates the bladder in each legging. The purpose of this device is to prevent *deep vein thromboses* (DVTs), which are clots caused by blood pooling in the inactive legs. These are dangerous, as they can break away and lodge in the lungs, becoming potentially fatal *pulmonary embolisms*. Prevention of DVTs is part of the reason you will find yourself wearing elastic, thigh-high compression stockings on both legs after surgery. These are also effective in reducing post-surgery swelling. Finally, you will have a large, foam rubber, wedge shaped *abduction pillow* (sometimes called an *abduction splint*) strapped between your legs to guard against dislocation of the newly installed joint. Is it any wonder why I wanted to avoid being moved too many times?

I was moved to my first, semi-private room uneventfully. I had no roommate. I think at that point that I must have dozed off. I had said goodnight to Margie and the rest was fuzzy until I responded to a knock on my door at about 1:30 AM. “My name is Vickie. I’m your night shift nurse. This is Nate. We’re here to move you to a private room.” Nate was a large man, perhaps 6’5”, 350 lb.—NFL offensive lineman size. However, he was very gentle for his size. This would not be my last encounter with Nate, but it would turn out to be much more pleasant than the next one. Fearing all sorts of post-surgery problems and feeling very fragile, I probably resisted moving, but in his convincingly insistent way, Nate got me moved.

In my own room, I found that it was difficult to sleep. I am not a back sleeper, but from this night forward for at least six weeks, I would be required to sleep on my back. There was no tossing and turning, given that the abduction pillow anchored my lower body. The air compressor that inflated the pneumatic leggings periodically was noisy. I did not get much sleep the first night after surgery. Overall, however, I was comfortable. I did not have to worry about voiding my bladder, because I still had the Foley catheter. I had no pain, because I still had the epidural and the PCA. It was dark and quiet and that was nice.

### Day Two: the best of times and the worst of times

Morning came early, as it usually does in a hospital. The first wave, at 5:30 AM, was the vitals person, who comes in to take blood pressure, pulse, and body temperature. Then, the nurse arrived with my medications. Recall that I had advised you to bring your own routine medications, such as blood pressure pills you might be taking, because it is generally much cheaper to use your own than to buy them from the hospital pharmacy. Well, either no one wrote, “Patient uses own meds” on my chart or no one read it. This was the essence of my first controversy; however, it was quickly resolved. The nurse quickly recognized the error, taking my drugs to the pharmacist, who examined them to be certain they were correct, then returning them to me. Subsequently, I was able to take my own drugs, but I would frequently have the same discussion when a new nurse did not read the chart. It became a comedy routine, as I would wait to see how it was handled each time. When I get the final hospital bill, I will be on the lookout for duplicate charges for drugs I supplied myself!

The next wave of troops through my room was the surgical residents. They examined the incision and changed the dressing, asked me how I was feeling, exhorted me to use the incentive spirometer to keep my lungs active and clear, and went on about their rounds. Yes, it was that quick.

### Getting out of bed

Day Two would be a busy one. I knew that I would be getting out of bed and I had no idea what to expect when that time came. The nurses fitted an overhead trapeze to my bed, which I would be using when it was time for the physical therapists to get me out of bed. I remember thinking of how it would feel to get out of bed at that point. My left (operated) leg felt like it was made of lead. It did not seem to want to move very easily at all. Still, I knew that it would move when it was time, and the time would come soon.

The physical therapists, Gene and Charlie, arrived in mid-morning. The first thing they asked me to do was recite the precautions to protect the new joint against dislocation. For a total hip arthroplasty using the posterior-lateral incision (the most common approach), they are:

- Do not bend the hip more than 70 degrees the first two weeks and 90 degrees thereafter. (This varies from surgeon to surgeon, but 90 degrees is common for the first six to eight weeks.)
- Do not rotate the operated leg inward.
- Do not cross the legs or move the operated leg across the central axis of the body.

I would be asked to repeat the recitation of these precautions each subsequent time a physical therapist came to see me. Some of the nurses also quizzed me on the subject. Clearly, they wanted to be certain I did not dislocate the new joint.

Charlie started me moving with some simple ankle pump exercises, which gave me confidence in the notion that at least my feet were still functional. A couple more standard, supine, in-bed exercises—quad and glute tensing—were next. Then, he unhooked me from several of the devices and helped me to a seated position at the edge of the bed. This was a great effort, and by the time I had completed it, I needed a minute or so to rest before I was ready to try to stand up. Gene had positioned a walker in front of me, and he instructed me in how to use my arms and my good leg to push myself off the bed. (This was a completely natural motion for me by that time, because I had practiced it ever since I had the pre-op visit from Bruce.) I was up and supporting myself with my good leg and my arms via the walker!

### A little stroll

Gene asked me if I felt like taking a walk. I said, “Hell, yeah!” He asked Charlie to fetch another gown to cover my backside, as we were going to be in the public hallway. I told them that I did not mind people gazing at my naked butt. Gene joked that it was probably for their protection. Now that I was properly sheathed, Gene would show me how to walk. I had practiced this before, too, but it is a little harder doing it the day after surgery. My first goal was to get out the door of my room, across the hall to the nurses’ station, and back. It went slowly, but my prior practice helped me get up a good rhythm. I walked to the end of the nurses’ station and rested. I could hear Margie exclaiming “Amazing!” and I guess it *was* amazing. Dr. G stopped by to ask how things were going and if I had any questions. I told him that the biggest question at that point would be whether I would have the energy to get back to my room! I was being somewhat facetious but still I was starting to feel fatigued. Slowly, I made my way back to the room, with Gene and Charlie

at my sides. They helped me to sit down in the chair. I felt exhausted, and a bit lightheaded and nauseous. I asked Margie to get my oxygen cannula back on. That helped a little bit. I was still not feeling very well, and I was sort of nodding off. This was hard work!

### Extubations

Everything was hooked back up to me and I was left alone for a while. The nurse, Jill, told me to buzz her if I needed anything. She told me that sometime soon, the “pain team” would send somebody to remove my epidural catheter, and then within a few hours thereafter, she would remove my Foley catheter. (Quite a convenience, that thing!) All went well when the time came. I was issued a calibrated plastic hospital urinal and a couple of stylish bedpans, and was instructed to use them to relieve myself.

The “pain team” arrived in the form of an anesthesiology resident. I was still sitting in the large, comfortable chair, relaxing after my heavy exercise. The pain team asked me to lean forward so he could pull out my epidural catheter. I balked at that, thinking once again of all the precautions I had been taught in my reading, in Bruce’s visit to my home and by the hospital physical therapists. I was not supposed to be bending the hip joint more than 70 degrees for the first two weeks. Therefore, I told the pain team to go fetch a physical therapist to supervise this operation. He was not pleased. However, I did not feel comfortable doing something I had been cautioned about repeatedly. When Gene arrived and positioned me properly, it took the pain team about five seconds to remove the epidural catheter. I could not even feel it coming out. There was no pain whatsoever. The pain team was finished, no doubt quietly celebrating the fact that they would not have to visit this finicky patient again.

The afternoon physical therapy session was uneventful. Of course, I was asked to recite the hip precautions. I walked a bit farther, got fatigued, and this time came straight back to bed instead of using the chair. The oxygen was once again a welcome thing as was the ice water on the bedside tray. I was exhausted. I decided to take a little nap.

Next, Jill arrived with an ominous looking plastic thing, stating that it was time to get rid of my Foley catheter. She said I was fortunate that I was on a urology floor, because all the needed equipment was there. She closed the curtain around my bed and quickly went to work. Once again, I had no fear. I had a Foley 17 years before, after abdominal surgery. Jill knew what she was doing. Asking me to take a deep breath, she yanked the hose out of me before I even knew it.

### What goes in must come out

Now, this is where the problems started. The evening shift nurse, Mike, told me that sometimes after removing a Foley, people could not seem to urinate for a while, partly due to residual effects of the anesthesia or due to irritation by the catheter itself. He further stated that if I could not show reasonable progress toward voiding normally by the end of his shift, he would have to do another catheter. This could be viewed as either a major incentive to urinate normally or a major psychological block against it! (Try *not* to think about elephants sometime.) As time passed, I got the feeling that nothing was going to happen.

Earlier, I had been feeling weak, with elevated pulse rate, elevated body temperature, and signs of anemia. Margie, who I will reiterate is a friend of mine who is also a physician, examined my chart with my permission and, noting that I had lost 650 cc of blood during the surgery, inquired about the possibility of transfusing the two units of my own blood that I had given prior to surgery. Nurse Mike agreed to call the doctor about doing that. It took quite a while to get clearance. Eventually, a very pretty young woman arrived from the blood bank with the first unit of my blood. Mike connected the appropriate tubing to

begin my transfusion. (I felt better immediately, for I had paid \$35 to have the blood shipped from the Blood Bank in Orlando up to Gainesville, and later I would discover that I paid another \$400 to have the blood stored and processed at the hospital!)

