My Student Elective

Surgery in Jersey City

ANGELA THOMAS

British Medical Journal, 1979, 2, 1493-1494

At 9 am on Wednesday 3 January I was to start at Jersey City Medical Centre. I had been told it was an old hospital, but as I drove up the twin 20-storey blocks, which comprise much of the hospital, seemed to contradict this fact. I was told later that it was built in the 1930s—that is old to the Americans.

Having waited 10 minutes for a lift (sorry, elevator), a comforting link with the hospital at home, I found my way to the fifth floor of the surgical block and was introduced to "the chief" and "the team" with whom I was to be working for the next eight weeks. Half an hour later I was in operating room B (the OR for short) trying to manipulate a fibroptic bronchoscope into the right main bronchus of my first patient and hoping desperately that the trousers of my extra-large theatre suit, the smallest size available, would not fall down. The bronchoscopy I did not manage, but fortunately I had more success with keeping my

trousers up and from then on never entered the OR without an assortment of safety pins.

I asked what the next case was. "You're changing a pacemaker" was the reply. The full implication of this statement did not hit me until a scalpel was thrust into my hand, and I was told, "Whatever you do, lady, don't cut the wire." "What wire?" I thought, as I began prodding the site of the pacemaker. "Ah, that wire." Having found it, I prepared to make my first surgical incision and managed without too much trouble to enter the pocket where the pacemaker was lying. Assisted and guided by the chief, I completed my first operation and felt elated as I went off for lunch.

During the afternoon I was shown around the hospital. There

are two main blocks, one medical and one surgical, which are joined by corridors on the lower-ground, ground, fifth, and ninth floors. At the top of each block are the residents' rooms and common rooms complete with a television and a refrigerator, which is stocked up with sandwiches at night. In addition, at the top of one block are some laboratories and at the top of the other the infectious disease unit. The emergency rooms and intensive and coronary care units are on the lower-ground floor (which is incidentally at ground level) to facilitate transport of patients from one to the other. Also on this floor is the room which houses the computer-tomography scanner. I entered the room and was introduced to the neurosurgeon, who grinned and waved a screwdriver at me. He always carried this, he told me, in case of emergencies—with the scanner I presumed, not his patients. Later during my stay, I spent an afternoon seeing the scanner in action and playing with the computer and tapes myself. The other floors in the hospital are taken up with the wards, operating and recovery rooms, conference rooms, and library.

Dawn doughnuts

The day began early, at 6 45 am sharp, on the intensive care unit for the first ward round of the day; then I had a hurried breakfast of waffles and coffee and was in the OR by 7 30. Drug companies sometimes provided breakfast and a talk or a film on the efficacy of their products. I looked forward to these with visions of bacon and eggs, toast, and marmalade. These hopes were soon shattered, however, when I discovered that the standard breakfast consisted of boxes of doughnuts—chocolate and peanut flavours. Too much for me so early in the morning.

We were on call every third night, and it was on these occasions that I saw most major trauma. Each member of the team covered a different division: emergency room, paediatrics and neurosurgery, routine admissions, and plastic surgery and private admissions.

One night when I was covering the emergency room, a message came through that the paramedics were bringing in a man with a traumatic amputation. We went to the coronary care unit to watch the monitor, which showed the patient's electrocardiograms and heart rate in the ambulance, and to keep in continuous contact with the paramedical teams. The man was losing blood fast and his blood pressure was dropping. From the electrocardiogram he seemed to have had a myocardial infarction and to be unlikely to stand a long operation under general anaesthesia. By the time the patient arrived the chief resident surgeon had been called, the anaesthiologist was prepared, and the blood bank had been alerted. Swiftly, intravenous catheters were inserted, blood was taken for cross-matching, and the patient's leg, which was barely attached below the knee, was strapped. An above-knee amputation was decided on since this operation would be comparatively fast. The patient was taken to the OR. Assessing his condition was greatly aided by the monitor, and much time had been saved in getting him to

theatre. The next day he was out of danger and he improved rapidly over the next week. He was, however, rather disorientated and insisted that he was in a restaurant—his main complaint being the appalling service and bad food.

