

# Art of Surgery

*a virginia surgical society project*



*A compilation of articles written between 2016 - 2019*

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2019



# Chartwork

Charles A. Harris, MD, FACS | 2019 Submission

“We are all creatures of our upbringings, our cultures, our times.” Oliver Sacks, *On the Move: A Life*.

“What lies behind us, and what lies before us, are tiny matters compared to what lies within us.”

Ralph Waldo Emerson

It seems at times to be the bane of every physician's existence: chartwork. Even after we've left the myriad challenges faced in our operating rooms, and our clinics, we carry home the burden of documentation. It is indeed ironic that in this age of EMR with “paperless” hospitals and offices, virtual mountains of “paperwork” remain to be conquered! The maxim that “If it wasn't documented, then it wasn't done” is as true today as ever, and armies of coders and record reviewers exist solely to make sure that this is so, with every ‘i’ dotted and every ‘t’ crossed. There is a clear impression that the paperwork is more important than the patients themselves!

Yet, in the midst of these mental misgivings, I remember the words of a wise clinician who reminded me that the medical record was “the chronicle of a life entrusted to us.” It was easy to forget this in the press of “getting things done” and out of the way. It was the life of a person that we were talking about after all.

I thought about this as I stared at the record of one of my breast cancer patients on the screen before me. “Date of Birth: 1940.” 1940. What kind of world were they born into? What was the world like then? What effect did it have on their parents decisions, and thus on their lives? What influence did it exert on their choices and subsequent health from stress, diet, loss of loved ones? Did it have anything to do with them being in my office for cancer?

In 1940, the world was a dangerous and uncertain place to live in. “...1940 was the fulcrum of America, in the twentieth century, when the nation was balanced precariously between the darkness of the Great Depression on one side and the storms of war in Europe and the Pacific on the other. It was a critical time in the shaping of this nation and the world, equal to the revolution of 1776 and the perils of the Civil War,” writes Tom Brokaw in his book *The Greatest Generation*.

We know, or should know anyway, that people do not get sick in a vacuum. The sicknesses we see have a greater context. Life in America in 1940 was about to change as world crises merged with innovation and a newer, faster pace of living. Not only was it the debut of the first peacetime military draft, but it was also the debut of Kentucky Fried Chicken and the first McDonald's restaurant opened its doors in San Bernardino, California. Home cooked meals slowly gave way to fast food which was generally fried and fatty. Did this have anything to do with the rise in breast cancer which has increased by 1% per year beginning in 1940?

I thought about the courage I saw in the face of this gentle lady when we first discussed her diagnosis of breast cancer. From her quivering lip and moistened eyes, you could see her mentally begin to “hang black crepe” in her response to the “C” word, which for her mother's generation carried a death sentence. But with the same steadfast resolve her mother's generation had confronted the “cancer” of Nazism and fascism afflicting the world in their day, she lifted her chin with resolute determination that I was grateful to see. As I reviewed the plan for surgery and the anticipated outcome based on present data, I sought to recruit the patient to our side. By dispelling her uncertainty and giving her a current perspective, I saw this now informed patient had become a real member of the team.

I began to understand what we in clinical medicine have intuitively known for years; “no two individuals react alike and behave alike under the abnormal conditions which we know as disease.” The patient’s response to disease is more than biology. The life lessons learned in the crucible of life, often times at considerable expense, were carried into the fight, and that has made all the difference. Auschwitz survivor, Viktor Frankl, observed, as he recounted in his memoir, *Man’s Search For Meaning*, “we who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of human freedoms - to choose one’s attitude in any given set of circumstances, to choose one’s own way....Every day, every hour, offered the opportunity to make a decision which determined whether you would or would not submit to those powers which threatened to rob you of your very self, your inner freedom; which determined whether or not you would become the plaything of circumstance, renouncing freedom and dignity to become molded into the form of the typical inmate.” That “it did not really matter what we expected from life, but rather what life expected from us.”

I closed the patient’s chart and signed off on it. I thought about her upcoming surgery, anticipating that she would do well. But as experienced clinicians also know, it will require more than our surgical skill. All of us know of cases and have personally lost patients despite a technically flawless procedure. The words of a familiar song rose in my hearing.

“When we have exhausted our store of endurance,  
When our strength has failed ere the day is half done,  
When we reach the end of our hoarded resources,  
Our Father’s full giving is only begun...  
His love has no limits,  
His grace has no measure,  
His power no boundary known unto men;  
For out of His infinite riches in Jesus,  
He gives, and gives and gives again.”

*She was counting on this and so was I.*



# Treating Patients Across Enemy Lines

Ashley Rosenberg, MD | 2019 Submission

When your enemy is injured what do you do? Due to a shared border with Syria, Israeli doctors are faced with just that dilemma. Over the last 5 years, countless Syrians have been injured during the Civil War, many with penetrating ballistic injuries. The Western Galilee Hospital in Israel is the closest hospital to a border in the country, just 6 miles from Lebanon. Western Galilee became a center for treating Syrian patients despite the distance, 1-hour drive, because of its expertise in trauma care. Between 2013 and 2018, 3,000 injured Syrians were treated at Western Galilee Hospital, representing 70% of all Syrians treated in Israel during the conflict. Forty percent of the 3,000 were women and children.

The question of how to logistically send patients across a closed and hostile border and transport them one hour to the hospital was a difficult one, but when you are faced with injured patients and soldiers running towards you for help, what can you do but figure it out? The root of the Israeli-Syrian conflict runs deep, there is hatred on both sides, but the Hippocratic Oath of doing no harm to patients prevents you from watching as the injured perish. Israeli and Syrian soldiers closely worked together to hand off patients to army medical vehicles and ambulances for transport.

Upon reaching Western Galilee Hospital, Syrian patients could not be placed in the bed next to Israelis; the conflict is too deep, and the hatred is too real. Due to the proximity to the border, Western Galilee Hospital built a fully functioning underground hospital with capacity for 550 beds. At a moment's notice, such as the second Lebanon War in 2006 when a rocket was shot from the Lebanon border hitting the second floor of the hospital, every patient in the hospital can be mobilized and moved underground in less than one hour. As a result of having this extra space, the hospital became an ideal treatment center for Syrians.

Countless patients were brought to the hospital, mainly in the night, and staff who were home for their time off ran into the hospital to help each victim. When the patients woke up from their operations and treatments, many pulled their lines and removed their wires upon realizing where they had ended up, in their enemies' care. Patients had to be talked to and comforted before eventually accepting further care. Syrians would mention that they were told growing up that Israelis cut open people's abdomens and dissect out their intestines. They believed that Israelis would torture them and use their organs. One Syrian patient, with a penetrating abdominal injury, was brought to Western Galilee Hospital and refused all treatments, saying that he would rather die than be treated by an Israeli. So, the doctors respected his choice and he was sent back to the Syrian border without treatment.

I met with Dr. Samuel Tobias, a neurosurgeon at Western Galilee who treated many of the Syrian patients over the last few years. He told me that "even terrorists have the right to be treated as if they were Israeli." What an amazing thing it is to put down all beliefs and hatred and treat patient after patient, even when a few of them tried to jump out the window when they realized they were in Israel. It got me thinking, was it the right decision? What would these Syrians do without the help of the Israeli doctors? Who would pay for their treatments? Where would they go for their recovery?

Dr. Tobias discussed how all patients should be treated to the full extent and we cannot lose our humanitarianism. Most of the Syrian patients had no hope without the help of the doctors. The Israeli government paid for the treatment of the injured Syrians and the doctors who came into the hospital on their time off volunteered their time for their enemy, to save their enemy.

Dr. Tobias mentioned that the hardest part was knowing that he could not provide the full course of rehabilitation each patient needed. Eventually, after a limited time of recovery and rehabilitation, the same cars which once brought them to the hospital took them back to the border and a friendly exchange again occurred between the Syrian and Israeli army and the patients returned to the warzone.

Dr. Tobias worked to communicate with Syrian physicians to ensure follow up care was provided for his many neurosurgical patients. Most of the patients were lost to follow up and Dr. Tobias will never know the outcomes of the many patients he treated.

What an amazing story of dedication to patient care. Each and every physician recites an oath to put aside beliefs about a patient to provide them the best patient care, but most of us are never faced with that dilemma. It left me pondering what I would do in such a situation, and also fueled with the selfless and excellent patient care that was delivered at Western Galilee Hospital.



# Tom S.

*Joseph Wilson, MD, FACS | 2019 Submission*

Tom was a big man, a full head taller, and I was a newly minted Otolaryngology (Ear, Nose and Throat) attending at a busy Navy training hospital. He was not just physically big, but in overall presence also. A master chief machinist mate in an inspection-ready uniform, it was immediately obvious why he had risen to the very top of the enlisted ranks. He exuded a “no nonsense” persona but was immediately likable and it was a contrast to see him in the clinic looking anxious and quite vulnerable.

Tom had been hoarse for 3 months or so and, more recently, had experienced some shortness of breath with exertion. He was a heavy smoker and had been for 30 years. As a prior first class machinist mate and smoker myself, I could understand the addiction: long hours on watch, perpetually broken machinery and a very cheap and limitless supplies of cigarettes all contributed to the ease of slipping further down the addiction slope. But now he was paying the price. He had a large laryngeal carcinoma. In the late 1980’s we treated these with external beam radiation therapy which worked very well on small tumors, fairly well on moderate sized tumors and minimally so on large tumors, like Tom’s. The concomitant radiation and chemotherapy, a much better regimen for advanced tumors, was still in the early research stage. The tumor showed minimal response to radiation and we elected, with Tom and his family’s consent, to proceed with complete laryngectomy (removal of the voice box) and a radical neck dissection on the same side as the bulk of the primary tumor due to the presence of a large node that showed the same pathology, on needle aspiration cytology exam, as the laryngeal lesion. (A neck dissection is an aggressive removal of lymph nodes, muscles, and occasionally the jugular vein, in an attempt to remove tumor that had moved to the lymph nodes and other tissues in the area.) Tom knew that the laryngectomy would mean the termination of his US Navy career and this concept, at age 48, was obviously troubling to him.

I also suspected that his family was a significant concern and he demonstrated the same amount of commitment to them as he did to his official duties. He and his wife had married when they were young and his children were all grown adults with self sufficient careers. However, they are still your children and there are worries about how they will deal with a parent’s illness, prolonged absence, or even death. His family was all there for significant discussions and decisions regarding his care. I sensed, though, that this was a slight contrast to his approach to decision making in his military life.

Tom also had long standing but well controlled hypertension and type 2 diabetes. His surgery went well and his healing complete. In fact, he was making progress using an electrolarynx to communicate. He was the perfect picture of motivation and compliance, and my respect, as well as special personal bond, grew stronger. His family was very supportive as well.

Several months later, during a routine scheduled appointment, I noticed a small mass at the far posterior aspect of the tongue and the junction with the entrance to the throat. This was not good news and a biopsy confirmed our fears: recurrent disease at the previous limit of resection. In all likelihood, it was more likely a microscopic area of residual cancer that had started to regrow. Further inspection showed that it deeply infiltrated the tongue.

Next came the very somber family meeting to discuss treatment options. This was a difficult task as I had allowed myself to develop a closeness with this incredible man and his family who had sacrificed so much for our country and community and it was very difficult to stay truly objective. In fact, to maintain this objectivity, I had presented his case to the Tumor Board (a collection of diagnostic and therapeutic experts that meets

on a regular basis to recommend treatment for challenging oncologic cases) and was sitting here now in front of him to present the findings of the Board. Unfortunately, options were very limited due to the previous failure of maximum dose radiation therapy. The recommended treatment was for glossectomy (total removal of the tongue) and a neck dissection on the side not previously done. The missing tissue would be replaced with a flap from his chest.

It is important to review what this would mean for my patient. In order to communicate with speech, we need something to make sound, the voice box, and a tongue to turn that sound in to intelligible speech. Tom no longer had the natural sound producing mechanism and we were telling him that he would no longer have a tongue either. He would be relegated to writing to communicate. I was talking to him about giving him a permanent and severe handicap.

Put yourself, for a moment, in his position. If you knew that you only had one more week to speak and to tell everyone that was important to you what you might want to say to them for the rest of your life, what would you say? Who would you start with? Who might you miss? How could you stop? Tom, exhibiting the same amount of motivation that I suspected he had shown all his life, asked simply, "When can we do it?"

The surgery took several hours and seemingly went well. His blood pressure was a bit labile during the surgery but nothing dangerous. He was slow to arouse from his anesthesia in the intensive care unit but that was preferable so that his blood pressure didn't spike from rapid emergence into post op pain. When he was awake I went by to see him and his appearance was as I expected: tubes and drains coming from under numerous bandages, monitors chirping away and a face with significant edema from having to remove the opposite jugular vein. Blood can find other ways back in to the vascular system but the lymph fluid does so with more difficulty and delay. I greeted Tom as cheerfully as I could and he responded by turning his head in my direction but he did not make eye contact. In fact his eyes just seemed to roam around as if searching for an image. Asking if everything was "OK," he pointed to his eyes and shook his head "no." It hit me hard: Tom was blind, and I was mortified.

An emergent consultation with an ophthalmology colleague confirmed my fears. The eyes had no light perception: a condition of complete and irreversible blindness. If my discussion with his family before surgery had been difficult, it didn't hold a candle to the one that I was about to have. How do you tell someone that the ability to see to write, the only remaining method of communication for their loved one, has now been lost? The family was stunned and I was deeply shaken and at a complete loss for further words. In fact, I was suffering from a significant crisis of confidence in my abilities.