Meanwhile, back at my bladder, things were not going well. I was able to dribble out only a little at a time. By an hour or so from the end of Mike's shift, straining and concentrating, I had only managed to produce about 300 cc. Mike made a deal. If I could get another 100 cc by the end of his shift, he would not give me the dreaded catheter.

Looking at my I.V. rig, there was the blood and a big bag of saline solution dripping rapidly into me. I knew that I was taking on a significant volume of fluids. Even if I eliminated another 100 cc in an hour, my bladder would be filling. Still, being a consummate competitor, I was able to produce the 100 cc and send Mike home without the need to catheterize me. As it turned out, I was only kidding myself.

My competitive spirit came back to haunt me. I knew that before the night was over, I would have to be able to do something about this problem. Vickie, the night nurse obtained the second unit of blood, hooked it up to the I.V. and it began dripping directly into my beleaguered bladder (or so it seemed). Later, she came by to check on me and noted that I had met my goal with Mike, but how were things going along those lines? I told her not so well. She told me that she would have an aide, Bobbie, do a bladder scan to see how full it really was. I told her that she would find it was up to about my back molars. Well, the bladder scan machine's batteries were in need of charging and Bobbie could not figure out how to plug it into an AC outlet, so rather than fool around with that, I said, "Bobbie, I don't need a machine to tell me that my bladder is about as full as it could get (and I have a legendary beer bladder). I can't seem to do anything about it, so let's get that catheter." Ever helpful and considerate, Bobbie said she would ask Nate to do it, "because men usually did not want women doing that to them." I said, "Oh, that's alright. I really don't care who does it as long as I get some relief." However, Bobbie was already on her way out the door in search of Big Nate.

It seemed like forever before Nate showed up with the catheter. I can only recall one time, after a beer party, that I ever seemed that full. I was at Nate's mercy. Fortunately, for a huge man, Nate was gentle and efficient when it counted. When he was done, he showed me a container, telling me that he had drained 1275 cc out of me. Apparently, though, it was not a record, not even on that floor of Shands Hospital. Someone else the previous week had amazingly produced 1900 cc! So much for my competitive spirit! The main thing was that I felt so much better. Moreover, after that, I was able to empty my bladder normally and completely.

Day Two drew to a very late close. I got only a few hours sleep.

### **Day Three: the march toward self-sufficiency**

I was feeling much better. I felt that I was "over the hump" with respect to post-surgery recovery. I was still constipated from the painkillers, but that would resolve in time. (I will not go into graphic details here.) I was actually looking forward to physical therapy and to spontaneously getting out of bed whenever I pleased. The morning of Day Three began as usual, but things were a little looser because it was the weekend. The residents showed up closer to mid-morning than to dawn, and there was a somewhat new cast of nursing characters. Twelve-hour shifts were standard for nurses on weekend shifts. That is not good for either the nurse or the patient. I noticed that the responses to the call button were generally very slow on Saturday and Sunday.

My was too warm. This is unusual, in that hospitals always seem to be chilly. Well, I like it cool. The attempts by hospital personnel to crank down the thermostat in my room did

not yield the desired effect. It was set at 60, but the room felt more like 80. I asked the nurses if they had a portable fan somewhere that I could borrow. They did not. Margie to the rescue! She volunteered to make a short trip to a local Wal-Mart for a fan. It turned out to be a wonderful fan for several reasons. First, it cooled me down. Second, its white noise drowned out the annoyingly intermittent sound of the air compressor for my leggings, allowing me to sleep more easily. Finally, it will continue to give others similar pleasure, for I donated it to the Seventh Floor when I left!

I had decided that I would set some of my own goals and hold myself to a higher level of post-surgery achievement and mobility than was usual for the hospital. After all, I was younger than most people who undergo this surgery, and presumably could perform better. One thing I insisted upon was that the bedside urinal be moved to the bathroom, so I would have to get my butt out of bed at least as often as I needed to urinate. This would require a little coordination with the nurses, because someone would still have to unhook me from the “leg squeezers” in order for me to get up. When I was done in the bathroom, someone would have to re-hook me up. The inconvenience was not a deterrent. I eschewed offers of help to get out of bed. I wanted to do it all on my own. Instead of being supplied with a washbasin and some washcloths at bedside for my bathing, I asked that towels, washcloths, soap, and so forth be supplied to the bathroom, where I would do my own sponge baths standing up. I requested that a “commode chair” of the proper height be installed over the toilet so that when my bowels began functioning normally again, I would go to the toilet without violating the motion restrictions instead of using a bedpan. I was anxious to get things going.

Other than the twice-daily comedy involving nobody reading my chart to see that I had brought my own medications, the hospital stay proceeded unremarkably apace. Physical therapy became a routine, twice-a-day, ever lengthening walk around the floor with the aid of a walker at first and then, later, crutches. I was feeling good about my progress and I started wondering about when I could leave.

### How long will I be here?

I was told in my pre-surgery briefings that I would be in the hospital between four and five days, and I would have to meet certain milestones before I could be discharged. Having read that in other countries people having the total hip replacement operation are hospitalized from 10-14 days, I had wondered if this was not cutting things just a little close. However, after three days in the hospital, having made significant progress, I knew that four or five days were probably going to be sufficient. I was feeling good, and I was feeling that I could do many things on my own already. Furthermore, I would be transferring to an in-patient rehab hospital for a while before going home. My target became four days.

Your surgeon will be keeping an eye on you by way of personal visits and the reports from the nurses, who are the front line troops waging the battle for your health. You will be expected to have regained some mobility with the operated leg before you can leave for either an in-patient rehab or home. Physical therapists will make careful notes about your progress. The nurses and doctors will also monitor your overall health. Before you are discharged, all systems will have to be functioning well.

### Walking milestones

You should be able to walk with the aid of a walker or crutches. If you have stairs in your house, you should have been able to walk up and down a flight of stairs. You should be able to do some limited tasks while standing. If you will be going to a rehab facility, which is advisable if you live alone, you will learn many more techniques. It is the hospital's job to get you past the acute care period. Either you or the rehab must take over from there.

### Medical milestones

You will be kept in the hospital until it is clear that you have no complications from the surgery. These would include infections, deep vein thromboses, lung problems, and problems with the actual prosthesis.

### Where do I go from here?

Generally, you would go either to a rehab or directly to your home after your successful hospital stay. In my case, because I live alone, a rehab was recommended. There, I would continue physical therapy, and I would receive occupational therapy as well. I had discussed the rehab option with various people in advance of the surgery and the feeling was that I would be spending from seven days to two weeks in the rehab. Those of you who have a spouse or significant other or a hearty volunteer living with you might opt to go straight home. It is a matter to be decided upon after consultations with your surgeon, other trusted medical advisers, physical therapists, and your family.

### Days Four and Five: the waiting game

While my goal was for a four-day stay, a slight hitch caused me to extend to five days. This had nothing to do with walking milestones or medical milestones. It had to do with no bed being available for me at the rehab hospital to which I was being transferred. I had been making significant progress with my physical therapy sessions, walking for relatively longer distances every day. I would still be tired after walking completely around the floor, but I was feeling stronger. I was using crutches as well as the walker. I was not very hungry, but the hospital food was nevertheless beginning to get on my nerves. Margie was gone, so I was lacking company. I was bored. Days four and five were spent playing the waiting game, accomplishing little but some extended TV watching and working toward getting that bed at the rehab.

During the planning period, I pondered the issue of how I would be transported from the hospital to the rehab about a two-hour drive. My options were either a private car or a non-emergency medical transport. I had been warned by the people at the rehab that it was a long ride in a passenger car for a new hip replacement. They recommended the medical transport. However, having practiced getting into and out of my personal car with Bruce, the physical therapist who visited my house, I was well aware that I could do so without great problems. As for the two-hour drive, I reasoned that I would be in a reclined position for two hours with my legs stretched out in front of me, which was the position in which I spent most of my hospital time. My car has a nice, wide door opening, and the passenger seat not only moves rearward a fair distance but also can be made almost completely horizontal. Therefore, my executive decision was that I would have a friend drive my car up to Gainesville, pick me up, and drive me to the rehab.

When the time came, I instructed my friend in how I would need to have the car arranged in order for me to get into it properly. I had grabbed a physical therapist from the hospital just to have a little skilled help around if I needed it. It turned out that I did not need it. Once the car was properly arranged, (which it would have been already if anybody had listened to me in the first place), I slipped into there just like a hot knife through butter.



