**Surgical Internship**

My next six-month internship rotation was in General surgery. I was assigned to the colored wards. Again, there was a registrar with whom I interacted. The consultant was a Dr Alan White.

I was more confident at this stage of my career. I could deal with any issue in obstetrics and most issues in gynecology. I was looking forward to doing something new. Daily activities included doing rounds, dealing with ER surgical issues that may involve admissions to our area of the hospital and doing outpatient clinics. There were assigned operating days two days a week. We were largely left on our own to manage the ward. The consultant did rounds with us once a week and was available if there were emergencies. When we were on call, we needed to be available for any surgical issue throughout the hospital

I became quite proficient at doing minor procedures such as placement of chest drains. skin grafts, drainage of abscesses and stripping of varicose veins. The registrar tended to do the hernia repairs and appendectomies. Towards the end of the rotation I started to do these as well. It was an apprentice type situation. The attitude was ‘see one, do one, teach one.’ The consultant did major laparotomies where gall bladders, stomachs and colon were resected.

Alan White was a very good surgeon and was originally from Zimbabwe. I remember him doing an appendectomy through a McBurney incision of about two inches taking only five minutes.

Prior to one of his rounds I had inserted a chest drain in a patient who had been stabbed. About 700ml of blood had drained. I asked for a post chest drain radiograph but had not seen it as I was confident the drain was in the right position because of the drainage. At rounds I presented the case and then pulled out the chest radiographs. “Here is the post intubation chest radiograph.” I was horrified when I looked at it. I could not see the chest drain lying in the chest; it appeared to be below the diaphragm. Was the blood that had egressed through the drain, a result of trauma induced by my procedure? I thought.

Alan White was quite amused. “Congratulations on draining a sub phrenic hematoma by an ingenious route.” I was not amused. I watched that patient carefully, but no problems thankfully developed. In retrospect, years later, on reflecting on this patient, I believe I had inserted the drain correctly. The appearance of a chest drain below the hemidiaphragm was purely because the drain was lying behind the dome of the hemidiaphragm. The true position of the chest tube would have been realized with a lateral chest radiograph.

One night we admitted a 20-year-old patient who had been stabbed in the abdomen. He obviously needed exploration. He was shocked, anemic and had a tense, rigid abdomen. I called the consultant on call. He was in private practice and did calls once a week. He had only been in practice about a year. He told me: “order 4 units of blood and set up the operating room. I will be there as soon as I can.”

I ordered the blood and arranged urgent surgery. I accompanied the patient to the operating room. I set up an IV and helped position the patient. By the time I had done so the consultant arrived. He rapidly opened the abdomen. There was a large amount of blood present which we sucked out. The bleeding was coming from a 2cm stab wound in the abdominal aorta. The surgeon controlled the bleeding initially by placing a finger on it. He then called for 2-0 prolene sutures and attempted to close the site. Instead of controlling the bleeding however it got worse and worse – the sutures were pulling through the aorta. I was feeling frustrated. The anesthetist was trying to give blood as rapidly as he could. The blood pressure continued to fall. I could see the situation was becoming an irrecoverable one. I did not know what to suggest or do. The surgeon tried larger and larger sutures to no avail. Eventually he said: “Enough. I cannot do any more.” He pulled off his gloves and went to talk to the family.

I was left to sew up the incision on the deceased young man. I was devastated by what I had seen. I wondered whether a better approach could have controlled the situation, but I was too inexperienced and junior at that stage to know these answers. This would change later. In my interest in the History of Medicine I later became aware that Alexis Carrel, a surgeon who had been awarded the Nobel Prize for Medicine in 1912 for recognition of his work on vascular suture and the transplantation of blood vessels and organs, had wondered the same thoughts that I had. He had been a medical student in Lyon France when Sadie Carnot, the Prime Minister of France, had been stabbed. The stab wound involved the portal vein, one of the major veins going to the liver. Surgeons were unable to repair the wound and the Prime Minister died. Alexis Carrel set out to develop means in which these wounds could be repaired, and developed techniques and principles of vascular surgery.

In reflecting on the case of the young man who died I now know he could have been saved. We had control of the bleeding initially – the finger was stopping it. What was needed was proximal and distal control of the aorta by clamping. I have since been placed in countless circumstances where there was excessive bleeding and, in most instances, this was able to be controlled. One needs to get control by placing a finger on the site or packing with sponges. During this period of control, the blood volume lost can be replaced. More importantly during this period a plan of further action can be thought of. Most instances of bleeding are from small injuries. The patients with large injuries and with massive blood loss do not get to the stage of reaching an operating room where control can be achieved.