Over the next few days, with a lot of help and record review by the surgery, anesthesia and ophthalmology teams, as well as intense literature search, we were able to determine that Tom had suffered from bilateral anterior ischemic optic neuropathy, a very rare complication related to blood flow to the cells in the optic disc at the very posterior aspect of the globe. Perfusion to tissue depends on the difference between inflow and outflow pressures and some tissues are more sensitive to even brief decreases in blood flow, the optic disc being one of them. Because we had raised the outflow pressure by removing the second jugular vein, the inflow pressure now was much more important. Both diabetes and long standing hypertension can damage a blood vessel's ability to generate an adequate blood flow and Tom had both of these problems. His few moments of decreased blood pressure intraoperatively would have been a factor in decreasing vital blood flow to sensitive tissues in the eyes. In addition, we had protected his eyes during the surgery by using a type of plastic goggles and the significant swelling of the face and eyelids may have added additional increases in outflow pressure and decreases in perfusion. All of this was Monday morning quarterbacking, or as we often say, the view through the retrospectoscope. It did nothing to help Tom, he would still be blind.

He spent several weeks in the hospital with intense wound care and even more intense physical and swallowing therapy. His family continued to be an ever present motivating force and the day finally came for him to be discharged to home with plans for intense home health nursing and home based rehab. Tom, being Tom, insisted on leaving as he came in, full uniform and on his feet. I had him brought from the ward to our clinic down the hall and had a quiet end office of the clinic so I could go over last minute instructions with him and his family. What I had to say next would be the most challenging discussion yet. How do you adequately apologize for a devastating complication, even if it was the result of good intentions and best efforts? How can you ever describe your complete feelings to the patient, especially to one with whom you had grown so close? Not knowing where or how to start, I just started.

“Master Chief?” I said. “One more thing I have to say before you leave today.” He slowly turned toward my voice, his wife supporting his elbow. “I don’t know how to begin or even adequately describe how devastated and profoundly sorry I am that you have suffered this complication.” There were a few seconds of intense and complete silence as I looked back and forth between his unseeing eyes and his wife’s face. Tom’s face was unreadable. He suddenly reached out with his ham sized hand and grabbed me by the front of my uniform and pulled me to him in a bear hug of embrace. Had he been able to speak, no words could have ever been uttered that would have expressed the same amount of understanding and incredible forgiveness as that embrace. I found myself, for the briefest of moments, glad that Tom could not see my tears.

It has been 30 years since I treated Tom and it has taken me that long to decide how to write his story but I have thought about him innumerable times in those intervening years. I have passed the lessons learned about ocular perfusion and intraoperative hemodynamics on to many residents in surgery and anesthesiology. They will have to learn their own lessons about personally dealing with complications and human spirit.

Tom died of widespread metastatic disease, undetectable at the time of his surgery, soon after his fiftieth birthday, about a year and a half after his first surgery. Had I known of these insidious areas of lurking death, I would not have subjected him to the second surgery and it’s severe consequences. More importantly, had I known of the lasting impact that he would have on my career, the way that I view perseverance and, most importantly, my understanding of forgiveness, I might never have left his bedside.



# Into the Light

*Alan King* | 2019 Submission

You're a floor below me, healing  
in your room. Both of us sore  
from the divine puppetry of science --  
God pulling the surgeon's strings,  
sliding the kidney from inside me,  
routing it to its new body in Connecticut.

And wasn't He present in the hands' deft dance  
and how hope lights the operating room like a stage?  
Your new kidney ready for its debut inside you,  
having traveled in a freight of prayers, 17 hours  
from Minneapolis to us.

Didn't our road here  
seem even longer --  
not being a direct match,  
the hiccup in lab results,  
us hurling our names  
into an Exchange pool  
deep with uncertainty.

And here we are -- in our beds,  
an elevator ride from each other, this moment  
like the 90-degree day beyond our windows,  
the cloudless sky, shadows receding  
in the sunlight.



# On the Other Side

*Minyoung Kwak, MD MPH | 2019 Submission*

“I will do some work to take my mind off it”

The usual solution.

Friends calling,

Mothers waiting.

Was I naïve to think I would never be

On this side?

Seeing my best friend

And her husband

In hospital gowns...

This is my place,

Not theirs!

They do not belong.

But my place is here now.

To wait.

Not doing,

Only waiting.

Putting trust in

Someone else's hands.

I can only do so much.

No room left in the OR.

My hands

too young.

My feet

only damp.

Still in training

Not yet a hero

All I can do right now

Is wait.



2018



# Meticulous Care of a Loved One

Frank Yang, MD, FACS | 2018 Submission

As the on-call general surgeon, my team and I were asked to evaluate an 85-year-old woman in the intensive care unit (ICU) with abdominal pain and abnormal laboratory results suggestive of a catastrophic event in her abdomen. Her vital signs were abnormal - heart rate too high, blood pressure too low, urine output marginal - signaling inadequate perfusion of her kidney tissues and, by inference, other tissues. Surely, her abdomen was distended and tender, ominous signs of ischemic or even already-gangrenous intestines. CT scan showed small intestine dilated with gas that could not pass and swollen intestinal walls, all adding to the clinical impression of intra-abdominal catastrophe. She had, in surgical parlance, an acute abdomen.

CT scan also demonstrated a large defect in the esophageal portion of her diaphragm (the hiatus), through which most of her stomach herniated into her chest, compressing her lungs. This was a chronic condition, unrelated to her acute abdomen.

My team and I decided that her only chance of survival would be through an emergency exploration of the abdomen, so called exploratory laparotomy, or Ex Lap for short, and correction of her catastrophic problem. Correction might entail removal (resection) of all gangrenous intestines. We recognized her operative and anesthetic risks were high, given her perfusion deficit, age and chronic conditions, which also included diabetes, chronic heart failure and emphysematous lung disease; in addition to the chronic hiatal hernia mentioned above, which further hampered her breathing.

Patient was obtunded from her illness and heavily medicated; therefore, not fully aware. So we discussed with her family the indications and risks of proposed Ex Lap and probable intestinal resection. During this discussion, we learned that Mrs. Jeanine Tomlinson is much loved and well adored by a large clan, all of whom concurred that everything needed and should be done, regardless of risks. In the months to follow, we came to learn just how important a matriarch Mrs. Tomlinson was to her large clan three generations deep and how crucial a central figure she was, gluing all generations together into a cohesive family unit.

Meanwhile, after our preoperative discussion, we expeditiously brought Mrs. Tomlinson to the operating room. It was evening already. The anesthesia team did a thorough job placing arterial line and central venous catheter to help with intra-operative and post-operative monitoring, thus enhancing management of her blood pressure, heart rate, etc. In addition, she was intubated in the operating room and placed on a respirator, which we planned to continue post-operatively until, or if, Mrs. Tomlinson survived and gained enough strength to breathe effectively on her own.

Through a midline (longitudinal) incision in her abdomen, we confirmed a long segment of gangrenous small intestine, rendered that way from a tight twist that pinched off the blood flow to those intestines. We “corrected” the problem by resecting all gangrenous bowel, thereby removing the abdominal catastrophe. Totally approximately 100 centimeters of small intestine was resected, still leaving enough bowel length to be compatible with life.

We confirmed by intra-operative exploration that just about all of her stomach was herniated into the chest. We pulled down as much of the stomach as we could from her chest back into her abdomen. But as soon as we let go, her stomach retracted back into her chest. So we pulled it down again and anchored her stomach to her abdominal wall by placing a tube through her abdominal wall and into the body of her stomach. This “gastric” (or G) tube could be used to vent or decompress her stomach in the immediate post-operative period, and later be used as an avenue for feeding her, in addition to anchoring her stomach within her abdomen.

The operation was successful: gangrene was removed, stomach was anchored, and she was brought to the ICU alive later that night, to fight for another day of life. Only we had no idea at that time, days would ultimately turn into seven months of hospitalization. Condensing the rest of her hospital stay: Mrs. Tomlinson's course was marked with many ups and downs. She could not be weaned off the respirator, as her lung failure deepened. Ultimately she required a tracheostomy. Through this tube in her throat, she eventually was able to breathe on her own without a mechanical device pumping air into her lungs. She could never be fed by mouth or even through her G tube. Every time either avenue was tried, she aspirated, further risking her tenuous lungs. So intravenous feedings went from temporary measure to permanent solution. This required a long-duration catheter extending to a central (chest) vein. Peripherally inserted central catheter (PICC) was the most expeditious route.

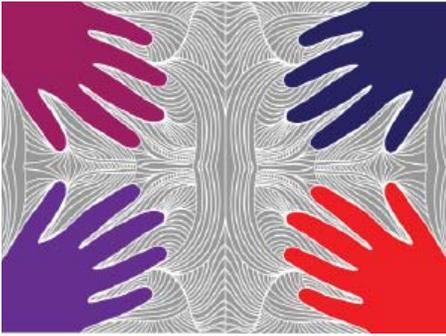
Her veins were too tenuous and too difficult for the PICC nursing team to cannulate, so radiology doctors had to place these PICC's every time Mrs. Tomlinson's PICC failed and needed replacement. Her midline abdominal incision became infected, as bacteria still wreak havoc upon humankind even seventy years after discovery of the all-important penicillin and despite numerous classes and generations of new and powerful antibiotics. Her wound infection led to non-healing of her abdominal fascia, which resulted in a large weak area – an abdominal wall hernia and wound problem.

During those many ICU months of respiratory and cardiac failure and dependence on artificial life support, all of us thought there was no chance of survival without continuation of extraordinary measures. We held many sessions with her family in the nearby ICU conference room. Mrs. Tomlinson had already outlasted many rotations of ICU doctors and support staff. I was impressed by one particular physician's assistant (PA) in the ICU. She had a thorough understanding of all of Mrs. Tomlinson's challenges and great grasp of future implications. She participated fully at these family conferences and always stated clearly to the family the grave outlook and reasonableness, and humanity, of withdrawing extraordinary care; so Mrs. Tomlinson could follow a more natural course and pass away in peace, and painlessly, supported by comforting medications to the end. All the staff agreed with this plan to withdraw extraordinary support, which we considered "futile." All of us participated in multiple family conferences.

Despite our ever-stronger verbiage, Mrs. Tomlinson's family insisted on continued full artificial support, always believed she will improve, always believed they will take her home. We, of course, honored their wishes after every conference, even if we did not subscribe to their belief; for we had seen much more than they have, and our expert opinion was based on years of collective clinical experience. But little did we know how wrong, and ignorant, we were.

During these many months, we came to know, through her clan, more about Mrs. Tomlinson's life and role pre-hospitalization. She cooked constantly everyday and always had her door open. Multiple generations of her extended family stopped by her kitchen any time, and there was always food and Mrs. Tomlinson welcoming them. She always asked about their day, listened with an open mind, provided a willing ear, supportive heart and kind words. It became apparent that without Mrs. Tomlinson, the clan would be lost without its head and would lose its spirit and energy. Furthermore, even while confined to the hospital and absent from kitchen and home, Mrs. Tomlinson continued to be the glue that held the clan together. She became even more the focus of the clan. During her long hospitalization, she always had family at her bedside 24/7, as her family devised a rotational schedule, so that from one to four people stayed by her bed, at all times. Mrs. Tomlinson continued to be the rally point for her clan and remained their matriarch, even comatose.

Her family sat, held her hand, stroked her head, spoke to her, even when she was sedated and comatose on the respirator. They brought her favorite blanket and pillow. By their ever-presence, they each came to know



her minute-by-minute needs. They offered to assist the nursing staff with more and more tasks, from wiping her to helping with dressing changes and even tube management.

After many months and to the surprise of the entire professional care team, Mrs. Tomlinson improved sufficiently to move out of ICU to a step-down ward. She returned to the ICU a few times when her condition worsened, but ultimately she went out to the ward and stayed there.

When it became probable that Mrs. Tomlinson could continue to survive, our case management team began looking for a facility to transfer Mrs. Tomlinson. Placement was difficult, as one facility after another declined to accept her, after reviewing her case and deciding they could not provide the intensity of care Mrs. Tomlinson required. So, the clan stepped forward and informed us they had come up with a schedule to take care of Mrs. Tomlinson at her own home. They devised this schedule around their own jobs, schools, immediate family care needs, etc., such that a family member could always be present at Mrs. Tomlinson's home. They also asked to be trained by hospital nurses on all the care Mrs. Tomlinson needed, from tracheostomy care to G tube to wound to even PICC and intravenous feedings, intravenous medications, as well as skin care and frequent turnings to avoid skin breakdown. I did not think any of the professional staff thought her family could succeed at providing such extensive care, even with the help of home health nurses. Nevertheless, hospital nurses laid out a to-do task list, and family came up with a schedule for their on-the-job learning.

Lo and behold, the clan "graduated" - they successfully learned all tasks and were "signed off" by nursing staff. After seven months' hospitalization, Mrs. Tomlinson had defied all odds given by professional "experts," had improved, was awake, understood speech, mouthed words in reply, which her family readily understood and had to translate to us. She was too weak to get out of bed and had become contractured, but her mind and spirit were all there, once again. Mrs. Tomlinson eventually was accepted by a long-term care facility, where she continued to improve even more and was ultimately discharged to her home. She could not get up to cook, but she remained the matriarch, and her triumphant family continued to gather under her wings.

At discharge, her family thanked all of us over and over for the care we provided and for "saving" Mrs. Tomlinson's life. In fact, we had long ago chosen the hospice/comfort care/death off artificial life support route. It was her clan's unwavering belief, even in the face of increasingly stronger words professed by "experts," and the family's resolve and persistence in learning and providing bedside care that really saved her and preserved her status as their immortal matriarch.