## Chapter VIII. Moving to an In-Patient Rehab Hospital

I had chosen a rehab hospital in Orlando. I felt that if I would be cooped up for up to two weeks in this facility, I wanted to be close to friends who could help me. If I had rehabbed in Gainesville, two hours away, it would have been an unbearable inconvenience to these kind people. This, of course, required some logistical planning and some potentially uncomfortable traveling for me. As I had mentioned in the previous chapter, I debated with myself over the wisdom of being transported in a private automobile, but eventually made the decision to do so. Had I known that I would be able to progress through rehab in record time, I might have stayed in Gainesville for those few days. However, I had no way of knowing that at the time. With a friend, R.D., driving, I arrived at the rehab at around 5:00 on the fifth day after surgery.

### Where did you come from and what are you doing here?

The rehab hospital was not used to patients arriving via private car. It took my friend what seemed to be quite a long while to find somebody inside who could bring either a wheelchair or walker out to the car. Finally, a physical therapist arrived with a wheelchair. She wheeled me into the room that was assigned to me and left. I thanked my friend, stating that I was now an inmate, and I would await further instructions from the keepers.

Well, I waited. The only people who visited my room for the next three hours were a couple of nurses or aides who told me I was in the wrong room. That was rather irritating. I began to sense that there were some significant deficiencies in administrative areas. I would have expected that at some point within three hours after arrival, someone would have come to the room to tell me when the physical therapy sessions and meals would be held. But, no. Nothing. Therefore, I finally gave up on waiting and rang the nurse call button.

When the nurse arrived, I expressed the concerns I mentioned above. Here I was and no one seemed to know. That brought a small flurry of activity, when it was determined that a patient had walked in the back door instead of the front. Yes, patients were usually transferred there on stretchers. I was semi-ambulatory. So what? They had been given all my paperwork, and there was no excuse for not knowing I was there. What also became clear to me during the course of the instruction diatribe I was given was that my rehabilitation would be impeded by some of the CYA policies in place in this hospital. The view presented to me by that evening nursing staff was that it was a real kindergarten atmosphere, which was contrary to what I had gleaned when I evaluated the place before surgery.

I made it clear that I had progressed to a point at which I was almost completely self-sufficient and that what I did not need was handholding. This inspired the charge nurse to ask a question I would hear again and again: "Might I ask you a question? **What are you doing here?**" I stated that the reason I was there was to build strength, endurance, and range of motion for my affected limb, not to be coddled and monitored at every moment. I do not think my point got through.

I was very unhappy that first night, feeling that I could do better for myself at home with a visiting physical therapist. As it turned out, I probably could have done as well. The rehab was geared toward a significantly older age group, a slower progressing group prone to slips, falls, and accidents. Accordingly, activities were less ambitious than they could have been for a younger person.

### Getting to work

In the morning, after being visited by a physician's assistant, a physical therapist, and the rehab physician, another Dr. B, I felt a bit better about the place. The physician's assistant, after discussing my state of recovery with me, asked the musical question, "What are you doing here?" I laughed. It was good that people were starting to notice that I did not intend to malingering there. I had originally been told that I would probably be spending up to two weeks in the rehab. That would have been hard, if not impossible, to take. In discussing my specific situation with Dr. B, he estimated that four to seven days would be sufficient. That was somewhat encouraging.

Dr. B was a sincere, pleasant man. He remarked that I had progressed quite well at that point, just six days after surgery. Five weeks later, during a follow-up visit with him, he would tell me in absolute terms that he had never seen anyone progress so fast through rehab and be at the stage of recovery I was at that time. I gathered from the start that Dr. B was simpatico, a doctor who I could talk with about my recovery and general health issues related to it, and get good information in return. I had no choice as to who my rehab physician would be, so I am fortunate to have drawn Dr. B's lot.

The physical therapy was good, although I felt I could have been pushed quite a bit harder. I think the physical therapist assigned to me was happy to have someone closer to his age to talk with than the usual patient there, although I was still probably at least twenty years older than he was. In the mornings and afternoons during free periods, I would do high-speed wheelchair laps around the floor to get an upper body and aerobic workout. This was my idea. I suppose I was getting anxious to be more active. Surprisingly to me, the physical therapy did not include any significant aerobic workouts.

Most of the inmates were progressing slower than I was with respect to the physical therapy, so they tended to get more attention. Quite a bit of attention was paid to occupational therapy issues, such as functioning in the kitchen on one leg, getting around obstacles with a walker, or taking a shower. I received a little instruction on how to use a "sock helper" device, which was truly useful. Otherwise, I cannot say that I got much out of the occupational therapy. Most of the occupational therapy I needed was covered by the background reading I had done before surgery. Of course, we are all different, and you might find that hands-on occupational therapy enhances your post-surgery life tremendously. The people who conduct those occupational therapy sessions are experts who can help you to the extent that you need help.

By the end of the day, it was clear to me that I would need to negotiate with the doctor to get me into the early release program. The molasses pace was dragging me down. Therefore, when the doctor arrived at dawn, I made my proposal. "How about getting me out of here in three days?" I asked. After thinking about it for a minute, the doctor said he thought that it would be possible to do so. I would only have to show that I could ascend and descend stairs safely and the results of my blood tests in the morning would have to be acceptable. I was relieved and happy. There was a light at the end of the tunnel.

And so it went. During my discharge day, I met with the case manager and others to set up my home care and order the necessary durable medical equipment, such as commode chairs and my walker. The hospital preferred to use one particular company that provided not only the equipment, but also home nursing and physical therapy. I was told that the equipment would be delivered to my home, with the exception of the walker, which would be delivered to the hospital so I could use it to get to in which I would be taken home. Then, after appropriate discharge counseling, I was free to go. I was ready! The rehab hospital made certain that a follow-up appointment was scheduled with my personal doctor as soon as possible (for the usual CYA purposes). They also scheduled a follow-up with the rehab physician in approximately four weeks. At that appointment, I

would be scheduling the outpatient physical therapy that would constitute the third phase of my rehabilitation.

My friend R.D. arrived on schedule and I was on my way home. We stopped at the post office to pick up my held mail, and then got some groceries and the drugs that had been prescribed for me. R.D. helped me arrange some things around the house when we got there. I was ready for my first night at home!

## Chapter IX. Going Home

I was home a mere eight days after surgery. As I mentioned in the last chapter, before leaving the rehab, I had arranged through them to get the necessary equipment for my convalescence: walker, commode chairs, shower chair, and so on. Further, I arranged for home nursing care and physical therapy. The rehab personnel recommended one specific local firm to provide all those things. Unfortunately, they bungled it.

The first problem was that between the time I specified which equipment I needed and the time the equipment was delivered, somebody changed the order. I still do not know who changed it. When the delivery person arrived, all he brought was a *gigantic* commode chair that was much too wide to fit over any of my toilets. He said it was designed to support 400 pounds. Now, mind you, I am overweight, but not *that* overweight! The order I had given to the rehab outpatient coordinator specified a particular three-in-one commode chair, the same one that had been installed in my bathroom at the rehab. I wanted two of them, one for the upstairs bathroom and one for downstairs. The other items in my order were the walker, which had been delivered to me at the rehab, and a shower chair. Fortunately, the delivery person had the proper three-in-one commode chairs in his truck—at least he thought he did. I needed at least one and I needed it that night. It turned out that one of the two he thought he had was broken, but he gave me the other one. I told him that I could use the giant commode chair for a shower seat, just to simplify matters. The delivery person said that would deliver the second three-in-one first thing in the morning. I was beginning to have my doubts about his company.

In the morning, I received a call from the same man, telling me that he had an emergency in a distant town, which would cause a delay in delivering my equipment. I did not blame him, for obviously his schedule was being stretched too thin, but I was developing a very negative attitude toward his employer. He eventually arrived with the equipment at around 7:00 PM.

Additionally, the same company was supposed to contact me within 24 hours of my discharge from the rehab hospital to arrange for my home nursing and physical therapy. I had been discharged on a Friday, so I waited through the weekend and all day Monday, but I heard nothing from this outfit. On Tuesday, I called the rehab to speak with the person who had arranged for the equipment and at-home care. I told her what had happened and strongly asserted that I did not want these people handling my at-home care. She said that she would call them to find out why they dropped the ball but I told her that regardless of the response, they were fired. I discussed the possibility of changing to the Visiting Nurses' Association for those services, which the coordinator agreed would be a good idea. As it turned out, I was completely happy with the VNA personnel who eventually served me.

This experience of mine should illustrate the need for you to be assertive throughout your experience with the surgery and rehabilitation. There is no excuse for such poor performance on the part of a health care provider as I received from that company. I did not accept it and neither should you. Your hip might be temporarily compromised, but as long as you have functional set of vocal cords, make certain that you open your mouth at appropriate times and use it to obtain the best possible care from all providers.