I was not present when the surgeon went to talk to the family to console and explain what had happened. I would not have known what to say at that time, nor had I been trained to talk to families under these circumstances. When I became a consultant, it was my role to talk to families who’s loved one had died. It can be a very traumatic occasion if the situation had been unexpected. I approach the situation by being completely honest stating the circumstances. Families are tearful and many wail uncontrollably. Some are angry, and the operating surgeon may be the focus of that anger. It is important that families vent these feelings. The Moslem families, in South Africa, exposed to grief are stoical and do not react as other communities. They accept that death is God’s will and is part of life but hidden in their eyes I note that they feel grief as much as anyone else. I stay for a while then leave and offer to be available if there are any further questions. It is a sad fact of life that everyone does die and almost everyone is exposed to grief when friends and family die, but we recover from that grief and life goes on. I used to be terribly analytical of every death trying to determine the cause and whether it could have been prevented. I remember many of the early deaths that I was associated with in my career, but I do not remember the most recent. Time passed has brought the realization that death is part of living and that if one did one’s best, one cannot dwell on the circumstances.

As part of the six-month surgical rotation I spent a few weeks in Urology. Most patients had prostate problems, but there were also patients with kidney stones and kidney cancers. I became proficient in doing cystoscopies where the interior of the bladder is visualized.

There was one patient, Bill, on the floor who had widespread prostate cancer. He was obviously dying and was there solely for palliative care. On rounds the registrar and consultant tended to walk quickly by; they were embarrassed at what to say to the patient. The prevailing attitude amongst many of my medical colleagues and family members was not to tell the patient of a cancer diagnosis. After a few days of this attitude I went to the patient and said, “I am sorry we are not spending much time with you, but you have an incurable disease, prostate cancer and there is not much we can do for you in terms of cure. We are trying to keep you as comfortable as possible.”

The patient said very little. I think all he said was “thank you, Doc.”

The patient died two days later. I did not think much of this fact. His death was expected. I was approached by the family. The patients spouse said: “We are so glad you spoke to Bill. When we saw him last night, he told us what you had said. We have been battling for months how to break the news to him, but could never get around to doing it, it was such an awkward subject. You’re telling him the diagnosis took such a weight off our and Bill’s shoulders. Bill died at peace with the diagnosis. Thank you so much.”

This statement taught me to be honest with my patients. Sharing bad news is part of my job; I do it every day. Patients know the issues and can cope better knowing a diagnosis. I resolved, based on this experience, to tell every patient their diagnosis and have never regretted since doing so.

When I was a registrar doing cardiothoracic surgery, we operated on a patient with lung cancer. Unfortunately, at operation the cancer was too advanced, and his chest was simply closed. Doing rounds later he asked the surgeon, my consultant. “How did the surgery go, Doc?”

The surgeon answered: “Everything that needed to be done was done.” He did not lie to the patient, but he did not tell him what the patient needed to know. At that time, in the 70’s, we did not fall back on chemotherapy and radiation as a means of palliation. The attitude was that these forms of therapy made ‘you die twice.’

I received soon afterwards a phone call from the family of a patient that I had shared the diagnosis of irresectable lung cancer. They said: “what can we do? He’s asking where his gun is. He wants to shoot himself.” I thought to myself. ‘If that is the way the patient deals with his illness, how can I change his attitude? It may not be a bad way to go – it will avoid a potential miserable death.’

My answer however was. “Tell him ‘we know the news is devastating and we are just as upset with the diagnosis as you are, but we will be supportive and deal with issues as they arise. It would be more upsetting to the family if you committed suicide.’” I do not know whether my advice worked, or whether the patient did commit suicide.

While doing the urology rotation I became adept at doing cystoscopies - looking inside the bladder and eventually was doing myself the surveillance cystoscopies, in those who had had bladder cancer. I even did a transurethral and suprapubic prostatectomy under supervision. My consultant tried to get me to go into the specialty of urology, but this was not pursued further,

We had two memorable patients that I remember. One was an elderly man in his 60's who was admitted with a curtain ring wedged at the base of his penis. His penis was swollen and blue and he was in obvious distress. In the operating room we cut the ring with a ring cutter and dressed the ulcerated skin beneath where the ring had lodged. It was obvious what had happened - he was getting sexual gratification from the ring. One would have thought that would be the last time we would see the patient, but he was back a month later. This time he had the casing of a Bic pen lodged in his urethra. When he was asked how it got there, he gave a lame excuse of not being able to urinate, but we all knew the true reason.

Another patient was admitted with painful priapism, persistence of an erection. His was admitted by a fellow registrar who had failed to examine him properly, because he had missed one of the best palpable spleens you could imagine. He had undiagnosed chronic myeloid leukemia, the cause of his priapism. The patient was taken rapidly to the operating room and an anastomosis, made to decompress the penis, between the corpora and saphenous vein