Dedication: Dr. Eric Hume, MD

Joseph Bernstein, MD

I met Eric Hume briefly on a visit to Jefferson in 1989, but my first meaningful interaction was on a Tuesday in February, 2011, his first day as a staff surgeon at the VA.

We were sitting in the "Chief of Orthopaedics" office waiting for the first patients to roll back when one of the residents came by to ask about a consult from the Emergency Room.

The ER doctors had suspected an ankle fracture, we were told, so they got films. The ankle was fine. Yet on the lateral, there was a small line through the calcaneus. The resident proposed a boot and non-weight-bearing status. I said "Sure, it looks innocent enough."

To that, Eric said, "I can see why you think it looks innocent, but maybe we should get a CT scan first. The x-ray probably understates the severity of the injury. The fracture might be unstable, if it's not stable it might displace and if it displaces the patient will be sad. So we might want to fix this."

Not recalling that Eric had been doing trauma for years at Cooper and at Jefferson before that, I asked him "Do you mind if I crosscheck on that?"

"Sure," Eric replied.

I texted the trauma chief the x-ray and clinical history, and, as we have come to expect, got a helpful reply at once: I can see why you think this fracture looks innocent, but get a CT scan first. The x-ray probably understates the severity of the injury. The fracture might be unstable. If it's not stable it might displace. And if it displaces the patient will be sad. So you might want to fix this. See Essex-Lopresti British Journal of Surgery 39.157 (1952): 395-419.

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I did not fully appreciate it at the time, but that little encounter in so many ways encapsulates the Hume approach. It was knowing. It was modest. It was a gentle nudge. And perhaps needless to say, it was about improving patient care.

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Dr. Hume was hired at Penn to be an arthroplasty specialist. We had four joints on the schedule that very day I met him, in fact. I could be forgiven for assuming that maybe Trauma was not his world. Yet, as I came to learn, living in multiple environments, at home in all of them, is something Eric does particularly well (see Figure 1).

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Eric, it turned out, found a great niche in the arthroplasty world: everybody's friend. For some reason, joint surgeons enjoy a good feud. It seems that there is nothing like an argument over aspirin vs heparin or the merits of various infection-detecting methodologies to leave a room looking like a slaughterhouse. In this environment, Eric's respect for other people's ideas –and the people themselves – allowed him to see the merits of all sides to a question, and to disagree, if he must, without being disagreeable.

I particularly enjoyed listening to Eric debate a resident who was defending, say, kinematic alignment for total knee replacement, especially since Eric's performance, challenging a different resident who favored mechanical alignment the previous week, was fresh in my mind.

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After a few months of sharing the VA office every Tuesday, I also came to discover Eric's great fund of knowledge outside of orthopaedic surgery as well. In those pre-CHAT days, when one of our children would ask me "Why did that airliner crash?" or "How does a toilet work?" or, "Which is better, A/C or D/C current?" I would always propose getting back to them after work on Tuesday. I always was smarter after work on Tuesdays…

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Eric's good humor has to be acknowledged. If I can break the clubhouse omertà just a bit, I must confess that any whining or complaining you may have heard coming from behind the closed doors of the Chief's Office was me. Eric was—and is!—so darn cheerful!

And he'd be forgiven if he weren't cheerful, I should add. Medicine has changed so much since Eric graduated from medical school in 1978, and to the extent that these changes made healthcare delivery safer or more effective (and some certainly have), hardly any have made surgical practice more pleasant. Consider: our "Chief of Orthopaedics" office is 4 desks crammed into 89.2 square feet of windowless space, not that I am counting. And yet, despite this, despite malpractice insurance premiums going moonward while surgical reimbursements have dropped by 90% in real terms, despite every challenge, Eric is always whistling while he works.

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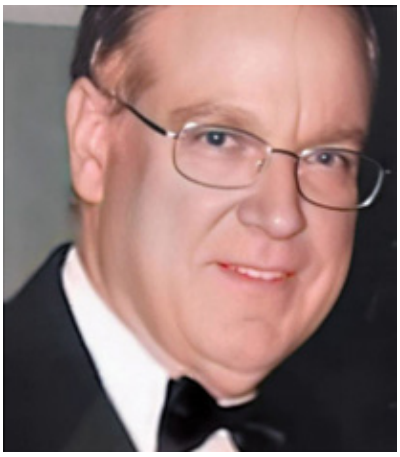
In the annals of orthopaedics, there is no Hume procedure and no Hume classification. Our city is unlikely to have a Hume Institute any time soon. Nonetheless, Eric Hume's legacy eclipses such monuments: his true legacy is the cascade of positive actions and good works undertaken by the more than 1000 students, residents, fellows, and colleagues he has inspired over a 40-year career.