### What equipment will you need at home?

#### Walking support

You obviously will need a walker, crutches, or both. Your health insurance will probably pay for one or the other. A walker is better for stability and using one is not as fatiguing

as is using crutches. The choice between the two will be personal preference, but you should get help from your physical therapist in making this decision.

You might want to think about buying a cane to use when you are past the walker or crutches stage. Perhaps in your case a cane will not be necessary. Canes are typically used for balance, not support. I find a folding cane handy for travel and attending sporting events. If you feel that you might be a little unsteady on your feet in these situations or in general, investing in one or more canes is a good idea.

### Toilet equipment

You are no doubt aware by this time that in order not to bend your new hip joint past the 90-degree limit, you will have to elevate your toilet seat. The “three in one” commode chair is a piece of equipment that fulfills this need. It fits over the toilet such that the seat is elevated, and it has arms for supporting your weight as you lower yourself onto it. As I have mentioned, I bought two, one for an upstairs toilet and one for a downstairs toilet. Of course, my insurance only covered one.

### Shower equipment

The rehab gave me a cheap long-handled shower “sponge,” which was actually a piece of foam rubber on a plastic stick. It is the right idea, but you could do much better by investing roughly \$10 on a nicer one. A shower chair with handholds is a good idea but you might have to fork over the money for it. I am told that health insurance companies consider shower chairs a luxury. Alternatively, you could have grab handles installed in your shower or shower/tub. It is a good idea to have a shower hose instead of a fixed head. One final tip: it might be hard to find these days, but “soap on a rope” is a great thing to have. Bar soap kept slipping out of my hand; then I had to go get my grabber to pick it up.

### Dressing aids

Three aids are standard for the hip surgery patient: a long-handled grasping device, a long-handled shoehorn, and a sock helper. In my case, these were supplied to me by the rehab, but I had also bought a grabber and a shoehorn on my own, so I could have them both upstairs and downstairs.

The grabber is somewhat like those long-handled devices grocers used to use to get items from high shelves. (I am barely old enough to remember corner groceries.) I found that the “extra-long” grabber that I bought was better fit than for picking up objects from the floor the shorter one given to me by the rehab. Apparently, the rehab takes a “one size fits all” approach. I am of average height, 5’10”, so the too-short grabber might be a point of considerable concern for somebody much taller than I am. It would be appropriate to ask the rehab if other sizes were available, but I was not astute enough to ask.

The sock helper is an interesting device. You will need to use it for quite a while after you go home, so learn it well. It is basically a rigid, hollow, semi-cylindrical, plastic form with a rope attached. You stretch your sock over the form, insert your foot, and then pull on the rope. It pulls the sock up your leg, then pulls the form out of the sock. You can make minor adjustments with the grabber.

### Living alone

If you live alone, you will find that there are small things that might have to be left undone until friends, family members, or household employees are available to do them for you. In my case, it was important for me to effect a gradual increase in my commitment to performing the usual chores around the house. However, the first night at

home, I had a small crisis. I was eating a bowl of rice, which I clumsily knocked to the floor. In a brief moment of panic, I did not know what to do. Not being able to bend over became a big thing. Should I call someone to clean up the mess? No, that would make me look stupid and helpless. Should I leave the mess for the next day when I would have visitors who I could ask to clean it up? No, that would be too kind to the bugs. As I calmed down, I realized that I could just clean it up myself by using my grabber—the longer one that I had bought—to hold a dustpan while wielding a broom in the other hand. Alternatively, I suppose I could have gone for the shop vac, but that would have been overkill. Where there's a will, there's a way. The grabber approach worked fine. (Perhaps I should have stuck around at the rehab long enough for the occupational therapists to show me that maneuver!)

Like Clint Eastwood's character, Gunnery Sergeant Highway, in the movie *Heartbreak Ridge* would say, "You adapt, you overcome." You will be fighting small battles every day, but with enough determination, you will be winning most. As the victories pile up, it will become apparent that you are winning the war. It only took me about a week at home to realize that I was not handicapped. I was only slowed down for a while. However, if I had not undergone the surgery, I surely would have been handicapped. This thought inspired me to work even harder at rehabbing myself.

One difficult solo maneuver was strapping the abduction pillow between my legs without bending excessively. After a couple of nights of struggling with it, I determined that using my long-handled shoehorn in conjunction with my extension grabber, I could fasten the Velcro straps easily enough. The whole procedure would eventually require less than a minute to accomplish. Undoing it in the morning was a little more difficult due to the grabbing power of Velcro. At that time of the day there is a great incentive, because I am usually on my way to the bathroom. I likened the experience of sleeping with this abominable thing to having a small dog that likes to share my bed. The difference was that unlike the dog, if I kicked the pillow, it would not get out of the way. Moreover, it surely was not going to bring me the newspaper. This was another of the inconveniences that would have to wait for the six-week follow-up before I would be able to ditch it. In the meanwhile, I had to continue strapping myself in for a good night's sleep.

By the way, I mentioned that I was not a back sleeper, which I thought would make it difficult to get any sleep. Actually, like the venerable Gunny Highway, I was able to adapt. However, one weird thing I noticed is that I sometimes woke up talking in my sleep. This might have been more attributable to the narcotic I was taking for pain control than to sleeping on my back. It is a good thing that I know no state secrets!

One thing you will not be able to do by yourself is change your compression stockings. They are just too constrictive at the ankle to enable you to get them over your feet without bending too far at the hip. Perhaps your surgeon will give you a different timetable, but mine has directed me to wear the damn things straight on through to the six-week follow-up exam. These dastardly hose might well be impossible for even an unimpaired person to don without assistance. You will need help. Make the best of it.

You will be pampered. Friends and family will do what they have been taught since early childhood: bring food. Did I ever get a great pot of chicken soup from the neighbors one Friday night—it was just like my grandma used to make! You will receive so many offers of help that you will have to disappoint some of the helpful folks by telling them that all your needs have been accommodated. Alternatively, you might want to do as I learned to do. Keep a list of little, non-urgent things you need, from which you can assign items if somebody absolutely insists on doing something to help. You can avoid hurt feelings and have some additional company, besides.

### **Nursing and physical therapy at home**

Your doctors (and, of course, your insurance company) will determine how many home visits you will need from nurses and physical therapists. Your surgical dressing will need to be changed daily, assuming that you have come home before the stitches or surgical staples have been removed. A visiting nurse if necessary will complete the unstapling task, at home. The nurse will monitor your vital signs and look for evidence of infection or other emerging problems. Assuming that everything goes well and that you are generally capable of taking care of yourself with assistance from friends and family, you will only need a few nursing visits.

Physical therapy is of paramount importance in the recovery from hip surgery. A visiting physical therapist will set up a program for gradually increasing strength building, range of motion, and aerobic exercises that you can accomplish in your home. He or she might bring some aids that will permit exercising against resistance, such as Thera-Bands, which are large, calibrated elastic bands. As you stretch them, their resistance increases, allowing a reasonably good workout without expensive equipment. You will probably want to purchase some ankle weights, which will give you a more strenuous workout as your leg strength increases. The physical therapist will evaluate any exercise equipment you already have for use in your program, making sure that it is set up properly to not exceed the limits of motion set by your surgeon.

In my case, the insurance company sprang for six visits from the visiting physical therapist, Ann. This was broken down into three visits per week for two weeks. Ann used the time wisely to guide me toward self-sufficiency in continuing the program she created for me. Ann also performed hazardous duty beyond the call of duty by changing my compression stockings several times.

Once Ann completed her stint, I would take over the physical therapy program she had established for me on my own, increasing repetitions and duration regularly. Later, when I was better able to get around town, I commenced outpatient physical therapy. In this manner, I had the benefit of the amalgamated ideas of many different physical therapists, with the corresponding benefits to my rapid rehabilitation.

### **A humorous aside**

Now that you are a bionic woman or a bionic man, you should prepare yourself to be an object of curiosity and the brunt of some innocuous humor. You will almost certainly be asked if you will trip the airport metal detectors with your new hip. (The correct answer is “sometimes.” It depends on the sensitivity of the individual detector. Your surgeon’s office will give you an explanatory card to show the security people. So do not worry.) You might be asked if your hip clicks or creaks when you walk. (Mine is quiet as a mouse, unlike the natural one it replaced.) No doubt, you will find these questions and jabs as humorous as I did. None of them, however, was quite as humorous as the telephone conversation I had with my well meaning, worrywart mother several weeks after the surgery.

We were on a non-hip-related subject when she hit me with the following *non sequitur*.

“Could you be struck by lightning?” she asked.

I was not even thinking about the hip. I was momentarily taken aback by the impertinent question.