In the year since Mrs. Tomlinson went home, I saw her in the emergency room several times. She was even re-admitted a few times for infectious complications. Each time I saw Mrs. Tomlinson, she was clear minded and mouthed words asking me to relay her hello and gratitude to various members of the professional staff involved in her care. At each visit, I was impressed by the health of her skin – no breakdown, despite her prolonged bed-confined and contracted state. Every week, a page of blood test results appeared on my desk, showing me her chemistry and blood count. These were almost always in good order, attesting to her stability and the meticulous care her clan and home health nurses provided. When the first anniversary of her original discharge came and went, and Mrs. Tomlinson was still home and stable, I marked this miraculous occasion by giving voice to the date; in particular speaking with the attentive ICU PA -- and by writing this chapter, with my gratitude for all my coworkers, especially my admiration for Mrs. Tomlinson's clan and my awe over Mrs. Tomlinson's determination to not only survive, but to continue to thrive as the matriarch that she rightly has been, is and will be. Congratulations!

# You Can't Please Everyone

Frank Yang, MD, FACS | 2018 Submission

It is true; you cannot please everyone, no matter how good your intention may be. Throughout my long career, I came to be known for my good bedside manner with patients and their families. I listened to them and took time to explain diagnosis, prognosis, and proposed procedures in a thorough and understandable way. I was polite and I returned calls from my patients and families. It was important to me to maintain good interpersonal relationships with patients, families, and coworkers. More than a few times, healthcare coworkers likened my demeanor to that of a pediatrician than what is typical for a surgeon. I took that as a compliment.

Despite all this, there were a few notable exceptions in which patients or their families did not get along with me. In fact, a few of them thought I was downright rude to them! It was also true that communications, or in these cases, miscommunications or misperceptions, were the culprits, rather than any ill intent on my part or on the part of patients and their families.

Years into my practice, a new patient came to see me. He sat on the exam table, and an older-appearing woman sat in the chair next to him. After introducing myself and greeting the patient, I turned to the woman while asking, "Is this your Mother?"

Silence enveloped the room for an awkward second. The man then answered in a slightly angered tone, "This is my wife." OOPS! The proverbial foot in mouth! Only this was a very large foot. I felt my face grow warm and red from embarrassment.

Since that incident, I decided I should not have nor will I ever assume any relationship, even seemingly obvious ones. I further decided I will ask an open-ended and safe question, such as "... and how are you related?" Allow the patient or family to fill in the blank was to be the safest approach and should keep me from repeating my social transgression.

This new approach worked well for years until one day in a hospital room I encountered a Caucasian male patient, elderly and nonverbal, accompanied by a middle aged African American woman. After introducing myself, I turned to the woman and asked, "How are you related to Mr. Smith?"

She nearly exploded out of her chair as she protested loudly, "I do NOT have 'relations' with my residents, no way, not now, not before, NEVER!" She continued on and on. So, she was the director of the rest home in which Mr. Smith resided, and I had just accused her of having "relations" with her client. Eventually she bought my explanation and accepted my apologies, even though she continued to huff and murmur something under her breath for the next minute or two.

This called for refinement in my approach. I no longer used the word "related" or anything that sounded similar. Instead, I reframed my question in a truly open and leading way, ".....and this is your.....?"

Since this refinement, I have not encountered any more problems on my part, although I have unintentionally stirred up a hornet's nest a few times. For example, one evening in the emergency room seeing a young woman with abdominal pain, I asked the patient, regarding the young man sitting very close to her ER stretcher, my "safe" question, "..... and this is your.....?" Before she could answer, he blurted out, "fiancé."

"No, not fiancé, just boyfriend," she sat up in the stretcher, abdominal pain notwithstanding, and corrected him right there and then, on the spot. He took it, remaining motionless and expressionless. Poor guy, I thought.

Well, there probably was a whole lot more to that story than met the eye.

There were a few other similar instances in which the patient and visitor did not agree among themselves on the proper titles and relationships between them. But by and large, I managed to stay in the clear and have not committed social transgressions on my part, at least when it came to naming relationships.

However, I have fallen prey to miscommunications and misperceptions of a different kind. One day as I was writing in a medical record in the intensive care unit, a male voice approached the counter and asked if I would reassign his Mother's nurse. I looked up to find a man standing in front of me. He explained that his Mother (in ICU room #2) did not need an argumentative nurse and would I please ask that nurse to leave and give them a different nurse.

I explained I did not know his Mother, she was not my patient, and I did not have the authority to make or change nursing assignments. The man said he was a policeman, and he knew how these things worked. I agreed to help if I could. Before I could finish speaking to him, he turned and began walking away. Feeling disrespected, I said, "Please don't turn your back to me when I am trying to answer you." He did not like that. And I could hear how I must have sounded to him. I wished I had kept my comment to myself. But it was too late. He was already angered by my response. He countered, "Wha'chu gonna do? Arrest me?"

Ok, this encounter clearly was going in the wrong direction, rapidly. So I decided the better part of valor and in the interest of service, I could just get up and walk over to room # 2 and see what was going on and what I could do to help this man with his request. I saw that the nurse he was referring to was a nurse's aide, assigned as a sitter to prevent his Mother from self-harm. Since restraints have become all but banned from hospitals, demented or combative patients prone to pulling out their catheters and intravenous lines were given sitters, whose watchful eye and quick interventions replaced the wrist restraints, hand mittens, and even vests of bygone days.

I gently suggested to the aide that in this case, she might consider asking the nurse to come and help sort things out. The nurse came into the room at about that time and spoke with the son. Nursing supervisor soon assigned a different aide. All was well, so I thought.

Later as my rounds continued, the policeman son met me in the hallway and let me know that I was absolutely of no help to him earlier; instead he found me confrontational when I pointed my pen at him and then stood up in front of him. I had a pen in hand as I was writing in a chart at the time, and I must have "talked with my hands" but never intended to point anything at him. As for standing up in front of him, I stood up so I could walk to his Mother's room to see how I could help.

But the best policy with me as a doctor and he as a family member, a client of the hospital, was for me to defuse the situation and prevent further misunderstanding. So, I apologized to him for given him the misimpression. He was still angry. I apologized again, only to hear him say, "Any time a 90-pound guy stands up to me, and I am looking DOWN at you right now, I see you are asking for trouble." He continued, "I want you to stay away from my Mother, have nothing to do with her." He was not done yet, "And get out of my face, now!"

Ok, reasoning was not going to work in this situation. Additional explanation was only going to anger this man further. Not wishing to give him any more fuel to get madder, I continued down the hallway, only to hear him say behind me, "Later....."

There was a particular instance in which a patient did not wish my company or care, an instance that remained in my mind. Early in my practice and on-call one night, I was called out of bed to see a patient in the ER with abdominal pain, possible gallbladder attack.

I arrived at the ER and found the patient to be an elderly Caucasian woman. I noticed that as I interviewed her, she kept her gaze away from me, answered with the briefest possible answer, and kept a standoff demeanor toward me.

Knowing I had not said or done anything to offend her, I decided to clear the air and allow her to have her say. "Ma'am, is there something wrong with me being your doctor?" She began to open up, "Yes, there is." "What is it?" I asked.

"The War" was her still-brief answer. "The War? Which one?" I sought clarification. "The BIG one." she contended. Oh, World War II, I figured. Relieved and smiling, I explained, "That was Japan. I am Chinese. We were on the same side."

"Then there was that other war" she was not smiling and was not going to let me off the hook that easily. "Which one? Oh, you mean the Korean War?" I opined. "Yes" she confirmed.

Well, let's see. Those were the North Koreans. But, wait, the Chinese joined the "other" side. But those were the Red Chinese from Communist China. My parents were Nationalist Chinese. In fact, they were anti-Communist and escaped as refugees to Taiwan, which has always staunchly stood on the same side as the USA.

But, it would be way too involved to get into all that with this woman now. Besides, I did not think any of that would make any difference to her already-made-up mind. So I offered, "Would you like me to get you another doctor?"

"Yes, I would." she answered without hesitation, still not making eye contact with me.

I called Dr. Davis. He would be a good one for her. He was Caucasian and an officer in the US Army Reserves. After I explained the situation to him, he readily accepted the referral and let me off the hook.

Driving home that night, at first my heart was still racing, as I felt "discriminated against." Besides, being awakened out of bed to have this happen only made me feel worse.

But before I reached home, I had put myself in her shoes and imagined that perhaps she lost a husband in the Pacific Theater of WWII. Then perhaps she lost a brother or even a son in the Korean Conflict. Maybe the pain of these grave losses was just too much for her to bear.

All my previous negative feelings dissipated as I began to feel more empathy for her and her loss, or presumed loss. To this day, I hold no grudge over her, only sadness for her and her loved ones.



# Fair to Middling

Frank Yang, MD, FACS | 2018 Submission

Mr. Albert McDaley was a jovial hardworking man, who was finally near retirement after a long career in a rural community, where he was born, lived, worked, raised a family and added to the family tree his forefathers had started in that location. Now he was fully intent on living the good relaxed life of retirement, which he had long earned.

Recently he had developed a nagging discomfort in his upper abdomen. He wanted to ignore it, for there were plenty other things to tend. But, at the insistence of his wife of almost 40 years, he came to the doctor's.

Mr. McDaley looked healthy in a slightly round body typical of those between middle age and senior citizenship. He had a ruddy complexion, topped with a serene look and frequent smile. He was a "jolly good fell'er", the kind of person one envisioned serving hotdogs on the church lawn and trudging to the voting booth every other year to do his civic duty. He felt fine, except for this nagging discomfort; not even a "pain," but it just won't go away.

I enjoyed meeting Mr. McDaley and helping him get to an answer. I ordered a battery of screening blood tests and a CT scan of his abdomen and pelvis, and asked him to return for test results. All his blood tests returned within reasonable limits, nothing worrisome. But CT scan showed a mass at the head of his pancreas! What's more, there was no detectable plane (or space) between his pancreas and the major blood vessels that coursed behind the pancreas. Enlarged lymph nodes were seen near and far from the pancreas, plus "spots" showed up in his liver. All of this pointed to that dreaded clinical impression of incurable pancreatic cancer.

Clinical "impression" rather than "diagnosis" because I did not yet have tissue confirmation. That could come one of few different ways; the most telling was needle biopsy of the "spots" in his liver. But the diagnosis – answer - was, unfortunately, almost never in doubt. And the prognosis, in Mr. McDaley's case, was terminal. The involvement of the major blood vessels, as suggested by CT scan, virtually made resecting the pancreatic head technically dangerous, or in surgical parlance: inoperable. The presence of liver spots, if proven to be metastatic pancreatic cancer, rendered the disease incurable, in that day and age. So, good 'ole Mr. McDaley, as he neared long-anticipated retirement, most likely had an inoperable and incurable cancer: metastatic pancreatic cancer.

How will he take the news? How will I tell him?

At his return appointment, Mr. McDaley was as jovial and friendly as ever, and he still looked great and felt no worse than he did when we first met. After the greetings and per my usual, I sat down and told him the findings in clear terms, but with a dose of hope. Hope because I long learned I was not the final word and because the seemingly obvious did not always pan out to be the case. And because I had been told that everyone needed some hope, even a sliver of it, in order to go on with life.

After discussing with Mr. McDaley the various findings, I explained that so far this was just my clinical impression, and that liver biopsy could help define the diagnosis, and we could then go from there. As with almost all my patients, Mr. McDaley accepted the news stoically, showed little to no outward reaction and had very few questions. He wanted time to think more about it.

I remained amazed, in nearly thirty years of medical practice, at just how strong and collected nearly all patients were, even upon receiving dreadful news. Hardly anyone broke down - I considered breaking down totally understandable. I could only imagine the waves crashing within them, the sinking feeling, and fear. But outwardly, most patients held it together. Perhaps their emotions found fuller expression after they left me and reached their families. Perhaps that was appropriate, or at least better, by their thinking, to share their emotions with people close in their lives.

In the age before the push for outpatient workup, Mr. McDaley was admitted to the hospital to undergo liver biopsy and other myriad of tests and to receive consultations by other specialists. Each day as I visited him in his hospital room, Mr. McDaley was always cheerful, friendly and pleasant, more like a tourist waking up or resting at a hotel, than a cancer patient just hit with news of terminal disease. Liver biopsy, done with a needle without open surgery, confirmed metastatic pancreatic cancer. Each day brought another piece of bad news from a test or a not-so-hopeful opinion from a consultant. All this made it that much more amazing to me that Mr. McDaley maintained such a peaceful demeanor and even cared about how I was doing.

One day as I entered his room, I greeted him with my usual, "How are you, Mr. McDaley?" He replied, "I am fine, and how is your day, and how are you?" His questions floored me. Here he was, probably at the worst period of his life, facing heart wrenching news daily. And he asked "me" about my day and how I was?! Such is the goodness in Mr. McDaley.

After I quieted my surprise at his question, I muttered, "Oh, fair to middling." "Fair to middling?!" Mr. McDaley lit up and cheerfully asked, "Do you know what that means?" "Uh, yeah, it means I am doing so-so." I replied.

"Let me tell you. Oh, have you got a couple of minutes, Doctor?" inquired the ever so thoughtful Mr. McDaley. "Yes, of course; especially for you." I replied.

Mr. McDaley went on to explain to me, as I sat down beside his bed: Fair to middling was terminology used in the cotton industry. The words referred to particular grades of cotton. There were better and worse grades of cotton, compared to fair to middling, which was about average grade.

