

Justified Decisions

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In these times of a pandemic, worldwide social unrest, recession and record unemployment, current events and the phrases associated with them can be heard in a different context and unexpectedly lead to a deeper understanding of our own life events, in my case 45 years in surgical training and private practice. And in my case, that understanding led to a confirmation of the decisions I made long ago...

Part One

“Have you heard that the surgical rotation final examination is going to be an oral?” my classmate said confidently. “No way,” I challenged, as the other rotations did not have an examination, much less an oral. But he stood his ground and upped the ante, “and there are going to be three examiners.” In the face of such conviction I had to accept his word. But, three, three examiners? There are only two for the board oral examinations and we are just third year medical students at the University of Florida.

“Why does the surgery department have to make everything so melodramatic?” flashed through my mind. It seemed preposterous but my classmates and I were appropriately intimidated.

The next day as I entered the smallish, unimpressive, institutional green examination room, I encountered an unexpected sight. I had drawn the lot of having one of the two most respected, and feared, examiners on my panel. Dr. J., as he was known, the abbreviation for his long and difficult Polish name, was an imposing interrogator. He was the head of the department of Plastic Surgery; a tall, slender, bald man with a fringe of silver hair and rimless glasses, seemingly old before his time.

He had already achieved international acclaim for having reconstructed a cancerous esophagus by harvesting a loop of the patient’s small bowel and meticulously connecting its blood vessels to those of the recipient esophagus, performing an autologous transplant, one of the critical steps on the road to the transplantation of organs between individuals. He would go on to greater achievements and recognition in the course of his illustrious career.

His presence added an additional layer of apprehension. I vainly hoped that our previous history, which included an unexpected social encounter, would serve me in this setting. The occasion had been a barbecue in my hometown hosted by a more senior medical student that allowed us the opportunity to relate on a different plane. There he had been casually dressed, laughing, thoroughly enjoying himself as he devoured his meal in a fashion that only occurs at a barbecue. I had left that encounter with the impression that we shared a mutual appreciation, perhaps even fondness, something that would seem to be confirmed by our interactions in the years to come, but not on this day.

The two other professors started the questioning and I, perhaps even ably, parried their queries. But their names and their questions were but a prelude, lost to my memory.

After the first two doctors completed their portion of the examination, all eyes turned to Dr. J. I stiffened in my seat as his reputation was that of an unmerciful examiner. As I caught the gaze of his pale blue eyes behind those rimless glasses there was no hint of recognition and I realized that a personal connection would play no role. His mission would be to determine my level of knowledge and to impart his wisdom. There would be no sparing the insecurities of a young medical student.

His line of questioning began with the case study of a hypothetical trauma patient in the emergency room. The years have washed away the cause of the injury but the patient was complaining of severe chest wall pain and was in respiratory distress. After leading me through what I felt was a successful back-and-forth regarding the history, physical examination and laboratory studies, he entered the phase of determining the diagnosis and treatment. This too was progressing satisfactorily with my having correctly stated the diagnosis of tension pneumothorax, a fatal complication of a collapsed lung.

I was aware of the treatment but wished to have a definitive examination prior to committing to the insertion of a chest tube. But to my request for a chest x-ray, and to my great consternation, he replied, "The portable x-ray machine is not available." What are the chances of that? It is 1969 and every emergency room has access to a portable x-ray machine and we are in a premier medical center. But it was clearly not my prerogative to question.

As I digested this completely unexpected information, he bore into me, "Your patient is pleading 'I can't breathe.'" With these words, the patient was no longer hypothetical and I had psychologically taken full ownership of my decisions and actions.

Silence prevailed as I pondered whether anyone especially I, a third-year medical student, could create a 2 inch incision in the space between the patient's ribs, dissect through the skin, subcutaneous tissue, intercostal muscle and that transparent membrane, the pleura, and enter the

sanctuary of the chest cavity with its beating heart and the rhythmically expanding and contracting lungs...without x-ray confirmation?

Immediately following the time it took those thoughts to stray through my mind, he broke the silence and flatly pronounced, “Your patient just died.”

Even his fellow inquisitors seemed taken aback by the drama of the moment as I grasped, if only in the abstract, the finality of my patient’s death and the futility of any effort to rectify it.