“Well,” I responded after pausing to think about where this line of questioning was going, “I live in Central Florida, which is the lightning capital of the United States, where

people are struck fairly often, so I guess I could at some point become a lightning victim, too.”

“No,” she said. “I meant because of the metal in your hip.”

She said this in all seriousness. I had to laugh, but I eventually told her that it really would not make much of a difference because it really does not significantly decrease the electrical resistance of a path lightning would take through my body to ground. I should not be any more vulnerable than a non-bionic man should. However, I have been formally educated in physics and my mother has not. She was laboring under the misconception that metal objects attract lightning. Lightning is not fussy. It just takes the path of least resistance to the ground.

### Progress at home

If you create mildly ambitious goals you can look forward to achieving, your convalescence will seem to proceed more quickly, and you will accomplish more. There will always be things to look forward to, some of which will seem mundane to those around you. For example, that first shower I was permitted to take 48 hours after the staples are removed was a delight. I could not wait when the time finally came, timing it almost to the minute. Being able to run a load of dishes through the dishwasher and get them back in the cabinets was another happy accomplishment, as was doing a load of laundry. Stripping and changing the bed, taking out the garbage, and sweeping off the front sidewalk were all minor goals that I accomplished easily in time.

I have heard from other hip patients at this point in their recovery that they feel fragile and fear moving and bending too much. Of course, the restrictions that have been drummed into your head all along must be observed, lest you dislocate something. The temptation is to be very safe, sometimes to the extent of compromising the patient’s rehabilitation. If your surgeon gave you a 90 degree restriction, it does not mean that you should stay in bed all day lest you put yourself in a situation where you might potentially exceed 90 degrees. In my case, I felt that if I *could* get to 90 degrees, I *should*.

### Stairs (the hard way)

It would have been possible to rent a hospital bed to allow me to sleep on the first floor of my house, but I am a stubborn guy. I insisted all along that I would use my entire house during my recovery, and I meant it. Getting up and down the stairs would be a major obstacle, but I was up to the challenge. At the least, I wanted to go downstairs in the morning and back upstairs at night. This would not be too bad, or so I thought. It was not easy. The first day or two, before I refined my stair-climbing technique, were replete with major stair struggles. It took several minutes to get up or down the stairs. It was bad enough that I stuck with a single ascent and descent for the first couple of days.

However, we learn from adversity. After those first two days, I taught myself to get up and down those stairs in less than 15 seconds. Using my folded-up walker as a support on my left side and the hand rail for support on the right, I would ascend or descend one step at a time. Going up, I led with my good leg; going down, I led with the operated leg. (A memory aid for this is “good leg to heaven; bad leg to hell.”) Three days after coming home, I was able to get up and down those stairs four or five times a day.

### Meals

One of the major inconveniences of my recovery involved meals. In order to observe that 90 degree restriction, I would have to eat in one of three places, none of which resembled a dining table and chair. Standing up was one way. Of course, I would have to be balanced on one foot the whole time, which made it difficult. Another way was seated on



a high stool next to the counter between my kitchen and family room. This is where I had most of my meals. It was pretty cumbersome to eat there, particularly when I had to serve myself. It took too long to maneuver my walker through several trips back and forth. The last alternative was dining while sitting in my recliner. This worked well if the food was something that did not involve much manipulation with utensils, such as a sandwich. Carrying the food there was a multi-step procedure with the walker. I had to use ingenious methods to carry things while using both hands for the walker. Accordingly, I could only carry one plate of food or one drinking glass at a time. If you have someone who can serve you, as I did when I was fortunate enough to be visited by friends, you can sit and relax while somebody else does the work.

The first meal seated at a proper dining table was something to look forward to, not unlike the first shower. It was about five weeks into my recovery when I felt I could attempt that. I have been dining at the table ever since.

### Laundry

Doing laundry was another adventure. As I have mentioned, my house has two floors. The bedrooms are on the second floor, as is the laundry room, which is actually a closet with a washer and dryer. Between the master bedroom and the so-called laundry room is a long hallway. My biggest problem was moving a basket of laundry down the hall. I determined that a rectangular, plastic laundry basket would fit nicely between the two hand holds on my walker, which had wheels on its front legs. Thus, it made a nice laundry cart that served to allow me to wheel the laundry basket from the bedroom to the laundry room. The only real problem was bending down to pick up the laundry basket. I had developed a technique for bending down to pick things up off the floor without using the grabber. It involved bending at the waist while extending my operating leg behind me and balancing on the other leg. This maneuver should not be attempted by anyone who has balance problems, but it served me well.

### Driving

Later in my recovery, I stepped up the magnitude of the goals. I began to drive the car for short trips to the bank or the post office at about four weeks post-surgery. This is about the same time as I decided to curtail the use of the walker. At first, I used a cane, but by the middle of the fifth week, I decided that it was not necessary. In a major test of my self-sufficient capabilities, I drove to Sears, walked in with no cane, no pain, no limp, and no sweat, bought a washer and dryer, walked out, and drove home. Yes! I was almost there. A friend called on Friday of that same week, asking if I wanted to have lunch with her. It would be about a 16-mile drive each way. I said, "Sure! Yeah, let's do it!" I did, and another milestone was surpassed.

The following day, I took my car to the regular Saturday free car wash at my dealer (they do it to keep us coming back). Then I went to the supermarket to buy a full load of groceries. I accomplished both with no problems.

### Stairs (the normal way)

Two days later, I was able to walk up and down stairs in the normal, foot-over-foot fashion. The first instance of doing this occurred spontaneously and accidentally. I was upstairs when I heard the doorbell ring. Without thinking and without my cane, I ran down the stairs to answer the door. It was only when I was downstairs that I realized what I had done. Then I had to try going back up. I was able to do that, too.

### Do not try too much too soon

I felt that I was ready for my six-week assessment, and for subsequently stepping up the rehabilitation. I had lost over twenty pounds in the aftermath of surgery and I felt good. Perhaps too good, as I will explain later. All of this sounds very good and encouraging, but in my follow-up with Dr. G., he told me very clearly that I was moving too fast. More about this in the next chapter. In the meanwhile, I would caution those hip patients reading this that my extraordinarily rapid progress should not be used as a guide against which to measure their own progress. Some might progress even faster; others might need more time. Indeed, I grew overconfident and soon had to be reeled in by Dr. G. The proper, personalized plan for your own rehabilitation must be developed in consultation with your doctors and physical therapists, augmented by your own motivation and perspiration. Nevertheless, remember to keep it within the limits you were given in your instructions by the surgeon

## Chapter X. Six Weeks, Twelve Weeks, and Beyond

This chapter describes the second phase of my recovery, starting with the six-week follow-up visits with the surgeon and the rehab physician. I describe those visits, as well as my experience with out-patient rehab. Then, I share my experience with various areas of life in which I was able to resume activities as well as or better than I had done before surgery.

### Six-week follow ups

The usual time for the first, crucial follow-up visit with the surgeon is six weeks post surgery. This appointment is usually set before the patient leaves the hospital. It was included among my discharge instructions, which I did not scrutinize closely until I got home. When I did, I noted that the appointment was scheduled eight weeks after surgery instead of six. I called my case manager, Linda, to note the discrepancy. “The residents scheduled that; I didn’t” was her response. I chuckled at the implication that orthopedic surgical residents could not properly count to six. Linda, among her many other positive qualities, knows how to count. She fixed the problem, moving my appointment to a more appropriate date.

The rehab physician had also scheduled a follow-up appointment for earlier that same week. I believed that this was a good idea, inasmuch as it would provide an appropriate forum for discussion of the path forward through continuing physical therapy.

### Rehab physician

My first follow-up was with the rehab physician, Dr. B. I was a bit irritated with the administrative incompetence of his office and the medical industry in general.\* Even though the rehab hospital at which Dr. B had treated me had all my information, I was handed the ubiquitous clipboard in order to construct yet another personal medical history. I think I would have felt better if they had sent me the form in the mail during the five weeks since the appointment was scheduled. I finished the task and waited to be called. I noted that other patients were being called by their first names, a big pet peeve of mine.† While I know that this country is becoming a much more casual place, the last place I wish to be treated impolitely is a doctor’s office. My name is Mr. Goldfarb. We

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\* At the risk of boring you with my continual harangue about the modern day U.S. healthcare industry’s sad lack of concern for the individual patients, I shall beat on this again. Why can’t one hospital or “provider” pass information along to the next when there is a sequence of activities concerning the same patient and the same ailment? The lack of communication might be somewhat understandable in a situation in which diverse entities were handling various parts of the treatment. However, when the staff at the rehab physician’s office tell me that they cannot get information from the rehab hospital at which the physician practices, requiring the patient to repeat the same paperwork exercise as had been done for the hospital, something is drastically wrong. I do not know whether this sort of thing is an expedient that is created by either overworked or lazy doctor’s office personnel and condoned by patients who are used to being told what to do. The more work offloaded onto the patients, the lower the overhead for the doctor’s office, and in the macroeconomic sense, for the entire industry. Alas, that saving is not passed through to the patients and the process is prone to errors and omissions.