In the emergency room I also came across many stabbings and gunshot wounds. All stab wounds to the abdomen were routinely explored since this was the only way to rule out a perforated viscus beyond doubt. One man who had been stabbed and was therefore taken for a laparotomy was found at operation to have no intra-abdominal injury. This was surprising since the knife had penetrated a full 10 cm. The patient owed his good fortune to the thickness of his superficial fat layer.

Surgical clinics at the hospital took place three times a week and were always hectic. Each visit to outpatients cost \$30 (except for the removal of stitches, which was free) before any investigations or procedures were carried out. This, however, did not deter the people of Jersey City from attending. All sorts of problems presented themselves, and during these sessions I did most of my wound dressing, lancing of abscesses, and learning of Spanish since many of the patients spoke only this language. One word which cropped up more often than most was *dolore*, which always seemed to be *mucho* and in every part of the body about which I inquired. At the end of these clinics I most missed that peculiarly English idea of tea time.

Many operations were memorable for one reason or another: the closure of a neural tube defect in a 6-hour-old baby; an appendectomy (as the Americans call it) at 3.30 in the morning; and the amputation of both legs of a drunk who had passed out in the snow and got frostbite with gangrene and septicaemia. One I shall never forget, however, was the craniotomy at which

I was actually allowed to drill through the skull. The electric drill usually employed was not working and only the hand-powered one was available. Since this meant that progress through the bony vault would be slow, it was considered safe to let a more junior member of the team try. With me at the drill the progress was even slower than anticipated—it was very hard work. Eventually I was through. The delicate operation that followed contrasted considerably with the part I had played, and I was more than content just to watch for the remainder of the time.

My last day arrived. We were going out for lunch to celebrate, and when I walked into the chief's office at 9 am—I had allowed myself the luxury of a late start—I was not dressed in the usual green pyjamas. "What," inquired the chief, "Not operating today?" He said he had a special case for me and led me to the operating suite. There I saw a large policeman self-consciously squeezed into a scrub suit. He was guarding my patient. My job for the morning was to remove two bullets: one from the patient's arm and one from his leg. I was amused that despite the premedication and wounds it was still thought wise for the patient to be handcuffed to the operating table and for the policeman to continue his guard in the operating room itself. Too many prisoners had escaped down laundry chutes and in stolen clothes for any chances to be taken.

As I scrubbed for the case I thought back on the last eight weeks: the people I had met, the things I had seen, and what I had achieved. I had been lucky that the surgeon I had worked for believed in learning from practical experience. "See one, do one, teach one" was what he had told me, and by following this advice I gained confidence and knowledge.

Personal Paper

Appointment in Samarra

L J WITTS

British Medical Journal, 1979, 2, 1494-1496

The suspension of *The Times* has doubtless affected different people in different ways. Usually, I look first at the weather map and reports and then at the deaths column and obituaries. Retirement allows me the leisure to pursue trains of thought, and I have been thinking about obituaries in the period when there have been none to read. In the old Arabian story, which John O'Hara used as the epigraph for his novel *Appointment in Samarra*, Death says to a merchant in Baghdad, "I was astonished to see your servant in Baghdad for I had an appointment with him tonight in Samarra." But all of us have an appointment in Samarra.

There is at least one short story in which a man dreams that he reads his own obituary notice in *The Times*, and I think there was one occasion on which by mischance an obituary

notice was published of a man who was alive and well. The point of these stories is the foreknowledge of imminent death and its effect on a man's feelings and actions. This kind of prevision should not be unduly disturbing to those of us who have passed the psalmist's span of three score years and ten and perceive that we can no longer "ripe and ripe" but only "rot and rot." Indeed, a man who dies suddenly, with faculties intact, when the normal span has been reached, is much to be envied.

Yorkshire businessmen were said to be anxious that they should "cut up well"—in other words, leave a large fortune. The rest of us are more concerned with the reputation we leave, though to the agnostic this should be a matter of little importance. I have never felt any desire for posthumous fame such as inspired Nelson and Keats. I have often thought it would be interesting to work out what governs the length of medical obituaries in *The Times*—worldly success, a large private practice in social class I, genuine achievement in science or the arts, are obviously important. Longevity would show a negative correlation, for by the age of 80 a man and his achievements begin to suffer what Sir Thomas Browne called "the iniquity of oblivion." My father-in-law, who lived to 93, gave up reading the death notices because so many of his