He further explained that he cut his teeth working in cotton fields and factories and grew up in that industry, and devoted all his working decades to cotton, eventually rising to higher management. That was why Mr. McDaley's eyes opened up when I unknowingly used a term near and dear to him. I learned something from Mr. McDaley that day.

I also learned from him that he had saved money over many years for a boat and eventually bought a fixer upper of a boat. He had planned to renovate this boat and sail it in his retirement. Sailing that boat was going to be the core of his retirement existence, his enjoyment, and something he had looked forward to, saved for, and pinned his hopes on.

Hope is a strong thing. It is essential for life. Where there is no hope in one aspect of life, let there be hope in another part.

A couple of days later, Mr. McDaley asked me in a pensive and probing way, "Doc, what do you think I should do? Go for all these experimental treatments the consultants are talking about or try surgery or what?"

I thought for a couple of seconds, looked at Mr. McDaley in the eye, and said softly but with conviction, "I think you should go home and work on that boat. And go sailing. Enjoy it."

His eyes smiled and his face relaxed, "Ok, Doc, that's exactly what I will do." He had hoped, as I had hoped, that he will work on that boat, doing what he enjoys.

And with that, we readied his discharge, and Mr. McDaley left the hospital, with a prescription for pain medications, for that nagging discomfort had by now progressed to pain. I gave him my card, and he agreed to call me should he experience any new symptom or question.

And we parted.

He never called.

I thought about Mr. McDaley from time to time. Perhaps no news was good news?

Six months later, I received a piece of mail, from Mrs. McDaley. She had written me a thank you card, in which she expressed gratitude for taking care of "Al" and for advising him to go home and work on his boat. And that he did. He worked on it diligently and got it to sailable condition. She enclosed a color photograph of Mr. McDaley standing and smiling in his shiny white boat. He sported a brimmed hat, dark glasses, and a broad smile.

She went on to say in her card that this picture was displayed for all to see - at Al's funeral. She closed with, "He sailed!"

I felt my eyes water and my throat get lumpy. I very much appreciated her card, letting me know that Mr. McDaley realized his long wish, although too briefly. I was at once happy for him, yet very sad, for him, for her, and their family.

But I knew he had left them with wonderful and loving memories. If he had touched me dearly in our very brief encounter, I could only imagine how very much more Mr. McDaley had thoroughly enriched all of their lives during his enduring life time.

To this day, many years later, Mr. Albert McDaley remains one of my most special patients, because he was a most special person to begin with.

He was way above "fair to middling!"

He was good to the core.

He was hope eternal.



# The Wonder of the Day

C.A. Harris, MD, FACS | 2018 Submission

*“Men go abroad to wonder at the height of mountains, at the huge waves of the sea, at the vast compass of the oceans, at the circular motion of the stars;  
and they pass by themselves without even wondering.” -Augustine*

*“Man is the only animal that laughs and weeps; for he is the only animal struck with the difference between what things are, and what they ought to be.” -William Hazlitt*

Traveling the road from Haiti across the border into the Dominican Republic dramatized the contrast between the two countries. The smooth asphalt surface on the D.R. side, with its lush greenery stood in stark contrast to the brown deforested land and the cracked, pot-holed road on the Haitian side. We gratefully welcomed the change, after the tooth rattling, dusty, bumpy Jeep ride to the D.R. from Port-au-Prince. After three years in-country as missionaries to Haiti, we had forgotten what a smooth road was like!

My wife and I, with our three small children, had been engaged for the last three years in the care of the wonderful people of Haiti through both medical and spiritual ministry, and now had been recruited to help with a one-week Medical Group Missions project in the D.R. on the other side of the island, Hispaniola. We viewed it as a privilege and a type of vacation. In Haiti, over the last 3 years, we had grown to be impressed with the Haitians' generosity of spirit. On many trips to the interior of the country for mobile medical clinics, we would be covered with the white dust of the arid central plateau, and these giving people would bring their limited, precious water to us for cleaning up. With no electricity for refrigeration, their only meat for the last six months may have been the goat tied up behind the hut, but which they would gladly kill and serve to us in our honor. (My favorite Haitian meal to this day is goat meat, black bean sauce over rice, plantains and a limeade called jus citron.) The memory of those kindnesses even now, also reminds me of their unselfish hearts, who, even in their abject poverty, withheld no good thing from us, as their guests. The warm smiles, laughter around the fire, and the rhythmic cadence of Creole, which was spoken country-wide by the common people who spoke little to no French, still summon up memory upon memory of their winsome ways, and myriad kindnesses.

We made our way to Sabana Grande de Boya', in the northern coastal area, where the Dominican government had made a facility available to us for use as an O.R. and clinic treatment area. Patients were already lining up to be seen, and I was surprised that the vast majority of these were Haitian; many of whom had immigrated to the D.R. to find work in the sugar cane fields. Many of them had been born in the D.R. and spoke Spanish fluently. Yet, in spite of having assimilated the culture, these Dominicans of Haitian descent were made to feel ashamed of their ethnicity and culture. The rift of the two cultures is centuries old and is based on ethnic and color prejudice. This age-old racial prejudice has the new name of Antihaitianismo and has been institutionalized; ingrained into Dominican children from school textbooks that portray Haitians as the “eternal enemies of the Dominican people”, or as savage, beast-like creatures who exist only to destroy the Hispanic traditions in the Dominican Republic. Images of Haitians, even today, are depicted with crude, ape-like features, likening them to animals, and not human beings with inherent dignity. This hatred came to a boil in 1937, when the dictator of the Dominican Republic at that time, General Rafael Trujillo, set out to “whiten” his country by driving out the darker skinned Haitians. Trujillo even so despised his own heritage of a Haitian grandmother, that he wore make-up to lighten his skin color. The General projected this self-hatred by ordering the deaths of Haitians living in the border cities. These Haitians were identified by their inability to pronounce the word perejil, which is the Spanish word for “parsley”. Most Haitians could not roll the “r”, and made more of an ‘l’ sound in their pronunciation of the word. That slip of the tongue cost them

their lives. This effort at extermination was called the “Parsley Massacre” and is estimated to have killed between 9,000 and 30,000 people. It remains an open wound on the collective psyche of both cultures. I noticed that the Haitian patients in line, were quiet and looked down at the ground. They spoke softly in Spanish and not in their native Creole, at least not in public, since this was frowned upon. The oppressive cloud of *antihaitianismo* was trying to have its pernicious effect even here.

My first patient of the day was a shy, Haitian young man in his early teens who was there to see about getting his inguinal hernia repaired which was indicated on the record he brought with him.

I lowered my head to look up into his downcast face and said, with a smile, in Creole,  
“Koumon ou ye, timoun?” (*How are you doing, youngster?*)

He slowly lifted his head, with eyes wide in surprise to see this doctor who spoke to him in his own familiar language! His face lit up as he smiled back and said,

“Oh-oh, Dokte! Ou kapab pale Kreole?!” (*OMG, Doctor! You speak Creole?!*)

“Mais, oui, mon che! Tou temps!” (*Of course, my friend! All the time!*)

He turned to shout out to his friends and family who were waiting in line, too,

“Ah mezami, Dokte sa kapab pale Kreole! Ou pa bezwin ront!” (“*My friends, this doctor can speak Creole and you don’t need to be ashamed!*”)

“Ki jan yo’ rele’ ou, timoun?” (*What do they call you, youngster?*) I asked him.

“Henri. Henri Christophe, Dokte’. Mouin contan pou’m fe connaissance ou!” (“*Henri. Henri Christophe, Doctor. I am happy to meet you!*”)



From that point on, Henri’s entire posture and demeanor changed, as we continued to banter in his native tongue about his family, his long walk to the clinic from his village, his hard work in the cane fields after school, and the need to help take care of his younger brothers and sisters.

After Henri, the whole team made a point to speak to the Haitian patients in Creole, and the whole atmosphere for the rest of that project was transformed. And what had done it? Something as simple as a smile, a kind word in their native tongue spoken in love, and the implied affirmation of their intrinsic worth as people, had completely dispelled the stifling, intolerable cloud of hatred called *antihaitianismo*.

We were able to easily repair Henri’s hernia later that week, and he was happy for it. But I am not sure what made him happier; having his hernia fixed or having his ethnicity validated, his dignity restored, and at least for one brief shining moment, just being himself and enjoying other people who responded to his heart’s cry to “See me.”

It was truly *the wonder of the day*.

# First Internship Day & Bug in Ear

Frank Yang, MD, FACS | 2018 Submission

The morning of my first day as an intern in a five-year general surgical residency training program in a university medical center began with orientation led by the chairman of surgery, faculty attending surgeons, a chief resident – someone in his fifth and final year of training (post graduate year five – PGY5) and a senior resident in his fourth postgraduate year (PGY4).

The senior resident gave an inspirational speech to the wide-eyed PGY1's. He extolled us to always be mindful that the ability to “cut on someone” is to be regarded as a most special privilege, never to be taken lightly, but always with full respect for the patient. How true! I remembered that exhortation all through my five years of training and my subsequent nearly thirty years of surgical practice.

He also imparted to us the three keys to surviving surgical internship – eat now, sleep when you can, and don't muck with the pancreas (only he did not use a word as polite as muck). All three keys proved to be sound advice, not only for that internship year, but for the rest of my training program, as well as for my subsequent long practice.

As surgical interns, we soon learned if we did not eat on the run, we were not going to eat at all. Many times we downed cans of pre-made feeding formula out of refrigerators behind nursing stations, in order to be able to see straight and have energy to go to the next task on a long to-do list. At those times we did not mind the unnatural taste or pasty nature of the stuff. It provided calories and filled our stomachs, somewhat. But we had to be careful, for we soon found ingesting too much of the stuff without solid food led to “bowel runs.” And which surgical intern had time for that?!

The ability to eat fast, and just about anything, and swallow hard, while racing up stairs turned out to be a survival advantage in surgical residencies. To this day, whenever I had to eat quickly in-between cases, I still marveled that no surgical resident or attending I knew had ever choked, aspirated and died before he/she could get to the next case.

We interns also learned to grab power naps here and there, sometimes in the most unthinkable places, to rejuvenate our tired bodies and minds. We soon gained the uncanny ability to catch some much-needed sleep while standing in the operating room, holding a retractor, squeezed between senior, chief, and attending. After being on-call all night, surgical interns were “rewarded” the next day with the privilege of coming to the OR to watch and learn, but really to hold retractors for those doing the interesting part of the work. There definitely was “Zen” in sleeping standing up, while holding a surgical retractor perfectly still, and never snore. We were almost always that tired the day after call. But the “real” Zen laid in the ability, while sleeping and holding a retractor steadily, to still hear, respond, and answer correctly grilling questions posed by attending surgeons to the most junior member at the OR table.

If medical students scrubbed in, then they were the targets of those questions. If they could not answer the questions, then the cannon sights pointed toward the intern. It became obvious to me that the same attending asked the same repertoire of questions. So after being caught unprepared a couple of times, I looked up the answers and wrote them on index cards, which I then kept in my OR locker. Before scrubbing in a case, I stole a moment at my locker to refresh my memory by reviewing the card according to the attending's name posted for the upcoming case. This worked well, saving me embarrassment and saving the next guy (PGY2) from being grilled.

As for the third key, we were told of the fragility of the pancreas and how not to damage it, for this organ readily leaked and abscessed, leading to great misery for the patient and his/her intern. We came to see many bad pancreatic cases during our time in training, most induced by natural causes, if alcohol over-consumption could be considered a “natural” cause.

After morning speech, general surgical team roster was passed out. I was assigned as the surgical intern in the emergency room. That was going to be my home for the first month.

The ER kept me busy the rest of that first internship day, all evening, and almost the entire night. I took histories and did physicals on numerous patients, mostly abdominal pains and some abscesses. Under the direction of a senior resident and attending physician, I helped take care of those patients who could be treated in the ER. And I consulted the inpatient general surgical service on-call for those that needed admission.

In the case of the blind calling the blind, those consults were then worked up by another first-day intern, a member of my class of equally new interns on his/her first rotation, under the tutelage of another set of senior, chief, and attending. That was the vertical order of workups in a hierarchy-laden surgical training environment.

In time we became deft interns, with great hands-on techniques, able to draw blood from and start IV's in seemingly dried-up little veins, place catheters in neck, chest and leg veins in no time flat during emergency resuscitations, pass tubes and catheters into just about every body orifice, and help stabilize the sickest of patients on artificial life support in our ICU's. In fact, nearly thirty years into my post-residency career, I still owe the ease with which I insert these catheters to the instructions and practice received during my first internship year.

In subsequent training years, we rose to junior then senior and soon chief residents (although never soon enough from my-then vantage point). Each year we were given more independence to do more cases and more complicated cases, and we taught those junior to us and imparted to them what we had learned. By our chief year, we were the operating surgeons for almost every case, with attending surgeons having less and less hands-on involvement. As one attending put it, “You will be doing this for pay in a few months - so have at it” while he watched. That was the idea – see one, do one, teach one.

In the days before legislated resident work hours and in a surgical training program where many rotations required every-other-night call, we were on 36 hours and off 12. And those 36 hours were almost always very busy, with “incomings” around the clock, and the already-admitted patients frequently going “south”. We often sarcastically lamented that it was too bad we were not on-call every night; for being on-call “only” every other night meant we had to miss half of the pathology and half of the clinical opportunities. Such gallows humor were readily understood and appreciated by fellow gallows mates.