† OK, so I am on the soapbox again. I feel that submitting to the prodding, probing, and loss of dignity through which one must persevere when undergoing medical treatment is bad enough without the further dehumanization of being patronized by doctor’s office personnel. Anywhere else where you buy products or services, you receive respect commensurate with your status as a customer. A patient is also a customer, sometimes responsible for very large amounts of revenue to the medical organization in question. Why, then, am I shown proper respect by personnel at the offices of my stockbroker, my banker, or my auto dealer, but not at the offices of my doctors and dentists? I let them know when they cross the boundaries of propriety. If enough of us complain, this disrespect for patients might eventually abate.

are not on a first name basis unless we are friends or family or until I introduce myself that way. My turn finally came. Fortunately for her, the assistant who called me used both first and last names.

I was ushered to an examining room where vitals were taken. The doctor arrived shortly thereafter. He marveled at the quickness of my recovery, stating that he had never seen anyone recover from total hip arthroplasty that quickly, especially with only three days in rehab. I beamed, but then quickly contained my pride. It was the surgeon, Dr. G, who deserved the credit, not me. I might have put some hard work into rehabilitation, but the extremely skilled and competent surgery put me in a position to be able to do so. I had none of the pain or muscle spasms that were frequent complaints of Dr. B's other patients. He agreed that the surgery was extraordinarily good, without even minor complications such as swelling or a painful incision. I silently congratulated myself once again for choosing Dr. G as my surgeon.

Dr. B discussed the path forward with me. I would reduce the pain medication to Tylenol (acetaminophen), and I would continue with the physical therapy. I wanted to do outpatient physical therapy, even though he thought it might not be necessary. My reasoning was that I was on my own, and I was therefore likely to be doing something wrong. I wanted some supervision by a professional physical therapist in order to keep myself on the proper course. Sometimes, we think we are doing the right thing but we do not quite do a particular exercise as we were instructed. This can be benign, but it also can cause much damage. I would be seeing a physical therapist twice a week to ensure that I was doing things right and moving forward.

### Surgeon

Two days later, I visited Dr. G for the six-week follow-up after surgery. I walked in without a cane or crutches. As I mentioned previously, Dr. G was unhappy that I was not using any support for walking. I was so enthusiastic about being able to walk painlessly that I had unwittingly ignored Dr. G's orders. At six weeks, I should have been using a cane on the opposite side to reduce the weight borne by my operated leg. This would continue through the twelfth week.

In addition, I was not to be doing any fancy maneuvers on the stairs. It was back to one step at a time, with additional support to keep the weight off the left leg. I would continue to observe all other precautions, getting into and out of chairs and cars properly. Six more weeks. I could tolerate it. I would have to.

Dr. G explained the reasons for this. No matter how good it feels, the uncemented prosthesis is not stable until bone grows around it and into its roughened surface. The critical period for this process is the first twelve weeks. Dr. G has had experience with thousands of hips, which is one of my reasons for choosing him. It was time to listen to the voice of experience.

"At some point five years from now, you don't want to be kicking yourself for doing something stupid now that causes the joint to loosen then," he said.

Of course, I did not. Loosening is one of the most frequent causes for revision surgery. I wanted this new hip to last as long as possible, perhaps 15-20 years, not a mere five or fewer.

I asked a few questions about various related issues, such as whether to continue sleeping with the abduction pillow and whether to continue to wear the compression stockings. I also wanted to know, per requests from my doctor and dentist, which drug Dr. G preferred for antibiotic prophylaxis before and after invasive medical and dental

procedures. This time I listened to the answers and this time I would not improvise on my own.

Because I was planning to do more physical therapy, I asked Dr. G whether he had any specific instructions for the physical therapists. In addition to ensuring observance of the 90 degree bending restriction and the 80 per cent weight restriction, he implored me to avoid any exercises that involve heavy abduction or adduction.

Dr. G will keep an eye on my right hip (the “good” one) to get some data points, which would help him in determining about how much longer it would be before I would have to consider total arthroplasty for it. Obviously, I want to wait as long as possible, but I pledge that I will not let it deteriorate to the extent that I did the left one, where pain dominated my life. The right hip was asymptomatic at the time this book was written. However, if and when the time comes, it will be no surprise to anyone that I will choose Dr. G as my surgeon once again.

My next follow-up was scheduled for one year after surgery.

### **Out-patient physical therapy**

Having been cleared to start out-patient physical therapy, I scheduled the first session for Thursday of the follow-up week. My insurance company had cleared me for 10 sessions.

At my first meeting with my physical therapist, Vivian, I gleaned that I was dealing with a very experienced professional. We discussed my progress to date and the restrictions imposed upon me by the surgeon. She asked me to demonstrate the exercises I had been doing at home, commenting on my technique as we went along. It turned out that I was rushing through some movements that I should have been belaboring.

Vivian measured my leg strength and range of motion in several directions. Like the rehab physician and others, she was surprised by my progress at that stage. Then it happened. I heard the question I had been waiting for: **“What are you doing here?”**

My answer was that I was there to increase range of motion, strength, and endurance. Vivian promised to do what she could, although she felt that in view of the restrictions imposed by Dr. G, which would not allow the use of some of the machines, I could probably obtain good results by continuing what I was doing at home, with appropriate adjustments. Nevertheless, I felt that I would benefit by having a knowledgeable physical therapist directing my rehabilitation for a while.

Thus, we began my out-patient sessions with some standing and supine exercises. Vivian seemed apologetic that she could not do any more. There was no need for such concern. We both wanted to observe Dr. G’s restrictions. I stressed to Vivian that it was worthwhile having her observe me and that she should be vocal if she saw me doing something wrong.

We scheduled two sessions per week. These proceeded uneventfully until the sixth session at which Vivian announced, “Today is your graduation.” The following week, I was to see Dr. B, the rehab physician, for another follow-up. In view of that, Vivian felt that she had completed her job. I was to let her know if Dr. B felt that any more work was necessary. She measured my strength and range of motion again, noting that my range of motion had increased about five degrees.

I had originally expected that out-patient therapy would be much more intensive than it was. Of course, the restrictions imposed upon me limited what I could do there. Nevertheless, it was worthwhile if all it accomplished was showing me how to do the exercises correctly.

### **Dr. B: a final followup**

A week after my last physical therapy appointment, I saw Dr. B. He continued to marvel at my rapid progress. In fact, the first thing he said to me was, “Six sessions of physical therapy and they let you go?”

Dr B gave me a cursory check-up, obtaining the now expected, positive results. Everything from my surgical incision to my strength and gait was as close to perfection as it could be. “I want to work more with [Dr. G]!” he exclaimed.

I asked about what sort of exercises I should be doing from that point, now that I was done with formal physical therapy. Aside from continuing with the exercises I was doing, Dr. B advised me to start walking increasing distances once I got past the 12-week period of restrictions. Also, “anything in the pool” would be fair game.

We had a brief conversation about dislocation precautions. By this time, I realized that no doctor was ever going to go out on a limb by advising me to exceed any of the standard restrictions. Also, avoid low toilet seats. OK, so I was on my own.

I would not need any more follow-ups with Dr. B, but he told me to keep in touch with him regarding my progress with this book.

### **Walking for fun**

Finally! After 12 weeks, I could ditch the cane and walk normally. I really mean normally, too. For such a long time, walking meant limping severely, compensating for my painful left hip. It was no longer necessary to do this. However, telling the body to do something it had not been able to do for years required concentration. The natural tendency, forged by years of habitual limping, was to continue limping. I would expect that first blast of pain upon getting up from a seated position, then when I did not get it, I would continue to walk gingerly, anticipating its return at every step.

I had practiced walking straight and true both with and without the cane. I used a long hallway in my house for this purpose. At one end is a window, which would function as a mirror at night. Thus, I was able to watch myself walking and correct problems as I walked.

Prior to the 12 week mark, I had been doing a little walking here and there with support by a cane or other device, of course. Around the house sometimes I would forget the cane as I moved from room to room. The hip felt so good and natural that I had to remind myself to use it. When I went to the supermarket to buy groceries, I could use the shopping cart for support. I tried not to overdo it, but a large supermarket with long aisles provides plenty of opportunities for practicing walking.