When we go to work with gusto; when we make sure we are knowledgeable and apply that knowledge for our patients' benefit; when we consider our rivals' arguments in the best possible light; and when we respond to some knuckleheaded administrative fiat with a chuckle or wry smile, we are placing yet one more stone on the living Hume Tribute. In embodying these virtues, we not only honor Dr. Hume's legacy but perpetuate it. Hence, it is



with immense gratitude that the residency class dedicates this issue of the Journal to him and it is with immense respect that I lift a glass to toast him: Here's to Dr. Eric Hume—a true giant in our field—whose legacy is measured by the indelible impact he has left on our hearts and minds.

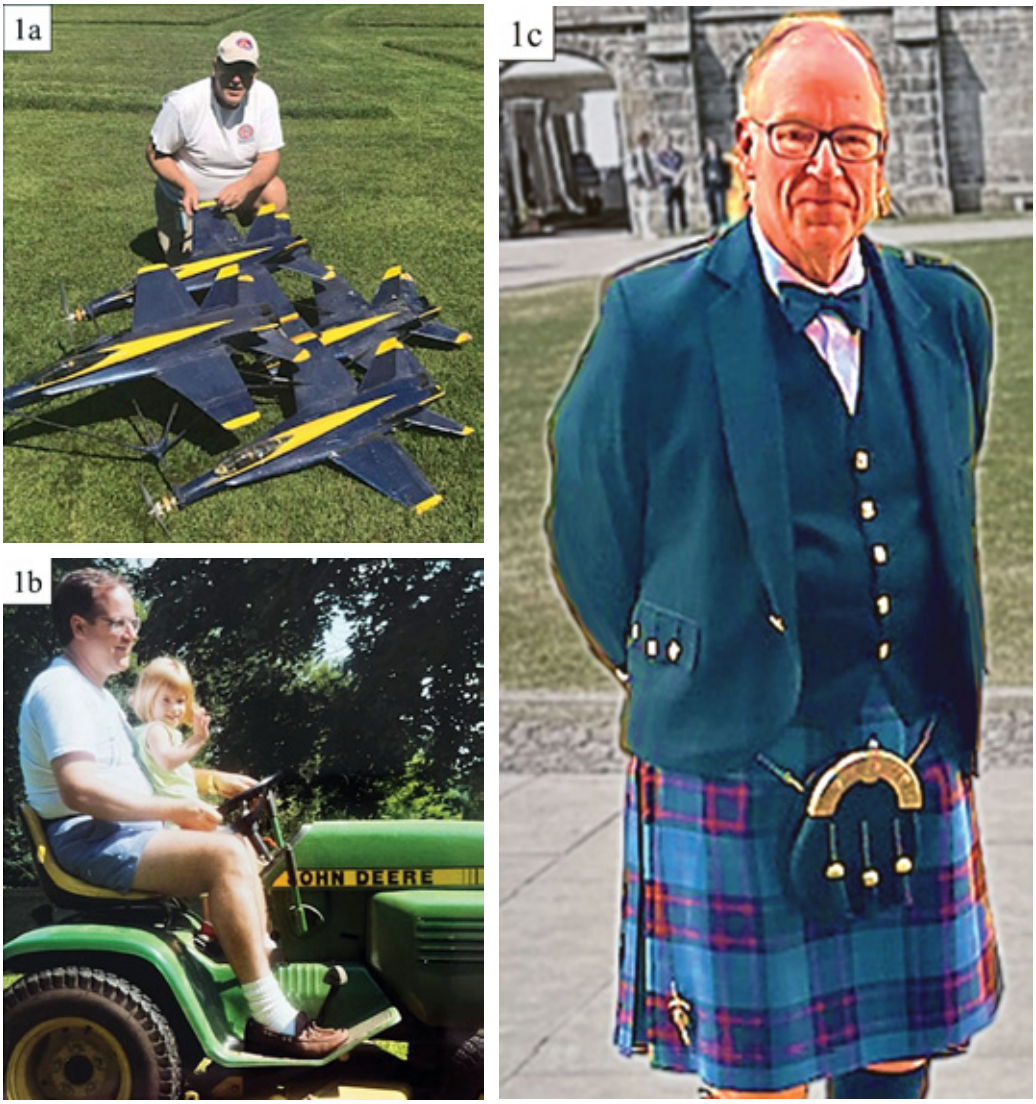


Figure 1A – 1C. Traditionally, the superhero is characterized by many costumes and modes of transportation. (Photographs courtesy Lenora Hume).