Years later I remained surprised that some house staff (as interns and residents were known, since we spent so much time in the “house” – hospital) were married or had significant others or even small children during their internship and residency, and these relationships survived. Admittedly many relationships did not. But those that did, I surmise, did so mostly because of the loving accommodations and endless patience on the spouses' part. Spouses of house staff of successful and enduring relationships deserve nothing short of sainthood, as do their most accepting children. Most house staff were likely not present very much outside the hospital. For those moments they were present, they probably fell fast asleep or were grumpy from severe sleep deprivation.

On the other hand, house staff in relationships or even had children probably also benefitted from loving support and “refuelings” during their arduous training years single unattached residents did not have. Since relationships are a two-way street, house staff themselves probably deserve credit as well for their contributions toward those successful relationships.

One virtue espoused by the designers of surgical residency was that the rigorous training environment toughened us and prepared us for the “real” world of surgical practice. True to an extent, for we all developed the ability to work hard, work late and still be able to function and answer the needs of our patients the next day, including doing surgery on them.

Another virtue, from my standpoint, was that by the end of my five-year residency training in general surgery, I have had enough hands-on experience to feel confident and ready to “do it in the real world” on my own, without the crutch of an overseeing attending. In fact I had accumulated over 1,000 operations in which I was the operating or teaching surgeon, in addition to many other countless cases in which I assisted.

I went straight from graduating residency to solo practice in another town. In nearly three decades of practice, I rarely came across a case that I hadn’t already encountered, in some form or fashion, during my training. This spoke to the breadth and depth of my university residency training program.

Meanwhile back to my first internship day, I was placed on-call that first night. This seemed strange to me at the time, perhaps even wrong, to have the newest member of the team on-call the first night, in this huge ER in which anything could happen. It has been said: you do not want to get sick on July 1, for that is the start of the internship year. On that day, every intern in every teaching hospital throughout America is brand spanking new. And that could very well be the doctor treating you. I soon learned that the lowest man on the totem pole got the privilege to be on-call on day one, on almost every service, everywhere. Years later, when I established a practice and began hiring surgeons, I made sure new hires were not on-call their first night or first weekend. I often took those calls, allowing them at least a few days to get acclimated to their new practice environment.

That first night at my ER, as in just about every other ER throughout America, many patients came, not with dire emergencies, but with subacute or even chronic illnesses. They used ER’s more like walk-in clinics. Maybe they did not have access to routine medical care, or they could not get anyone to bring them to a clinic during regular hours. In any event, the walking wounded kept me and my overseers busy deep into the night.

That night, after the higher-level doctors left, I remained to continue my work as “the ER doctor” on-call. It had been a long day and night when the ER was finally empty, and I was able to see my call room for the first time. A cubicle around the corner of the ER, my call room had a hard twin bed, a small desk and lamp. And of course a phone, so I could answer my pages.

I remembered as a student, one night I was at a restaurant bar when I noticed a couple of young men swaying their pagers in front of some young women and trying to impress the ladies that they had pagers?! Perhaps they were medical students (from another school of course) or interns somewhere. They brandished their pagers as pickup tools. Well, I quickly came to feel during my internship year, my pager was not my friend. It went off way too many times, and usually late at night. I never brandished my pager. I tried to get rid of mine.

By the time I finally was able to leave the ER and lie down on that hard twin bed my first night on-call, it was already the wee hours of the next morning. I felt tired. Exhaustion had overtaken the excitement

associated with the start of my surgical internship, the day for which I had longed and worked so hard, for so many years. I knew I would have no trouble falling asleep in an instant. My eyes had just barely closed when my pager went off. It was the ER. I had just come from there. What could be there that they needed me already?! Did they not know I was trying to get a little bit of sleep and that I already had a very long day and night?!

I staggered into the ER, eyes burning from fatigue and still miffed (ok, more than miffed) that what little precious sleep I was hoping to get before early morning work rounds was not going to materialize. Pushing open the large doors, I was greeted by the harsh bright lights of the ER, made worse by the white walls and white curtains dividing the stalls. My eyes burned even more.

A young man sat at the edge of a gurney, holding his ear, with his neck bent, back hunched, eyes tightly squeezed shut, torso still. But every several seconds, his body suddenly bolted and tensed, as he let out one blood-curdling scream after another. The bug was on the move again, in the ear he was cradling!

Apparently the sound of the bug moving magnified many fold when the action took place in one's ear canal. And apparently this young man had convinced himself, and thus became hugely fearful, that the bug was going to burrow into his brain, any second, perhaps with the very next fateful crawl. He was most likely conjuring up mental images alike some bad horror movie of a giant bug digging into his brain, taking up residence, eating his brain matter and growing into an ever-enlarging monster – inside his head! Each successive image was probably scarier than the previous one.

This extreme fear overtaking an able-bodied, well-built, otherwise tough guy was manifest in his screams. The first time I heard him scream, I literally flinched reflexively. I had, up to that point in my life, never heard a grown man scream like that. It made my skin crawl. Nurses and aides flanked his sides. They were trying their best to comfort him, but to no avail.

When my eyes met the staff's gaze, they had the look of relief, as in "Help is here – soon this man's screams will stop." But the look they got in return in my eyes was one of bewilderment and confusion, as in "I am just an intern, my very first night. I haven't a clue what to do!"

Nurse Leona informed me this man was in his barn when he felt something fly into his ear. The rest was history. My first thought was "Why was he in the barn at this horribly late hour and not in bed?! If he had been in bed, as any sane person should have been, I would be sleeping now." My second thought which immediately followed was "Yikes, I have no idea how to help this man."

Deciding honesty was the best policy, I motioned Nurse Leona away from the gurney and admitted that after all those years of higher education, medical school (no less in one of the best centers of excellence and research in the nation), and all those books, labs, exams, theories, practical's, human dissection, etc., I was now totally lost and useless, stumped by a simple case of "live bug in the ear." I whispered to Nurse Leona, "There was no mention in any medical school book I can think of on bugs in the ear. What do I do?" My killer biochemistry classes did not teach us how to kill bugs in the ear.

Nurse Leona motioned me even farther away, to be out of the patient's earshot, smiled reassuringly and told me, "This is what you do....." She gave me a verbal recipe step-by-step. She had seen this done many times in the ER. Never mind all those medical school books.

That was the first time a nurse helped me out of a tight spot, and it happened on day one. It was

foretelling that a nurse would be my guide and mentor on my first night as an intern, for there were to follow many other times in my training and subsequent long career when nurses and techs kept me out of trouble, or more appropriately put, kept my patients out of harm by me. Their help included double-checking medication doses I had prescribed, assisting me at taking out a rapidly hemorrhaging spleen, warning me about irate patients or families before I walked into the room, and countless other instances.

Nurse Leona patiently explained the steps I needed to take, from putting a speculum gently into the ear, to injecting Lidocaine, to retrieving the offending bug with forceps. Her very nice instructions were interrupted only by another round of the man's blood-curdling scream.

Ok, this sounded simple enough, I thought.

I walked back to the gurney, while trying to look the part of "the doctor," even though in this case the nurse was the real expert. I gently put a speculum in the ear. That tickled the bug, which started crawling again. The man screamed! This time only inches from me. I startled at his scream, but I had a glimpse of the offending attacker. It was unlike anything I had ever seen.

The tail end of the bug, hugely magnified, filled my speculum. I could see the bristles on its hindquarter, the gray wing tips, and those large bent legs. What a grotesque sight, the back end of a magnified bug, right in front of my eyeball! Little did I know at that point, I will see many even more grotesque sights in my long career.

"How do I get the needle into the squishy end of a moving bug?!" I asked Nurse Leona. She replied, "Oh, no, you don't need to inject the bug. You just fill the ear canal with Lidocaine, and the bug will stop moving." Ahh, I thought, the Lidocaine which numbs the human animal will paralyze and kill the entire bug. Clever! They should have included that pearl in medical school books. Why didn't they? This was a very practical and useful piece of knowledge. There must have been other interns out there over the decades who found themselves faced with hindquarters of bugs in ears. I wondered if they had the good fortune of a mentoring nurse?!

I did exactly as taught. And lo and behold, the bug stopped moving. The man seemed relieved. Screaming stopped. I retrieved the bug, ever so carefully, so as not to disrupt its fragile body. Had that happened, I would have had to dig in even deeper to get the rest of it out. I was sure the man would not enjoy that!

Holding the bug in the jaws of my forceps a few seconds longer and under a spot light, I marveled at the now tiny and motionless carcass of a bug. Such a little thing could cause such big agony! The man also looked at the bug, probably thinking similar thoughts - how unbelievable and surreal all this had been, for both of us. I offered him the bug, but he wanted nothing more to do with it.

Truth be known, the bug was wedged in the ear canal and could not have burrowed any deeper. Truth also be known, the bug was probably even more fearful of its predicament than the man was.

Two grateful men left the ER that night; he hopefully back to his house, not the barn; and I back to my call room. No sooner had I laid my tired body on that hard bed, a deep rumbling started, and continued unceasingly just outside my door. As it turned out, the escalator had started rolling, called into action by its automatic timer, signifying the start of the second day of my internship. Dawn had broken. Six AM morning rounds was just a short hour away. Rats! Or more appropriately, Bugs! Well, if I just brushed my teeth and skipped showering and stayed in the same rumpled scrubs, I could get 55 minutes of sleep. Sounded like a

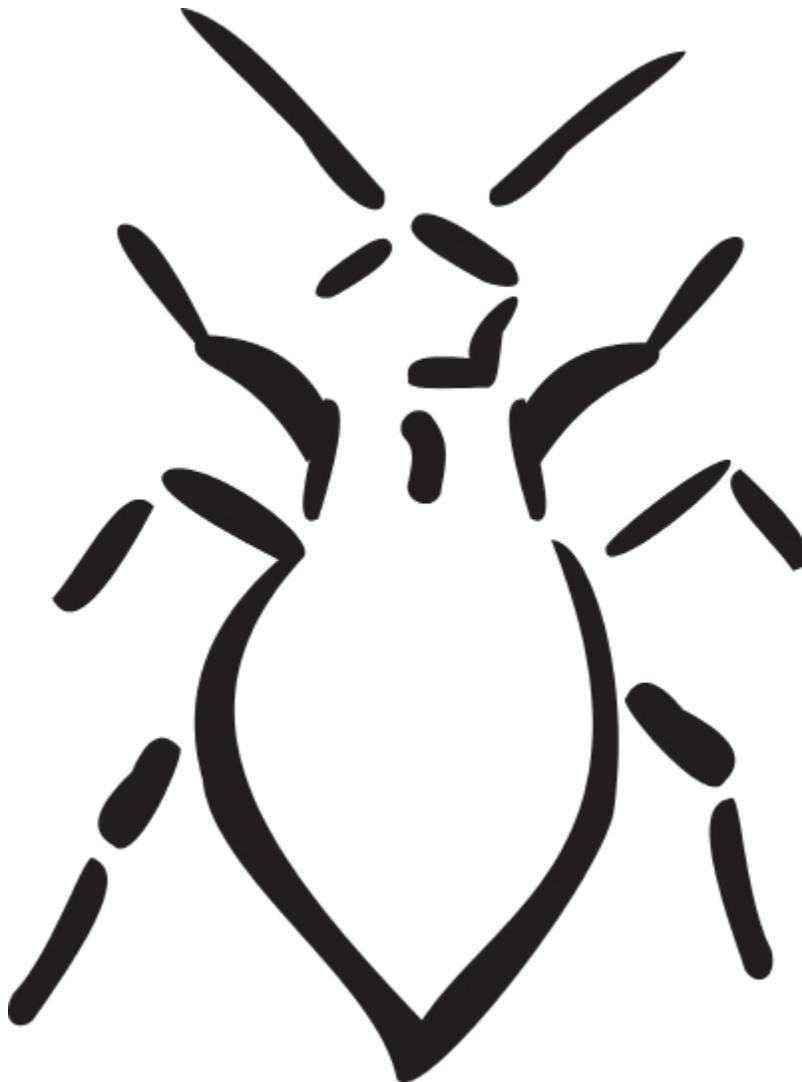
great plan to me.

The senior resident's words rang true in my head as I fell asleep like a light – Eat now, sleep when you can, and don't muck with the pancreas!

I did not know it that night; but relatively speaking, this was going to be one of my better on-call nights. There followed many nights during those five years of surgical residency in which I slept none at all. And the patients were much more numerous and much sicker, requiring much more “running around” on the intern's part, and much more demanding work, physically and especially mentally. This was particularly true on rotations through trauma, vascular, intensive care units, and general surgical services. Those were also the services that taught me the most, and best prepared me for post-residency independent practice.

One night several years later when I was in private practice in another town, a friend called my house to say that her husband was working outside and, you guessed it, a bug flew into his ear. “No problem” I replied, “Meet me at my house.”

I knew exactly what to do, thanks to Nurse Leona. I drove to my office and brought home the necessary material. The friend and her husband came over. I took care of the whole thing in a minute or two, while he sat on my kitchen stool. He too did not want the bug in the forceps. I looked like a pro, like someone who had done this many times, full of confidence and armed with knowledge. I did not tell him this was only my second time until the deed was done. But I told them the Nurse Leona story and gave her full credit.



# The Homeless Man

Frank Yang, MD, FACS | 2018 Submission

All of us in health care have taken care of many homeless men and women. One particular homeless man stuck in my mind, and the minds of many of my coworkers who also took care of him.

One day as the surgeon on-call, I and my team were called to see several injured men in a row. It turned out all of them came from a nearby farm fair. We found out this was an annual fair, showcasing horses, mules, farm produce, etc. But alcohol and carelessness also marked this event. We received, among others, a man in his thirties kicked in the abdomen by a horse after he fell off drunk, a man in his twenties hit by a passing car as he walked intoxicated, and a couple other fell-off-the-horse accidents and some altercations/assaults. The man kicked in the abdomen required emergency surgery because the horse kick perforated his intestine. The man hit by car suffered a broken leg.