Once the 12 weeks passed, it was time to start walking in earnest. There is a nice, shaded walking path around my community that is conveniently 1.5 miles around. This would be a great place to start walking were it not summer in central Florida. Shaded or not, the daytime temperatures in excess of 90F, with humidity to match, are a deterrent to walking. In the evening, when it cools down, we have the voracious mosquitoes. Therefore, the solution was the shopping malls, which are about as prolific as the mosquitoes in this part of the world. Being air conditioned, with long, straight runways and a few steps and ramps here and there, the malls were ideal for those first long, unaided walks.

For the first walk, I did two laps around one nearby mall. The following day, the new hip felt sore. I allowed it to rest a couple of days before I tried another. The next walk around a different mall twice produced only minor soreness. I will keep up the mall walking until

the outside temperatures come down a bit, when I will revert to the walking path in my neighborhood.

I have always enjoyed walking for exercise. Recalling the drudgery of walking in my pre-surgery days, I am enjoying it all the more. Instead of wincing and grimacing with each step, I am marveling at the absence of pain!

### **Sleeping my way**

I told you in a prior chapter that sleeping on my back was not natural for me. Because of the induction pillow, I was not able to roll over. My usual sleeping position is on my side or on my belly. It was sometime between six and twelve weeks that I ditched the abduction pillow and began to experiment with sleeping my way. I bunched up a soft pillow between my knees and rolled over onto my right side. It felt fine. I slept this way for a while. Ultimately, I was able to roll over onto my belly, which is the preferred sleeping position. When I could do this, I felt that life was really heading back to normal.

### **Dressing**

After 12 weeks, it was still necessary to use the sock helper to get a sock on my left foot, but I could do the other side without assistance. I needed the grabber less and less as time went on. The long-handled shoehorn was still a handy thing, though. I still could not tie shoelaces, so I was “stuck” with slip-on shoes for quite a while. I had purchased several pairs of both casual and dress shoes in slip-on styles before my surgery. Hence, this requirement really did not get in the way.

### **Back to the garden**

I could do anything in the garden that did not require stooping. Obviously, the weeds would have to wait for me to develop the capability for getting down to their level or, more likely, for me to buy a long-handled weeder. My garden had declined a bit because of my neglect during the long summer of my convalescence, and summer can be brutal to a Florida garden. My plants no doubt breathed the vegetable equivalent of a sigh of relief when I became able to achieve communion with them once again.

## Chapter XI. Conclusion

This book has chronicled my journey through hip replacement, from the onset of pain through surgery and early rehabilitation. It is my hope that my experiences have proven useful to the reader who is about to embark upon a similar journey. Above all, what I wish to emphasize is that you do not have to live with excruciating hip pain. Modern orthopedic surgical techniques can provide almost complete relief from pain without significantly compromising an active lifestyle.

Complete recovery for me will take about a year. With a non-cemented joint, the natural process of bone growth that is required to secure the prosthesis requires that length of time. Twelve weeks after surgery, however, I can say that I was almost there. I no longer had post-surgery fatigue. I was pain-free and for the first time in almost ten years, I was not taking heavy daily doses of NSAIDs. I was walking without a limp, which I had not done for at least six years. I arranged some vacation travel without having to plan around my hip pain. I had not been able to do that in many years.

Now that you have read my saga, it is time for you to return to Chapter II, which recommends three more books on the subject. They are each excellent books; if you have time, I would advise you to read all three. You can never have too much information; you can never be too well prepared. There are many other excellent sources of information on the Web if you are adept with searches. With your favorite search engine, using the keywords “total hip replacement” or “total hip arthroplasty” will provide a good start. Regardless of whether you obtain your information from reliable sources on the Web or from books, magazines, or professional journals, arm yourself with as much information as you can digest.

The theme of this book is that pain from hip degeneration need not rule your life as I let it rule mine for years. If I have succeeded in convincing even one reader to choose total hip replacement surgery over debilitating pain, then I have accomplished my objective.

I encourage you to share your experiences with me. I welcome any communication relevant to the subject, including critical comments about the contents of this book. I can be reached via email at [goldfarb@mrbig.com](mailto:goldfarb@mrbig.com).



## Epilogue

Almost eight months have now passed since my hip replacement. I am back to report on my recovery. This chapter will sound like I am blowing my own horn. I suppose that I am, but I am hoping that in doing so I am providing encouragement to those of you who have trepidations about your life after surgery. As any thinking person would, I had thought quite a bit about what would happen in the aftermath of surgery; I wondered whether I would be able to do everything that I had not been doing prior to surgery because of hip pain. Thus far, I can say that—within reason—I can!

Before I chronicle some of my exploits, I would like to thank the many people who have sent me e-mails after reading this book. Their hip replacement sagas have been very positive and uplifting. If I never find that publisher with deep pockets, I will have been rewarded many times over by knowing that I have helped others who have reached the hip replacement decision point. Thanks for writing and thanks for all the kind comments about my meager work.

### One, two, buckle my shoe

Doing things with your feet is one of the major problems after hip surgery. One is cautioned not to bend too far, but doing anything with feet requires such bending. The fear of dislocation becomes ingrained to the extent that I did not even try. I had bought shoes with Velcro closures prior to my surgery, so that I would not have to concern myself with how to tie shoes thereafter. For six months, I wore them and other slip-ons in my shoe collection. (I am an aspiring male version of Imelda Marcos.) However, I can now bend down and tie my shoes. Each time I can do something new with my feet, I rejoice.

For example, there was the time I forget to take the sock helper along when I was visiting my family in South Florida for Thanksgiving. Oops! I could have cheated by wearing no socks to Thanksgiving dinner—things are that casual in Florida—but I decided to live dangerously, putting the sock on unaided. It turned out to be no problem. However, I still could not help thinking that I must have come close to dislocating the hip. I had been cautioned that a dislocation could occur with no warning whatsoever, and I envisioned myself being carted away to the hospital with my sock half on. No such drama occurred. I still use the sock helper at home, because I do not want to take silly risks. It is here, so I use it.

The toenails on my left foot were getting a little long when I visited my cousin Paula in New York in October, four months after surgery. I intended to do a lot of walking in the big city. Walking with long toenails can be painful. Paula offered a pedicure, and who was I to refuse. She did a wonderful job, for which she should receive hazardous duty pay and a government pension. The next time I needed to cut my toenails, I was back in Florida, and Paula was in Japan. Thus, I could not call her for a rush job. (Her employer never would have understood.) Toenail clippers in hand, I steeled myself for the inevitable dislocation and gingerly initiated the task. It was over in a flash—far too easy, and with no dislocation!

I mentioned in the previous chapter that I had been doing a little gardening, but could not stoop to pull weeds. I am now proud to say that I can actually pull weeds, but I still prefer to let somebody else do it.

### Three, four, travel some more

I like to travel. My wanderlust even existed when I had so much hip pain that I paid dearly for even short, domestic trips. Whether traveling by car or by airplane, there was

pain; whether I was traveling for business or pleasure, that pain would get in the way. I could drive only a few hours without having to make a pain stop. I also had to wonder whether the massive doses of anti-inflammatory drugs were impairing my reaction times, making me a dangerous driver. When I traveled by air, I had to bring along a folding cane, which enabled me to hobble through airports. Standing up after a long flight was an exercise in how much pain a person could endure. Yet I dragged along carry-on baggage and battled for position with the other frequent flyers. A day of travel wore me out so completely that I was worthless the next day. One of the big lifestyle improvements I was hoping to derive from the hip replacement was the ability to travel painlessly, and to be fresh and ready for action the next day.

The first out of town trip was a few days after the September 11 tragedy. A friend, Georgia, who was moving from Florida to California, planned to drive her car there. Another friend, the now infamous Dr. Margie from Louisville, had planned to meet her in Orlando to make the drive with her. Visions of the movie *Thelma and Louise* entered my mind when I learned of the grand plan. In any case, air travel was disrupted by the terrorists. Margie could not get to Orlando. She worked out a plan whereby she would take a Greyhound bus to Birmingham, Alabama and meet Georgia there. In the meanwhile, a hurricane was churning in the Gulf of Mexico. I did not want to let Georgia drive alone in the rain all the way to Birmingham, so I volunteered to do the driving. I did not know how my hip would react. I now know that there was nothing to worry about. Not only was I able to drive twelve hours, half of which was rough going through blinding rain and tropical storm force winds, but also I was able to maintain an even disposition throughout, not once getting upset at Georgia or her two dogs, not even when she broke the clip on my radar detector. I might have been able to accomplish the drive before surgery, but I would not have been able to avoid being an angry sourpuss.

My first air trip after hip surgery was a football weekend in Pennsylvania. I wondered whether I would be up to traveling at all at that point in September, a mere three months after the operation. I would never know until I tried it, so this was to be the perfect opportunity. I would be with friends who could take care of me in the unlikely event that anything bad happened. I made travel arrangements in such a way that my hip would be pampered. Being a frequent flyer, it was easy to get first class upgrades so that I would have some room to stretch out and exercise the leg. (Of course, the danger of deep vein thromboses (DVTs) had been drummed into my head.) I also rented a car that was large and luxurious. The weekend turned out to be an uneventful success, although my alma mater, Penn State, lost the football game to Wisconsin. I did a lot of walking around the campus and in town, feeling only minor soreness.

