*Member of our class working at Addington included Anthony Crutchley and Rob Waspe.*

**Starting work as a Doctor**

**Obstetrics and Gynecology**

Obstetrics and gynecology were my first rotation as a medical doctor. I started work on the 1st January 1974 which, like most countries around the world, was a public holiday. The hospital was Addington Hospital, a 12-story hospital block on the Durban Beach front. Through the windows we could look out over Durban Bay where more than 50 ships were anchored, waiting to enter the harbor. A few months earlier the Yom Kipper war between Israel and its Arab neighbors had resulted in blocking of the Suez Canal. Ships now needing to travel from the Far East to Europe had to travel around the tip of Africa. Below the hospital were the famous Durban Beaches already crowded by those swimming and surfing. It looked inviting. Accommodation for the doctors were in quarters one block behind the hospital. We were charged a small rent and meals were provided.

Addington Hospital was a very popular posting for medical doctors, especially those unmarried. There were plenty of nurses, who stayed in a multistoried building alongside the hospital, waiting to get hitched to a young doctor; the beaches and its attractions were an additional attraction. Lifestyle for the medical staff was idyllic. The underlying approach was work hard and play hard. Evenings were often spent in a pub that existed in the Doctors Quarters and darts and table tennis were played late into the night. On Sundays we all paid 25 cents and rented a movie. During the reel changes beers were bought and the mothers checked the babies asleep in the rooms upstairs. It was not unusual for some physicians on quiet days after that had completed rounds to go to the beach. Nurses were instructed to get hold of the physician by hanging different colored towels outside the floor window. A red towel indicated an emergency, a yellow less urgent.

I had found out that I was on call that first day and I arrived in the ward on the 9th floor promptly at 7 am. The nurses had just handed over shifts. I did not know anyone and was feeling somewhat apprehensive not knowing what my responsibilities were. I made small talk with the nurses. They made me coffee. The other interns and the consultants I would meet the next day.

Around 0830 the registrar, Ed arrived. He was a tall confident man and had been a registrar for some time. In South Africa progression to a consultant level was dependent on two basic requirements – enough exposure in a recognized teaching post and the obtaining of a higher degree or diploma. Ed had more than enough time working in the specialty but been unable to pass the exams associated with getting the higher degree.

We did rounds seeing the patients in the gynecology ward and then went to the obstetric floor. There were no patients in labor, but there were a few who had just delivered or had cesarean sections. The round was over in about an hour. We chatted, and I was told what my responsibilities were.

“Today is likely to be quiet. On the gynecologic side there may be a few admissions of threatened or incomplete abortions. In obstetrics you will need to see every admission and be aware of any potential complications. Keep me informed of what is happening and call if you have any concerns.”

The rest of the day was very quiet. Pagers did not exist; we were phoned either at the flat that we were staying in or via an overhead paging system which was hooked into the doctor’s quarters lounge and dining room. I was anxious and new to the system and kept phoning the switch board to let them know where I was. The evening however was completely different from the day. About 5 women in labor were admitted, one of which needed a cesarean section. I was up all night assessing the patients when they were admitted and taking calls from the midwives.

The following day I was exhausted. I got to meet the two full-time consultants and the other interns I would be working with. One was Frank Sabbatini, the father of Rory Sabbatini, the professional golf player. He was gregarious, confident and full of fun. Leon Regensberg was tall and intelligent. I recognized him as being a year ahead of me in Cape Town. We were allocated different responsibilities for the day; I was allocated to gynecology. For call we were expected to cover all areas of the hospital dealing with the specialty.

There was a lot of anxiety in the beginning and we would ask the nurse when we had a problem, what she thought was the best way to manage the problem. Gradually over time and with confidence we found that questions would be asked of us rather than the other way around. We learnt by trial and error, and from each other and a camaraderie developed led largely by Frank. Leon who had done a previous year’s internship was more confident having gone through the ropes already, but even he could be teased. It was the routine when we admitted a woman in labor to estimate the size of the baby. Leon had one patient in labor that he examined. She had never had a prenatal visit before. He estimated the baby as weighing 8lbs. He was correct, but what he missed was another baby weighing 7 lbs, a twin. “The baby came out and we were waiting for the placenta to follow, when suddenly there was another baby.”