“You needed to insert a chest tube,” was his final comment and with that I was ushered from the room.

Part Two

“What’s the page about?” my senior resident asked as our team of general surgery residents made evening rounds at Santa Clara Valley Medical Center, the county hospital located in San Jose, California. It was the end of another long day for this seasoned group who had been on this rotation for several months with its endless stream of stab and gunshot wounds, automobile and motorcycle accidents. We were a callous lot who depersonalized our patients by identifying them by their diagnosis or treatment, “the post op spleen in room 403,” rather than their names. And never was there a show of emotion even in the most heartrending situations.

“It’s the ER, they have an automobile accident on the way and the ambulance crew says the patient is unstable,” I replied. I was the in-house resident on call for the evening and no further discussion was necessary. Having been in this situation many times before, we wordlessly headed straight to the emergency room.

Upon arriving we were presented with a twenty something white male who was screaming in pain and complaining “I can’t breathe,” but unusually had no visible bleeding.

In the chaos that always accompanies these situations I heard my chief resident and myself barking orders. The nurses quickly responded and started cutting off the patient’s clothing, drawing blood for analysis and cross matching, and starting an IV to administer fluids, transfusions and medications.

I would be his primary physician and started the physical examination to find that his left chest was unstable, and although difficult to discern because of the patient’s cries, his left chest breath sounds appeared diminished. I reported this to my chief and as I did so his status began to deteriorate at a frightening speed and we appeared to be losing our patient.

Our eyes locked and he shouted, “It’s a tension, put it in.” Full sentences were not necessary as the diagnosis and treatment were clear to both of us. At this point, a local anesthetic would be injected prior to beginning of the procedure but in the urgency of the situation it is unclear if this was done. For decades I have searched the recesses of my mind in the fervent hope of finding a memory labeled ‘Injection of Local Anesthetic,’ but distressingly, it is not to be found.

His shrieks, as I made the incision to insert the chest tube, rent the air and my psyche. Following the completion of the task there was the comforting knowledge that the post insertion chest x-ray revealed the chest tube to be in the correct position, the lung expanded and the heart and major vessels in their appropriate locations.

The patient was stable and, at long last, quiet.

He was transferred to the thoracic surgery service and placed in the ICU. But as I was the in-house resident he was still my charge. And he continued to demand my attention as the drainage from his chest tube was bright red and his blood count continued to fall by the hour. A decision had to be made. It was now the early morning hours and the thoracic surgery Fellow, a sixth year resident, announced that he was going to perform an exploratory thoracotomy to locate the origin of the bleeding.

I, as was my role, would assist or so I thought. We all competed fiercely for the opportunity to do a case, any case, and then would casually mention it to our fellow residents as if it were of no import, always mentioning the speed with which it was performed to further substantiate our claim to competency. After the induction of general anesthesia and the positioning of the patient, this very pleasant, soft spoken Fellow with whom I had only a passing acquaintance, turned to me, only a third-year resident, and asked without irony, “Would you like to do the case?” The offer seemed incomprehensible, as if he were speaking in a foreign tongue.

“Yes,” was all I could muster to this inconceivable opportunity to perform a procedure that involved the cleaving in half of the human torso at the level of the chest.

The senior surgeon can assume one of two different roles in this scenario. One is the vocal, hectoring critic; the other a calm, encouraging mentor.

Fortunately, this Fellow was the latter and also a very trusting man. Suddenly I was no longer tired, but elated, unable to believe my good fortune. Although we were never able to identify any significant bleeder, the procedure went smoothly and as we closed there was no evidence of persistent hemorrhage.

The patient’s chest tube drainage steadily cleared and his blood count stabilized and I had a new red badge.

I basked in the knowledge that I had done a thoracotomy and as the days passed, the patient recovered uneventfully.

On the day of the patient's discharge, our team rounded on him one final time.

By this time it had become apparent that he had no recall of the agonizing experience in the emergency room and knew me only as the surgeon who had performed his procedure. During the course of the visit, the young blond male now buoyant in the news of his impending discharge, glanced my way and sincerely pronounced, "Thanks Doc, you saved my life."