Then we received an older man with abdominal pain. He appeared to be sixty to seventy years old, slight-built, mangled thin white hair, sun-leathered skin, and spoke Spanish only. He was dropped off at the emergency room by two farm workers who did not know him well but would only say that they were coworkers on a farm. The elderly man complained of severe stomach pain and did not appear to improve. So these two coworkers drove him to the emergency room, gave the above brief statement to the hospital clerk and drove off. There was no identification paper, address or phone number.

The elderly man said his name was Jose Roberto, he was seventy years old, and his stomach had been hurting for several days. Apparently he was a migrant worker at one of the farms. He had come to that farm as a loner and was not well-known by the other workers. Beyond that, even the hospital Spanish interpreter was not able to gather more information. Finally the staff concluded, with input from the interpreter, that the elderly man, in addition to his current stomach ailment, was slightly demented and produced sometimes incoherent speech incomprehensible to even the interpreter.

We began the task of solving this small medical mystery. Soon CT scan suggested an obstructed distal colon, and lower intestinal endoscopy confirmed a blockage low in the large intestine, beyond which the scope could not be advanced to further examine the cause of the blockage or the remainder of the (upstream) colon.

If the colon were left obstructed, then the blocked portion could continue to swell under pressure and rupture, leading to spillage of stool and bacteria throughout the abdominal cavity, causing sepsis and death. Therefore Mr. Roberto needed an emergency operation to at least decompress the blockage (through a colostomy) but hopefully to remove the offending cause as well (resecting the colonic segment with the obstructing source). We explained the essence of the above to Mr. Roberto, through an interpreter, but we could not be sure he understood well enough, because of his dementia. But we also realized this was an emergency operation, and the rules allowed us to go ahead with the necessary procedure even without the otherwise-prerequisite informed consent.

So off to the operating room we went. Upon exploring his abdomen, we confirmed a colon cancer as the source of his blockage. We were able to remove the offending colonic segment along with attached lymph node bearing tissues. We stapled off the distal segment (rectum) and brought the upstream colon out to the abdominal wall, fashioned a colostomy, and placed a bag over it. We also palpated the remainder of the colon and could feel no other obvious cancer; meaning, no other hard mass such as the offending one, although there was plenty of stool in the colon making detection of softer and smaller nodules nearly impos-

sible. His liver was free of palpable nodules, as were the lymph nodal chain along his aorta - all reassuring findings. His other organs including spleen, kidneys, bladder, both diaphragms, stomach and small intestines were all normal to intra-operative examination. We closed and were pleased we had done this near-unknown homeless Mr. Roberto a distinct service and prevented colonic perforation and a painful septic death. We noticed during preoperative blood testing, Mr. Roberto's platelet count was lower than normal, but not low enough to have precluded this emergency operation. And he did not experience excessive bleeding during the operation, even with his low platelet count. Postoperatively, however, his platelet count continued to fall.

Consultation by our hematologist/oncologist colleague led to the clinical impression that Mr. Roberto also suffered from idiopathic thrombocytopenic purpura (ITP), a chronic condition affecting his platelet count and increasing the risk of spontaneous bleeding. ITP could be temporarily corrected by high dose steroid therapy, but a more durable treatment would be removal of the spleen, which usually appeared normal by visual and tactile exam. Our consultant colleague also determined that even though Mr. Roberto's colon cancer had spread to some of the lymph nodes harvested, he was not a candidate for chemotherapy because of his ITP and anticipated unreliable return appointments to follow up potential side effects.

But all agreed that his spleen should be removed, since his platelet counts continued to drop further, as his ITP deepened, increasing his risk of spontaneous internal bleeding, risks that could be mitigated by removing the spleen. But all also agreed splenectomy did not need to happen on an emergency basis, as his colon resection had to, and informed consent could not be justifiably bypassed for this operation. Since Mr. Roberto was demented, the steps now involved finding his next of kin or asking the courts to appoint a legal guardian.

Our hospital case management team/social workers swung into high action. They elicited help from hospital, local and state police, and found a missing person report of the same name, generated in another state. But that particular birthday was off by two days from the birth date given by Mr. Roberto. So, there was no match. One curious and interesting fact was: someone noticed that whenever that particular state was mentioned, Mr. Roberto would follow that person around and repeatedly asked to be taken to that state. Perhaps that was his home state, perhaps he had family there. But there still was no match and no contact information. So the search continued.

By the way, we still wanted to examine the remainder of Mr. Roberto's large intestine, after a proper bowel prep to get rid of intervening stool. But colonoscopy especially with biopsy could lead to bleeding, so our gastrointestinal colleague understandably wanted to wait until after splenectomy when his platelet count rose past the bleeding threshold before doing colonoscopy. So we reaffirmed our course of obtaining informed consent for splenectomy before colonoscopy.

Finally hospital social workers petitioned the county court to accept Mr. Roberto as a ward of the county. After that, a judge could appoint a guardian. But it was to be another month before his case could appear on the court docket. So all of us continued to wait. Meanwhile, Mr. Roberto had long ago recovered well from his colon resection and colostomy operation. He was eating, stooling into his bag, his wound had healed, and he was no longer requiring pain medications. His platelet count was kept out of danger lows by daily steroid pills. So all seemed well, except he had started to "play with" his colostomy, causing the bag to leak. This then led to stool spillage, which then eroded his abdominal skin. Since tying patients' wrists or placing bulky mittens was no longer "allowed", hospital administration decided the most prudent action was to hire a sitter 24/7 by his side. The sitter gently reminded Mr. Roberto not to manipulate his colostomy every time he began to reach for his bag, and distracted him with other activities, such as coloring.

I noticed someone had given Mr. Roberto a coloring book, and he had a few short crayons, which were getting shorter every time I saw them on rounds. I also noticed the edges of the little coloring book became increasingly more frayed.

As the weeks wore by, and all of us waited for that all-important court date, Mr. Roberto had become more and more active. He often walked to the large bank of windows in the waiting room. He sat there, quietly gazing out the window, six stories up, taking in the sights, always accompanied by a sitter.

Finally court date came. Our hospital social worker was right there. She reported the judge heard the case, immediately accepted Mr. Roberto as a ward of the county and appointed a county social worker as legal guardian. As this was already Friday afternoon, the earliest date the social worker could be sworn in as legal guardian was Monday. So we waited another weekend.

Tuesday, I called the county social worker, now Mr. Roberto's legal guardian, introduced myself, asked for permission for Mr. Roberto to undergo splenectomy and explained the implications. After a good question-answer session, legal guardian gave permission. And I/we carried out the operation two days later, after preoperative steroid boost to elevate the platelet count before incision and surgery.

Mr. Roberto came through the splenectomy well, although it was technically a challenging operation, due to scar tissues that had formed in his abdomen secondary to his colostomy operation. But all went fine, and Mr. Roberto recovered well from his second operation by me/us, and his platelet count eventually rose, after what seemed like a very long postoperative week.

Now that his platelet count was maintained, and he was out of excessive bleeding risk, our gastroenterologist carried out colonoscopy through the colostomy stoma, after bowel prep, and examined the remaining rectal pouch again. Lo and behold, two other cancers, albeit much smaller, were uncovered in his remaining colon, upstream from his previous blockage.

I discussed further treatment options with my team and colleagues. In the final analysis, we decided the best course of action was to remove the remainder of Mr. Roberto's colon, including his colostomy. This would rid him of all his remaining colon cancer-bearing tissues (so called, completion colectomy), and would allow his small intestine to be connected to his rectal pouch. This way he could stool naturally and would no longer have a colostomy for him to manipulate, thereby making life more tolerable for him, negating the need and expense of a 24/7 sitter, and easing his potential placement in a facility.

This led to another discussion between me and the county legal guardian, whom I had called frequently to keep updated on Mr. Roberto's condition. I figured since she was the legal guardian, she might as well know more about him, than only hear about him when consent became needed. She grasped the picture well and concurred. A day before completion colectomy, I explained the operation to Mr. Roberto via on-screen interpreter. But Mr. Roberto could not understand. Nevertheless, I felt I gave him due process; even though by that time, I had already secured consent from the legal guardian.

Completion colectomy went well, although it was even more technically challenging than the splenectomy and much more time consuming, as we had to contend with extensive scar tissues throughout Mr. Roberto's abdomen. I repeated a positive note to my operative team, whenever the operation was hampered by technical challenges, that we were fortunate Mr. Roberto was a slender man, and his colon had not perforated when we first met him; either event could have rendered this completion operation even more difficult.

Postoperatively, Mr. Roberto's recovery was more painful and more arduous this time around, as this was his third and biggest operation since he was dropped off at our emergency room three months ago. Eventually he made a brave recovery and returned to his coloring book, short crayons, and walks to the large window.

He had nowhere to go. Still no family was found. No facility felt they had enough nursing help to meet all his needs. So he waited, as an inpatient on the same hospital ward that has become his new home. Meanwhile hospital social workers continued their effort. They had the police come to finger print Mr. Roberto as a last ditch step to see if there might be a match.

A few days later, we were told that his prints matched, twice. Once was a breaking and entering, for which he had paid his dues. But even prior to that, his finger prints matched a long ago arrest, when he was picked up for evading the draft.

Draft?! There had not been a draft since the Vietnam War. Yes, that was the one, I was told, for that arrest record dated from the 1970's. Ok, then, I said: "Good!" "Why good?" asked the social worker. Because if he evaded the draft, it meant he had a draft card, which meant he was (or is) a US Citizen, which meant he could potentially be eligible for all kinds of benefits and coverage, making placement in a facility much more likely, so he could leave the hospital and get on the other side of those large windows and be freer. "Oh, yes!" the hospital social worker seemed encouraged as well.

Meanwhile, I decided Mr. Roberto could use some newer coloring books and larger crayons. All of us knew senior citizens who in their dementia reverted back to some child-like behavior and tastes. For Mr. Roberto, coloring has become his main past time. I also noticed he leaved through the same wrinkled magazines.

So, I brought a stack of magazines with colorful pictures to rounds and gave them to Mr. Roberto. He liked those. A friend helped me select two huge coloring books and a large 64-color box of crayons and gift wrapped all those, as presents for Mr. Roberto. I kept those books and crayons in the back of my car, as Christmas was approaching, and I was going to give these to Mr. Roberto on Christmas morning.

One day as I was leaving Mr. Roberto's room, I happened to remember I had a lollipop in my pocket, probably from my secretary's desk. I held up the lollipop to see if Mr. Roberto might be interested in it. He eyes lit up, his mouth opened widely, in fact his whole face brightened, much as that of a child's. As he reached out with his hand, I gave him the lollipop, which he promptly opened and placed in his waiting mouth and remained all smiles as I left the room.

Ever since then, I made a point of colleting lollipops from my secretary's desk and from bank tellers. I found myself asking tellers if I could have more than one, how about four. "Of course," was always their answer, as I quickly explained these were for a patient, for I did not want anyone to think I had that much of a sweet tooth.

Each day on rounds, I handed Mr. Roberto a lollipop on my way out. This soon became a routine. He quickly came to expect a lollipop from me each day. One day as I headed to the door without producing a lollipop, Mr. Roberto made a noise, leaned toward me and touched his finger to the corner of his mouth. Ahh, I got it. I reached in my white coat pocket, took out a lollipop, his lollipop, gave it to him, and his face again and immediately brightened.

As Christmas neared, Mr. Roberto had been with us several months, fully recovered from his three operations by us, yet still awaiting placement. Even as a now-proven US Citizen and with funding as a ward of the county, he still had not been accepted by any facility. Because of his dementia, hospital social workers

appropriately did not want him discharged to a shelter, for he was not capable of ensuring his own safety or even knowing his whereabouts. So the wait continued. Scores of hospital staff and multiple sets of rotating resident surgeons and students had come to know Mr. Roberto.

I bought a dense pack of candy canes (red stripes on white candy) and added those to the wrapped coloring books and crayons. All awaited the arrival of Christmas morning.

But on Christmas Eve, I decided it was close enough, so I took the coloring books and crayons out of the back of my car and gave them to Mr. Roberto on rounds. It was December 24, one day early. He excitedly opened the wraps and beamed over his huge coloring books and new box of 64 crayons. I gave him a large lollipop but saved the candy canes for Christmas morning.

Next morning, December 25, almost as soon as I arrived the hospital, a team member asked me “Did you hear what happened to Mr. Roberto?!” “No, what?!” I replied. Mr. Roberto was sitting on the edge of his bed receiving a sponge bath by a nurse’s aide when he tilted over and stopped breathing and became pulse-less. As this was a witnessed cardiac arrest, the capable nurse’s aide immediately called for help and started resuscitation. Code team rushed to the room, and resuscitation was successful, in that Mr. Roberto was intubated, placed on a ventilator, his pulse and pressure were restored, and he has since been moved to the intensive care unit.

“Oh, Mine! Anything can happen, to anyone, anytime!” We have all seen that, but each time we still felt shocked. And once again we realized how little we could do and how little we knew, in the overall scheme.

I rushed to the ICU and found Mr. Roberto lying flat, still intubated and connected to the ventilator. But he was breathing over the ventilator: he was inhaling and exhaling on his own, in addition to the mechanical breaths provided by the machine. This was a very good sign and added to his chances of coming off the ventilator and continuing to breathe on his own. In addition, the overhead monitor showed decent vital signs, all in good range, another set of good prognostic indicators.