One patient was anemic, and I ordered a blood transfusion. It was the first blood transfusion that I had ordered as a physician. I was called urgently to the patient’s bed side by the nurse. “I think the patient is having a reaction!”

I rushed there. I had visions of anaphylactic shock developing. The patient had a diffuse red rash and was literally developing hives in front of my eyes. I had never seen anything similar, before or since. “I’m having difficulty breathing,” she said.

I knew exactly what to do. “Stop the transfusion, give 25mg Phenergan intravenously. Have adrenaline and hydrocortisone available if needed.” Phenergan is an antihistamine

The patient slowly felt better after the next half hour. The rash seemed to disappear as rapidly as it appears. I did not need to give the adrenaline and hydrocortisone.

When I mentioned the reaction to Leon, he stated, “Reactions happens all the time. I always give Phenergan intravenously before I give a blood transfusion.”

Patients were frequently admitted with cancer of the ovary. This disease often presents late as the disease often does not cause symptoms until advanced. The cancer spread within the peritoneal cavity and the thousands of small nodules of cancer ooze fluid which accumulates and is called ascites. Treatment is largely symptomatic - to make the patient as comfortable as possible. There was no effective chemotherapy then and surgery did not have any impact on the disease process. Patients were admitted with massive ascites to have the ascites drained. Ed showed me how to drain the ascites. “Percuss and find a dull area in the flanks. Inject local and then insert an IV cannula and tape it in place. Attach this to IV tubing and then attach the other end to a urine bag placed in a basin on the floor.”

I did this to one patient and was very satisfied to see the pale-yellow fluid draining. The next day on rounds the patient told me “I have been in agony. There is a sharp pain right where you inserted the needle. I am scared to breathe; it is so painful.”

The patient had drained about 5L of fluid overnight and her abdomen looked less distended. “I’ll take the cannula out. That should help the pain.” I said. I removed the dressing and removed the cannula and it was then that I saw what was causing her sharp pain. I had neglected to remove the needle from inside the cannula. My heart started thumping from anxiety. What if the needle had perforated her bowel while she was moving around? Am I going to be sued? I envisaged the needle right next to the descending colon and causing widespread peritonitis. I felt her abdomen. It was soft. Thank goodness. She had no fever. Her white cell count was normal. I watched that patient like a hawk and fortunately no harm developed. I had learnt a lesson.

Incomplete abortions were also a common reason for admission. Doing an abortion in South Africa was illegal, but many of these young pregnant girls went to back-street abortionists. I used to get a phone call about once a month asking me to do an abortion and I presume other doctors were also called in similar fashion. I always refused. The back-street abortionists, after initiating the procedure instructed the patient to go to the local emergency room. This was intelligent advice, but some young girls were admitted late; sick and septicemic and some nearly lost their lives. Doing a dilatation and curettage (D&C) to remove the remnants of pregnancy and prevent infection was a common operation and sometimes up to 5 cases a day were done. I was shown how to do the procedure by Ed and then did a few initially under his supervision, thereafter I started doing them on my own.

I never asked details about how the abortion was procured. I did not feel that it was my role to be a policeman or to be moralistic. I did ask how the bleeding started, but not once in my six months, was I told that an abortion had been initiated. I was told "I just started to have cramps and then bleeding." Some were certainly spontaneous, and some were criminally induced; most I could not tell. There were a few patients who had been told the ropes - those that hadn't eaten, knowing that an anesthetic was likely and those that had shaved themselves. One weekend we admitted a beautiful young girl who was having an abortion. She told me that she and her boyfriend were going to tell her parents she was pregnant the next weekend when she started aborting. When I examined her the fetus approximately four inches long was lying in the vagina. I decided to see if she would spontaneously abort and that if, after examination of the fetus, the placenta was complete, we could avoid a D&C. I watched her regularly over the next few hours, but progress was slow. Other obstetric issues occupied my mind until the head nurse informed me: "I just went and looked at the young girl who was aborting. I removed the fetus but the cord broke."