As I mentioned when I was talking about toenails, I went to New York City for a weekend in October. By that time, I knew that I could accommodate the air travel. Things were settling down a bit after September 11, anyhow. I had not visited New York for about 10 years. The reason for this was my fear that the big city would beat me up. I had lived in New York for five years earlier in my life, and I knew that a lot of stamina is required to succeed in just about anything in the big city. I was afraid that I would not be able to handle the walking, the taxis, the crowds, and just about everything else. This time, though, I was laden with optimism. My cousin and I went to theaters, to a basketball game at Madison Square Garden, to restaurants, and to parks. We walked, we took taxis, we rode buses, and we took the subway. Not once was there any pain. Not once was there any fatigue. Walking forty or so blocks in midtown Manhattan was probably the first big test of my walking ability. The results were excellent.

I was ready to test the hip for a longer flight. I made plans to visit friends in Jolly Old England. This eight-hour flight would surely test my mettle, especially because I was unable to get the first class upgrade on the eastbound flight. There again, in the past, I would have been in agony because of the small seats with little legroom. Worse, sitting in

a rows immediately in front of and behind mine, in the center section of a jumbo jet with 2-5-2 seating, were families with several infants and toddlers with small mouths that belied their ability to shriek loudly. I did not get even a minute's sleep on that flight. Yet I arrived at Gatwick at 9 AM in a good mood (no doubt relieved that "it" was over), and was even able to handle the announcement from my friends that there would be no toilet facilities at my destination until the following day because the septic tank had overflowed. I could only imagine what my response might have been if my old hip had been in control of my emotions.

One more pleasure trip is worthy of noting here, especially because it involved heavy use of the artificial hip. In December, six months after surgery, I went to California and Nevada for a two-week vacation. My plan was to do a bit of hiking in Southern California, and do a bit of gambling in Las Vegas. My hikes in California were generally five-mile day hikes over moderately hilly terrain. Aside from some huffing and puffing when ascending the hills, due to my being out of shape from so little exercise while the hip was hurting, I was able to accomplish the five miles easily. That Saturday, I was supposed to be visiting some friends for what I thought would be a lazy afternoon barbecue. When I got to his house, my friend David let me know that he wanted me to take a walk with him through his gated community—another three miles up and down hills. I find this commonly now. People, who have known me during the old days of moaning, groaning, and not being able to walk very well, now wish to see me walk. I am glad to oblige them.

The Las Vegas part of the trip was good, but it really did not serve to prove anything about my new hip. Thus, I will not comment much on it here. I will say that I was involved in a minor traffic accident in which I was hit from behind by an off-duty topless dancer. Even traffic accidents can be Las Vegas style entertainment!

There has been only one other trip between then and now (end of January 2002). I successfully completed a one-day trip to Pittsburgh to handle some family business. I started with the 5:35 AM flight out of Orlando and returned on one arriving shortly after 8 PM. In the snowy streets up north, I walked through salty slush, kept my balance, and froze my tush. It was a long day, but there was no pain, little fatigue, and I did not lose my temper even once!

Some of you are no doubt wondering about metal detectors and your new, metal hip. I have to say that not a single metal detector has yet detected my hip. This was surprising to me, because the hip prosthesis is a big piece of metal. Nine different airports since September 11, and one sports venue (Madison Square Garden) failed to detect it. I had prepared my speech and had my card ready, but never had to use either.

### **Five, six, pick up sticks?**

I have not yet picked up my golf clubs, which have been silently rusting for about 10 years. It has been that long since I played my last round of golf. I definitely want to get back into something competitive, and golf seems to be the best sport for me to accomplish that. My surgeon told me that basketball was definitely out of the question, not that it would matter. I once played a respectable game of golf, and perhaps I will be able to do so again. My clubs are 30 years old, though. If I find that I can actually swing them whenever I finally get the motivation to do so, I will have an excuse to spend some money buying a new set.

Why have I been dawdling on this issue? Aside from the fear that I have lost my swing completely and will have to compensate for the hip such that I will hit the ball even more cockeyed than before, I have not yet worked golf into my routine because I am filling the

time with a many other things for which there was a pent-up demand. Eventually, I will give golf the place it deserves in my schedule.

### **Seven, eight, this is great!**

Recreation aside, I am able to do everything I need to do around the house now. I have been up and down ladders with no problems. I have been down on the floor. I am up and down stairs many times a day. I can use normal bathroom equipment, handling even low toilet seats with ease. I am elated. Six months ago, I was happy to be able to get out of a chair without feeling that awful blast of pain. Now, I do things that I could not even do at all in the months before surgery, and I do them painlessly. Total hip arthroplasty made all this possible. I cannot even imagine how badly my life would have deteriorated had I not gone through with it.

### **Fun with medical bills**

I am going to shift gears for a moment to one of my pet peeves. No book of mine would be complete without a few parting shots at the sorry state of the health care industry. This time the subject is billing for medical services. Most of the bills for services relating to the surgery were paid by my insurer and by me within two months. However, the two biggest bills, from the hospital where I had the surgery and from the rehab hospital, have taken a while to straighten out. My insurer was the first culprit. The insurance company sent me an explanation of benefits for the hospital stay claiming \$2000 was my responsibility, but it was done in such a cursory, lump-sum way that it made no sense to me at all. It took me at least two months of irritating telephone calls to get them to revisit the matter. Finally, they did. In December, six months after surgery, I paid the hospital what I actually owed: \$825. The other bill, from the rehab, is still outstanding. This time, both the hospital and the insurance company agree on the amount, which is \$552. However, I have been asking for an itemized bill to support that amount for three months now without success. Again, I have been through the wringer of aggravating telephone calls and bi-weekly dunning letters. Every time I manage to speak to someone at the billing office, she tells me that she will take care of the matter. I have been making this simple request since November. It is now the end of January, and I have received nothing. I have even told the billing people to go ahead and turn the bill over to their collection agency, because I know I will get what I want if they do. The collection agency will get me a copy of the original bill, because it will be an easy way to make a quick buck.

The reason for this stupidity is something that is increasingly common in the health care industry. Hospitals have found that billing and collection is something they can effectively “outsource,” so they do. The particular hospital system that runs the rehab facility in which I spent three days is a large, regional, supposedly non-profit organization. I can recall a major dispute I had with them over a mere \$36 several years ago, where all they would have had to do was submit the claim to Blue Cross as they were originally instructed to do and, in fact, they were contractually obligated to do. Instead, it wound up going to a collection agency even after I had fully documented the case. The collection agent, upon hearing my story, communicated with the hospital, getting the problem fixed. That was perhaps 15 years ago, when the hospital organization was doing its own billing. Now, they employ a billing service in Atlanta, some 500 miles away, and they are even more screwed up than ever. Now that the function is not being handled internally, we add one more, communicative dissociation, to their long list of problems.

I have no doubts that I owe them some amount, for indeed I had a private room while my insurance pays only for semi-private accommodations. The detailed bill is necessary for me to confirm that the \$552 for which they are billing me is the appropriate amount. When I check out of a hotel, I resolve any difference with the cashier at that moment

because he or she presents the detailed bill to me. I am not accorded that same opportunity in a hospital. Hospitals must think that because they are supplying necessary services and because they are being paid largely by insurance companies with whom they have special deals, they are immune from the need to be courteous and accommodating when billing patients. They sling threats of collection and of damaging one's credit rating without even taking the time to determine whether anything is wrong. I ask you this: In what other industry do suppliers of services have the audacity to expect that one pay their bill without having any notion of what it represents? If a dealer repaired your car, then told you that the warranty covered all but \$552, would you not ask for substantiation of that amount?

They can send me to collection. I do not care. Let them take me to court. There, I will make them look like the disorganized, uncommunicative dolts that they are. This is silly. Just send me the itemized bill and I will pay the damn \$552!

There you have it. Not even three quarters of a year have passed since surgery, and notwithstanding some hassles with medical billing, I am enjoying life as I once never thought I could. If you still have any doubts about whether this surgery is right for you, read the books I have recommended in Chapter II, talk with others who have had their hips replaced, and talk with your orthopedic surgeon. This operation has proven itself over time, having helped many people lead normal, pain-free lives. I have no regrets.

I would again like to thank all of you who have read my story. I wish you all well with your surgery and recovery. Once again, if you have any comments or questions, I am happy to answer any e-mail directed to me at [goldfarb@mrbig.com](mailto:goldfarb@mrbig.com).