He was in good hands and well-cared by the ICU staff. I took one candy cane out of the box of many and taped it to his bed, specifically to the side rail closest to his face. This was Christmas morning, after all.

Later that day I spoke with the nurse’s aide who had initiated resuscitation. She and her coworkers told me that on Christmas Eve, Mr. Roberto colored his new books with his new crayons. So he got some use out of his “early” Christmas gifts. I had not always made good decisions in life. But I was and still am happy I made one good decision by giving Mr. Roberto his Christmas gifts one day early.

On December 26, when I returned to Mr. Roberto’s ICU bedside, I was very much dismayed to find that the candy cane I had taped to his side rail was nowhere to be seen. I looked on the floor, on the side table: not there either. I asked the ICU nurse. He did not know anything about the missing candy cane. He did not see anything taped to the side rail. Nothing was there since he arrived and started his shift. I surmised that someone had removed it, because it was probably against ICU policy to have candy taped to a side rail, even though I had made sure it was individually wrapped, not sticky to attract “bugs” and other untoward things.

In the days that followed, Mr. Roberto continued to over-breathe the ventilator, but doing so still weakly. He had suffered a sudden heart attack and had become “brain dead”. So even though he was “alive” in terms of cardiac and pulmonary circuits, he had no meaningful brain function. This was confirmed by neurologic consultants and studies they conducted. We sought input from palliative care consultants and repeatedly 35

engaged Mr. Roberto's legal guardian. In the final analysis, all agreed the most humane course, in the absence of meaningful brain function, was to withdraw artificial life support and allow nature to take its course. Accordingly, Mr. Roberto passed away shortly after New Year, apparently unaware of his surroundings, with no eye opening, in no apparent pain and with no apparent struggle. His body was transported to the county morgue.

Thus ended a long life, whose last years were marked by migrant labor and dementia. But prior to that, there were likely many stories of happiness, sadness, of conquests and achievements as well as perhaps disappointments, of families and friends, all stored deep within the recess of Mr. Roberto's mind, hidden beneath the curtain of dementia. These stories, although unknown to us, helped shape Mr. Roberto into the person we came to care and remained part of his totality.

As for the rest of those un-given candy canes, I kept them in my surgery locker. I saw them multiple times each day, as I came and went from my locker. I took a picture of those candy canes with my cell phone, as a way to remember Mr. Roberto. Then I threw the candy away, for they were intended for Mr. Roberto, and no one else should or could have them.



# One Night In Space Ops, Counting Down to Launch ...

Frank Yang, MD, FACS | 2018 Submission

T – 2 days. Various support crews assembled to lend their respective knowledge and skills to help ensure another smooth launch of the Space Shuttle. We came from far and near, representing multiple states and various bases. Our gathering point was Patrick Air Force Base (AFB), Florida. This time it was Endeavour's turn, as she – Orbital Vehicle OV-105 – readied to fly seven well-honed astronauts to the International Space Station (ISS). Endeavour was brought into being to replace the tragic loss of an earlier orbiter, the Challenger. The current Endeavour flight was to be the 123rd mission of Space Transport System, hence the designation STS-123.

And it was to be a night launch! At 0228 and 12 seconds – NASA liked to get it down to the second.

The particular support group to which I belonged was Department of Defense (DoD) Manned Space Flight Support Office at Patrick AFB, home of the 45th Space Wing, just a breeze south of Cape Canaveral.

T – 1 day. Pre-mission brief. I saw many familiar faces and some new ones. The assembled consisted of Jolly Green HH60G Pave Hawk Air Force Reserve Component (AFRC) helicopter crew based at Patrick, Marine Reserve C130 refueling tanker crew, range operators, Coast Guard members, NorthCom and AFNorth command and control personnel, DoD Surgeon and his crew from Patrick, NASA surgeons from Houston, Kennedy Space Center biomedical engineers, etc. Rounding out this large group of support personnel were those hardy and hearty Para-rescue Jumpers (PJ's) from various bases and four "Air Docs" of which I was one.

Air Docs were military flight surgeons specially trained for Space Shuttle rescue missions. In the event of a launch emergency, ranging from astronaut egress on the launch pad, to emergency return landing of the orbiter, to an over-the-water bailout of the space crew, PJ's and Air Docs would fly out in Pave Hawks crewed by Patrick AFRC, pick up the downed astronauts, and start emergency resuscitative measures enroute to hospitals ashore.

Of course launch emergencies were extremely rare, given sophisticated planning and stellar safety record for which NASA was famous. Our role as first responders was much like that of fire fighters. Public wanted fire fighters to be stationed in fire houses and instantly available. But at the same time, no one wanted these fire fighters to be actually called into action, for that meant there was a fire or fires in their very neighborhood. Yet no one felt comfortable living in communities without first responders at the ready.

Other than our primary rescue mission, we were also assigned a secondary task of "clearing" the Shuttle Hazard Zone of boats. The zone was an approximately 70 by 10 to 20 mile piece of watery real estate off Space Coast. For public's safety, boaters were strongly encouraged to stay out of that zone during launch.

For STS-123, there were two Navy Air Docs, one Active Duty USAF and one Air National Guard Air Doc. In addition, this time we were joined by a few distinguished visiting docs.

Other than the folks I saw in the briefing auditorium, there were countless others, each with his/her own set of special skills, assembled at many other places, on land, sea, air, in the USA and overseas, all geared up to support this launch. Each was playing a part in this intricate mission, this well-orchestrated multi-layered dance.

T – 6 hours. Pre-flight briefing started with a rousing five-minute video clip showcasing the heroics of Combat Search and Rescue (CSAR) crews, set to inspirational music. All watched silently and intently, feeling the gravity of what CSAR teams did. Video ended with the familiar yet true motto “These things we do, ..... that others may live”. Flight schedules were discussed and confirmed, watches hacked.

T – 4.5 hours. Step time. All Jolly flight crew, with their own survival gears on and loads of rescue equipment, stepped to their four respective birds, already readied by those dedicated ground crew. The flight line was dimly lit, the moon was but a sliver and fading fast. Not much cloud cover this night.

T – 3.5 hours. In a well-orchestrated and often-repeated performance, Jollies 1 and 2 departed Patrick for a short hop north to Kennedy flight line, where they were to remain on alert, in case of a launch pad emergency.

T – 3 hours. Jollies 3 and 4 departed Patrick and headed for the ocean to patrol the Shuttle Hazard Zone. I was in Jolly 3. This was night ops. But with Night Vision Goggles (NVG's) strapped to our helmets, night became green day.

On this flight, our bird carried two pilots, a flight engineer, a gunner, two PJ's, one Air Doc, plus a distinguished visiting surgeon, for a total of eight souls. Usually we flew with all doors and windows open, as we sit astride the open cargo bay, with our boots dangling outside and catching air. A “monkey tail” of thick canvass, leather, and metal buckle kept each of us harnessed to the bird. But on this night, we kept the doors closed. It was cool up here. Besides, there was no beach scene for us to enjoy at this time of night.

We began our patrol over the Hazard Zone. At 500 – 800 feet above the Atlantic, Jollies 3 and 4 encountered very few boats this night. It was not boating weather yet. Our NVG's aided by radars picked up a boat here and there. We spoke ever so cordially to the boat captains on marine band radio, reminded them of the impending launch, while range operators analyzed the boats' coordinates and advised the heading and speed that could get the boats out of the Hazard Zone by launch time. Nearby Coast Guard ships listened, poised to intervene if needed.

Throughout all this, fighter jets flew combat air patrol well above us and unseen, like hidden ghosts ready to pounce into action if an unauthorized aircraft entered the restricted airspace. We were sure to keep our Pave Hawk Blue Force (ie, “friendly”) transponder on. On this night, the ghostly high fliers were the F-15 Eagle crew out of Eglin AFB, Florida.

T – 1.15 hours. We chased our Marine Reserve C-130 tanker in a gentle left-hand turn, now having climbed to 2000 feet. With NVG's, the tanker glowed an other-worldly green, trailing two long black fueling hoses. As we closed in, our sturdy Jolly came under the effects of the much-larger tanker's rotor wash. We bobbed a few times, but the skilled pilots deftly made their connection on the first try.

T – 1 hour. We disengaged, bid farewell to the tanker crew, descended to 500 feet and continued our patrolling duty.

As we wound back and forth not far from the coastline, we could see the “Stack” all lit up. With the orbiter mated to the rocket boosters like an insect alighting still on a tree trunk, deceiving the uninitiated of the awesome power and violence about to occur, the setup was a majestic collection of orange and white magnificence. The most lit object on that marshy coast, STS-123 stood proudly awash in bright white light, with multiple luminous beams reflecting off its towering sides hundreds of feet into the night sky.

T – 10 minutes. Jolly 3 and 4 feet dry, landed and taxied in line to their earlier-arrived sisters 1 and 2. We disentangled our bent bodies from various vests and gear, grabbed our “brick” radio, and fast paced to the open steel girdle tower at the end of the tarmac. Flights of metal stair-steps disappeared beneath my flight boots as I hiked to a top perch, trained my camera, just in time to hear the long-awaited 10 – 9 – 8 .....

At the sound of “1”, thick white plumes bellowed out along the sides of Endeavour, followed immediately by a rapidly expanding fireball of orange, gold, then sheer white, lifting the huge Stack off the pad. The fireball intensified even more until it likened an oblong sun trailing fire and smoke, ascending into the heavens, with seven humans atop. Then the air started to rumble with a low-pitched yet powerful groan and rattle. Right on cue, Endeavour rotated, pointing her telemetry earthward, and powered away from the planet’s curve, lighting up a huge expanse of cloud cover, while leaving a wide trail of thick gray smoke as a farewell to those of us still bound by Earth’s gravity.

My buddies and I descended the tower, each clutching his/her camera, with our memories digitized and ready to share with family and friends back home. They say a picture was worth a thousand words. And boy, did we have pictures!

The four Jollies flew home to Patrick in staggered right. We hung up our gear in Life Support, debriefed, slumped in soft sofas nothing like the ribbed metal floor of the Pave Hawk, but still pumped up.

We wrapped things up, said goodbye to each other, as a multitude of other crews were also doing. Mission accomplished, at least our small part of the overall grand mission was now completed. We were of course ready to do it all over again for another launch or landing, as humankind continued to expand its reach farther and longer into space.

As dawn was about to break, we drove toward billeting, our tires hugging the pavement, careful to stay at the posted 45 mph. Yet Endeavour was long exoatmospheric. While we debriefed, she accelerated to 18,000 mph and orbited the entire planet. Before we reached our lodging, Endeavour was already well into her chase for the ISS and heading for her rightful perch high above Earth.



2017



# A Daily Reflection of a Third-Year General Surgery Resident

Woon Cho Kim, MD MPH | 2017 Submission

After morning rounds, I run to meet with a co-resident to hear about her recent mission trip to Ecuador. It is a rare opportunity for two surgical residents to break away from the wards for a quick coffee break. “We did some tough lap choles,” she beams, as we scan through photos of local hospitals taken from her smart phone.

Photos of the bare operating rooms remind me of my year in Rwanda. In pursuit of my interest in global medicine prior to residency, I lived in Kigali where I observed the local traumatologists in action. Electricity routinely shut off during cases, and overhead lights were substituted with bike headlights brought by the traveling surgeons. Autoclave machines malfunctioned frequently, and surgeons became creative to find instruments. Intravenous antibiotics were in shortage only to delay semi-emergent cases; waitlist for elective surgeries was already well over a year. The medical disparity I saw in Rwanda was unsettling and undeniable. Having also worked in Haiti, India, and Uganda, the unmet surgical needs globally fueled my decision to become a surgeon in hopes to be part of a larger solution.

Our golden ten minutes are up. I grudgingly tear myself away back to reality as my pager goes off. I am “needed in OR 18” it reads, and I gulp down my hot coffee. Everything else will have to wait. Once in the operating room, I struggle through a seemingly straightforward laparoscopic appendectomy. The patient is a healthy Spanish-speaking male in his thirties. I had met him a few hours back in the emergency department with his toddler and wife at bedside. His abdomen was quite tender, and I told him he would need surgery today. He grimaced in pain. He looked at his wife, who also did not speak English and appeared terrified in near tears. He turned to me for reassurance. “We will take good care of you,” I told him over the language interpreter. I gave him a firm handshake, which seemed to put him and his wife at ease, and I soon rushed out of the room to post the case.

Although I know the steps of an appendectomy by heart, I am unable to get through the adhesions in his abdomen. The palms of my hands start to sweat, because I am momentarily struck by the list of possible complications I can cause him if I cannot finish the operation safely. Just a few hours earlier in the emergency room, I had promised him to care for him as he consented for surgery. The attending surgeon is watching me closely and guides my hand to apply gentle traction with my non-dissecting hand. “Not too much tension, as you may tear friable tissue,” he adds. The remainder of the case moves along smoothly. I feel more relaxed as I close skin. I am thankful for my attending surgeon’s poise, patience, and expertise. I remind myself to review the appendectomy chapters again, as I feel a sense of guilt for not being able to care for my patient. I am also looking forward to my next operation to try out the new “traction” technique I learned from this case. I update the patient’s anxious wife in the waiting room, who jumps up from her chair to hug me.