I was furious. "Why did you do that. I was hoping that she would pass the fetus completely. Now we have to do a D&C!"

The young girl was below the age of consent of 21years. If she had married her boyfriend, under South African Law, she could give consent, as she would now be considered a major, but I now had to go and get consent from her parents who did not know she was pregnant. Did the parents now need to know their daughter had been pregnant?

I contacted the parents telephonically. I told them that their daughter had been admitted with excessive bleeding and that we needed to do a D&C. I did not tell them she had had been pregnant. I justified this by the argument that she was now no longer pregnant. I got telephonic consent and did the procedure. I often wonder whether she married her boyfriend.

My first surgical procedure was a tubal ligation following pregnancy. This was an easy procedure as the abdominal wall was stretched and the uterus was still enlarged. A small incision was usually made at the umbilicus and the fallopian tubes could easily be grasped. The anesthesiologists came to me beforehand and asked me how long an anesthetic I needed. I replied, “I do not know. This is my first operation.”

He said, “Do not worry, I will paralyze her, and you will have about 30 minutes.”

I had heard that it was necessary to make a bold incision, and not to be timid when doing a surgical procedure. After draping the patient, I made, pressing firmly, a small sub umbilical incision. I was surprised to enter the abdominal cavity with the initial incision. I grasped the fallopian tubes and tied them and sent a portion for pathologic examination. The operation was completed in five minutes. The generous, helpful anesthesiologist who tried to make my first operation easier needed to stay and ventilate the patient for another half an hour until the paralytic agent had worn off. Over time I could do more and more surgical procedures and by the time the six-month rotation was complete I had done a fair number of cesarean sections. I was also confident in being able to handle almost any obstetric issue, including breeches, forceps and vacuum extractions.

In the clinics we did antenatal clinics assessing the progress of the pregnancy and making certain that there were no complications that could impact the pregnancy. We assessed progress by simple palpation. There were no ultrasound machines that are available today. If there was concern about the size of the pelvis a pelvic radiograph would be done and pelvic measurements made.

On the gynecologic side we dealt with menstrual irregularities, prolapse and vaginal discharges. Common discharges were due to trichomiasis, or “trich”, a sexually transmitted infection due to a protozoal organism that results in a foul smelling, green, frothy discharge that results in itching and painful urination. Another common discharge was moniliasis or thrush, a disease not sexually transmitted but common in moist environments, in pregnancy and in diabetics. The former discharge is treated with a drug called metronidazole, the latter with topical applications. Occasionally gonorrhea and syphilis were picked up.

The relationship with the midwives developed. There were established experienced midwives as well as student midwives. Our role was to evaluate the patient and to be available if anything out of the ordinary occurred. The midwives did the routine deliveries. We were called if there was delay in progression of labor, fetal distress, or if an episiotomy needed to be sutured. Because we spent long hours watching patients progress, we got to know each other well over many cups of coffee. If there were patients who needed more careful monitoring, I slept in an unoccupied bed close to the labor ward. The midwives knew this and would get up to all sorts of mischief, such as sabotaging the bed or removing your clothes while you were asleep and then calling you out. Overall, the rotation was a very good introduction to Medicine. Most pregnancies do not need much medical help – woman have been delivering babies for centuries, even before physicians. Delivery of a baby is a joyful occasion to the medical profession as well as the parents. I was happy to be associated with these delights.

I enjoyed my time in the specialty but never considered it as something I would pursue full-time – it was not stimulating enough. Most patients were young and fit. My ambition at the early stage of my career was to be a general practitioner and I needed to be able to manage obstetric and gynecologic issues that came my way.