After an uneventful cholecystectomy and three urgent consults later, I finally sit down for a late dinner at home. I am exhausted. I recall my earlier conversation on the resident’s trip abroad. I look over at the stack of articles I saved on global health and surgical mission trips. Most of them are still waiting to be read, put aside next to the more frequented surgical textbooks. I then remember how difficult it was to get through a rather straightforward appendectomy. The articles will have to wait for now, because I will be accountable for many more lives to come, even when I no longer have a senior surgeon to turn for help. As surgeons, we are accountable for our patient’s wellbeing, and as a resident surgeon, I feel a pressing obligation to learn and advance. I skim through the surgical atlas on the appendix. And before I can finish the last paragraph, I find myself struggling to stay awake.

My daily routine is mundane but a universal experience for many surgical trainees. As a chief resident once told me, residency must be an intentional process. Time is limited, and because the more we know, the better we can care for our patients. The tender abdomens I encounter in the wards and operating rooms, along with the personal stories behind each disease process, are what I chose to make an intimate part of my journey. The promise I make with my current patients is, in a way, my promise to my future patients and the larger community I am a part of. It is a lifelong commitment to better my knowledge, technique, and perspective. As I make the transition from a trainee into an independent surgeon, I hope to incorporate this very dedication for learning into my practice moving forward. As I struggle to perfect one appendectomy at a time, I hope to become one step closer to becoming a global-minded surgeon as I aspire to be.

*If surgery is an art, learning it is another form of art that will never stop.*



# Unlikely Friends

C.A. Harris, MD, FACS | 2017 Submission

“B-cell lymphoma.”

Not what he expected to hear as the cause of his “blocked bowels.” He had come to the small Virginia community hospital for relief of the crampy abdominal pain he thought was from some bad chili he had eaten. His CT scan showed otherwise; an obvious small bowel obstruction, and at laparotomy the tumor of the distal ileum was evident, as were the enlarged lymph nodes in his mesentery. The resection had gone well and now, at his bedside, I was just learning about the man who in the ER, was only a “patient” that needed surgery. We were basically still strangers.

I waited for the word to sink in, searching for some clue in his face that would help me to help him on rounds that December morning.

“How’re you feeling, Mr. A\_\_\_\_\_?” I offered.

“How do you THINK I feel!” was his tart reply, his face reflecting wide-eyed astonishment.

“Sir?” I replied, still scanning his features for understanding.

“I mean just think about it! Here I am; a redneck from Georgia, sick, looking to get some help. And I look up and see you, a black man, standing over me with a knife!”

He kept a straight face, pausing to see my reaction.

I was thinking about how to diffuse the tension here. Not this again, I groaned inside myself, thinking about the racial epithets I had heard since coming back to the South; the ‘Stars and Bars’ tattoos, next to a Nazi swastika. “You see them one man at a time.” counseled my mother. One man at a time. I was preparing some pithy response, when my patient erupted into raucous laughter.

Relieved, I managed a wan smile at the discovery of his unusual sense of humor, glad that I didn’t have to deal with any real confrontation this early in the morning.

“Gotcha!” His eyes twinkled. “I’m really feelin’ okay, Doc. Just a little sore where you cut me.”

I listened to his heart and lungs, and in the silence of listening, my thoughts flew to another time when I would not have even been allowed to be seen as a patient in the very hospital where I was now an attending surgeon, and would eventually be Chair of the department.

“You’ve got some bowel sounds and we’ll see how you do with sips of liquid today.”

“Sounds good, Doc. So, what’s the prognosis?”

I reviewed the general statistics with him, and let him know that additional treatment would be necessary, beyond surgery. A glint of fear reflected in his eyes at the thought of chemotherapy.

“Not many more Christmases for me, huh?” he managed a smile now.

“Let’s just take it one day at time. That’s all any of us can do.”

“One day at a time.... yeah, you’re right there, Doc.”



I left him with his thoughts, and as I walked on to see the next patient, I had some thoughts of my own. It was 2001, just 3 months after 9/11, and the War on Terrorism had just begun. My 78 year old patient had his own battle to fight now, and I was called to fight beside him.

His name was Solomon. We would walk together through recovery from his operation and then ultimately through his days of chemotherapy. Sol went on to do well, and at my last follow up visit with him in 2007, there was no evidence of recurrent disease. In the process, I had learned about his children, the durable marriage to his wife, his love of fishing, his love of life. He sent me a Christmas card every year after that until he died of complications related to congestive heart failure many years afterward, his wife would later write. I still think of that December morning, when our paths crossed; the “redneck” from Georgia and “the black man with a knife,” and the unlikely friendship that grew from seeing “*one man at a time.*”

2016



# The Art of a Smile

*Sharline Zacur Aboutanos, MD, FAAP, FACS | 2016 Submission*

There are a few cars on the road as I drive to the hospital. It's about 6:45 AM, and I wonder where the other drivers are heading. The distance from my comfortable, suburban house to the city hospital is too short to really enjoy the hot coffee in my cup holder.

I review each step of this morning's first case as I pull in to the doctor's parking lot.

I get one chance to get this right. I have to get this right. To make her look good.

I meet my patient's parents in the cramped pre-operative holding area. It's hard to keep my voice low so other parents won't hear.

"We'll take good care of her. I'll find you afterwards to tell you how things went."

I could see the tears well up in the mother's eyes as the CRNA peeled the baby girl out of her arms. Baby was sleeping during this process and did not protest at the exchange.

Now asleep under anesthesia, I began to carefully examine the defect that needed repair.

"Calipers, Doctor?," asked the scrub tech.

"No, thanks. I usually eyeball it." I answered as I made my markings with ink.

She continued to hold it out towards me, knowing that I always change my mind.

Knowing that I like to double check.

"Look at that. Perfect." I said, using the calipers in the end.

"Being a millimeter off is like being a mile off."

Midway through the procedure, the anesthesiologist looks over the drapes. "Geez. Looks like a bomb went off."

"Yeah, the most controlled bomb you've ever seen." I replied, knowing how each edge was created. "Wait until I put it together."

Looking through my loupes, I do not participate in the chatter of the room on Monday morning. Careful approximation of each mucosal, muscle and skin edge takes concentration. Each stitch is the chance to give the child a better smile.

Towards the end of the surgery, the circulator leans over my shoulder saying, "Wow. It looks good, Doctor. What a difference. Now she can smile without the cleft in her lip. She looks beautiful now."

I nod. "I know she looks better, but she was beautiful before I started."

# Indispensable

Charles A. Harris, MD, FACS | 2016 Submission

*"The graveyards are full of indispensable men."*

*-Charles DeGaulle*

When they brought him into the E.D. that early spring morning, we did not recognize him as one of our own. He had been very nearly decapitated in the motor vehicle accident that took him from us. The state trooper who was at the scene said there were no brake marks on the road before Paul's (not his real name) low-riding Mazda 280Z ran underneath the semi-tractor trailer parked on the shoulder of the highway at 0 dark thirty that morning. The rising chief surgical resident had fallen asleep at the wheel, likely. Pushing himself, no doubt, to be back for morning rounds on Monday after attending the Masters Tournament in Atlanta, as he done every year. It was only when they looked at the things he carried on his person; his hospital ID, keys, Quick reference guide to phone numbers at the hospital, and a new engagement ring, which would never reach its intended owner; it was only then that we discovered who he was. It suddenly became very personal.

Our desperate and futile resuscitative efforts continued longer than reasonable, because we didn't want to let go. With tears in our eyes, we finally let our hearts surrender to what our minds already knew. Paul was gone. A good man; a good surgeon; someone you could count on. But why? Why didn't he just call ahead to someone on the team and say, "I'm not going to be able to make rounds on Monday; can you cover for me? I just need some rest and I'll be there later in the day."

I'm sure it had something to do with what I call "The Indispensable Man Syndrome", which says: Trust no one. If I am not there, it won't be done right. This is of course a myth. There is always more than one way to skin a cat. The tasks will get done. But this myth of indispensability drives the obsessive compulsion that "if it's going to be, it's up to me." There is also the concept of team loyalty ("They're counting on me."), just as in the military; we push the limits of reason, and endure mind-numbing fatigue for the 'guy next to us'; for our fellow surgeons. And no one wants to be labeled a "slacker", as much as we joke about it, for it is a cardinal sin to rest. "We are machines," we fool ourselves. In surgery, this thinking is prevalent, in training and long afterward. Yet, noble as it may sound, it flies in the face of the reality we all come to know.

I thought about the memorial service we had for Paul. It lasted about 20 minutes; a little longer than Andy Warhol's "fifteen minutes of fame" everyone supposed to get. But did the world stop turning? Did the operating rooms at the University Hospital come to a grinding halt, because we had a "man down"? Not even if that man was a chief resident? Of course not. So why do some of us live as if the world will come to an end if we are not there? If suddenly, our heart stopped beating and we dropped dead? What would happen? Our patients will be inconvenienced, briefly. They will possibly bow their heads; maybe there will be a tear, and a remark about "poor Doctor H——-", before their thoughts quickly turn to "well, now whose going to do my surgery?" And they will surely find someone, as we surgeons who remain close ranks and take up the slack left by the departed.

Yet there are some to whom we are truly indispensable, and ironically, they are the ones in our lives that get the short shrift; Our families. Our wives, our husbands, our children. They also count on us, yet somehow the 'team loyalty' concept does not translate to them. We dutifully relegate their attentions to "tomorrow" after we have taken care of other people's husbands, other people's wives, other people's sons and daughters. But it is to our families that we are truly indispensable. My wife will have only one husband. My children

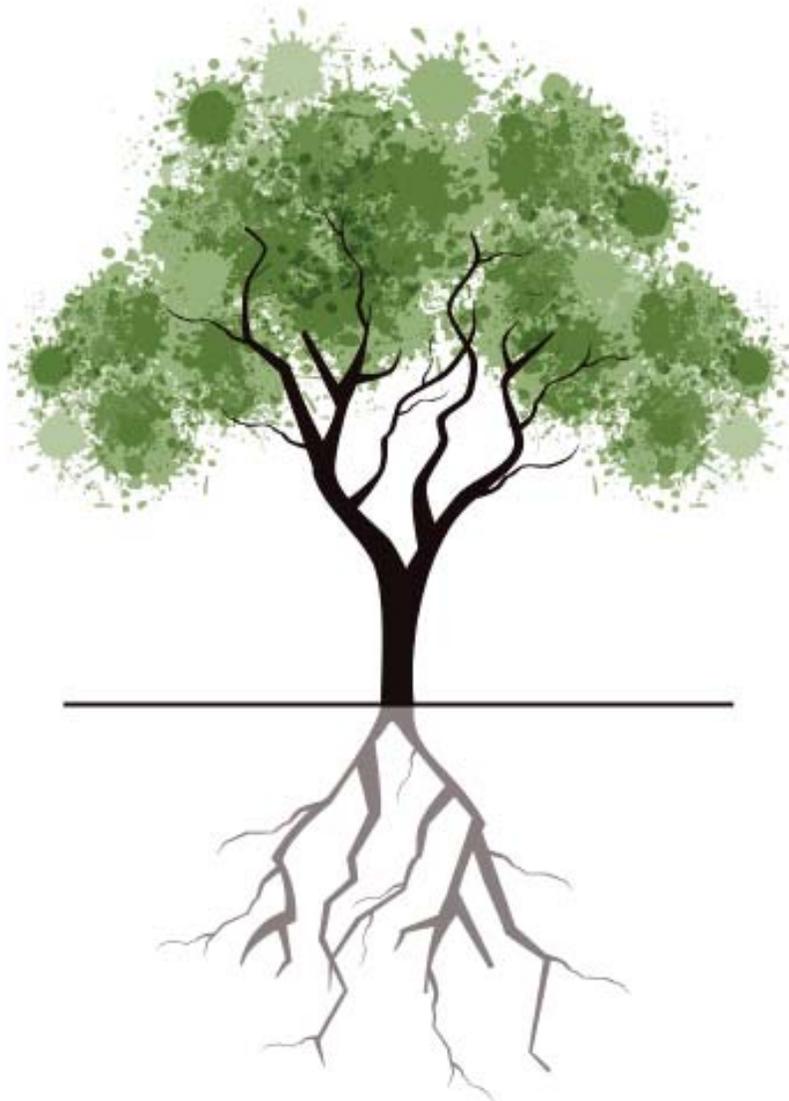
will have no other father. There may be surrogates, but none like me. What we bring , or should bring, to their lives is unique to our very individual characters, personalities, spirits. What they get from us, they can get from no one else. Our “well done”, our hand on their shoulder, our embrace when they are in need of encouragement and strength and love, means the most when it comes from us.

We planted a tree in Paul’s memory, close to the old hospital. I smiled at the irony. A tree is just the right metaphor about priorities. That tree will provide shade and shelter when it is fully grown, but it is totally and completely dependent on its root system. It is a reminder to me, and hopefully to us all, that a tree is only as strong as its root system; Families. None of us stand alone, and we would very quickly wither and fall without the life-giving sustenance we receive from them. For us, they are indispensable in the true meaning of the word.

Keeping our priorities straight is key to being successful at life.

Yes, we have an important calling as surgeons and there is no greater professional bond than that between our patients and ourselves. But we are more than what we do. We are also key members of families, who love us, support us and wait ...just to be with us. Life flows from them to us and back again; we are only whole together. And we are to them as they are to us; absolutely necessary, essential, requisite.

***Indispensable.***



*Surgery is an art,  
and although informed by science,  
is not a science.*

*As long as our focus is on caring for people, with their  
personal idiosyncracies, unique anatomy and biological  
features, our patients can  
never be reduced to a mere formula.*

*We must bring our shared humanity to the bedside  
to be effective surgeons and  
earn their confidence and trust.*

*It is also important for us to recognize that the most  
valuable intangibles we take away from our careers are  
the friendships we have developed  
with our patients in the course of their care.*

**We help them, but they also help us.**

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