Suddenly a welter of emotion overcame me and I quickly averted my eyes to avoid detection of the glint of moisture. As I tried to discern the different forces roiling my mind, I found that I was truly touched by the sentiment and more than a little proud, but the over arching emotion was one of guilt.

Part Three

Later, during that same residency year, I rotated back to Stanford University Medical Center, our home base located on the campus of the university. My role was general surgery resident in charge of the emergency room. This assignment was unusual in that we did not have a more senior house officer supervising us and we were the final word in our small corner of the world.

I alternated with another resident, 24 hours on, 24 hours off, and the most stressful part of those shifts was the dreaded 'closing time.' It was then that the alcohol or drug fueled argument was most likely to ignite, the flash of a knife or the glint of a gun most likely to appear. And the drive home the most perilous.

It was at this time of night that a call came in notifying us that an automobile and an immovable object had met with a violent impact. The expectations were for the worst, and forewarned, we prepared the large examination room where resuscitations were carried out for our new arrival. It was here that so many 'flat liners' entered only to leave for the somber journey to the morgue.

But this young man was not a 'flat liner.' He was alert, clutching his chest and loudly announcing "I can't breathe." Orders were called out and the frantic dance of the ER began.

I found evidence of rib fractures and futilely begged him to be quiet for a moment so I could listen to his lungs. Decreased breath sounds were detected and for the moment his vital signs were stable and a chest x-ray was ordered.

The call for “x-ray technician to the emergency room stat” reverberated throughout the quiet hospital. No response. I questioned the identity of the technician and, regretfully, learned it was someone with whom I had previously had a testy encounter due to her surly attitude and sluggish response. I feared the worst but consoled myself with the thought that it was inconceivable that she would ignore a stat call to the emergency room.

A second stat call, with even more urgency in the voice of the announcer, was broadcast as I prepared the chest tube tray and injected the local anesthetic in the chest wall as my patient now began to show signs and symptoms of a tension pneumothorax.

As the final call went out, I began the procedure with the full realization that there was no professor to advise me, no chief resident to command me; the decision was mine and mine alone. I could have reflected on the irony that I had been unable to obtain an x-ray in the emergency room of one of the finest medical institutions in the world, but I did not.

Containing my fury at her abandonment of duty and bolstered by my previous experiences, I completed the task without the confirming evidence of a chest x-ray. After the placement of the chest tube, the patient’s shouts begin to subside and his respiratory and cardiac status stabilized. He was transferred to the surgical ICU.

I fully realized that my actions could be questioned without a baseline x-ray to document the pathology.

A few days later my suspicions were realized when another junior resident, who was now caring for the patient, nonchalantly drifted by the ER during my shift to inform me that his chief resident was questioning my actions.

In part because I had previously worked with this chief resident, in part because I was livid with the x-ray technician, and in part because I had developed a disdain for the second-guessing of those who labor in the bright light and tumult of the arena, I responded more forcefully than was my habit.

“Were you there? Did you know the x-ray technician ignored three stat pages? It was a decision that had to be made in the moment with the best information available!” Not done, I added “Are there any complications from the chest tube? Is the patient improving? Does your chief want to talk to me in person? I’ll be happy to.”

Speechless, my colleague offered no further questions and as I waited not a word was heard from his chief or anyone else.

The patient thrived and I felt the soothing sensation of vindication.

Conclusion

More than four decades have passed and in my latter years I have found that I occasionally awaken in the quiet hours of the night and find a mental clarity that eludes me in the rush of day. And recent events that include the tragic repetition of the phrase “I can’t breathe” have prompted me during these sleepless episodes to connect these three pivotal events in my surgical education for the first time.

And having made that connection, view them with a new insight and a renewed thankfulness for a professor who made me so uncomfortable and a resident who spurred me into action as both tormentor and lifesaver. They prepared me for that moment when that very situation arose once again and the responsibility weighed solely on my shoulders. As I lie there, if those breathless cries echo in the night, they are now reconciled. And if those distant voices question, they no longer threaten.

As my mind wanders back to the endless news cycle, I consider those whose professions also require them to make life and death decisions, such as the law enforcement officer who must decide “Is that a cell phone or a gun” in the hand of a fleeing suspect. And who, in an instant, must make the weighty decision as to the justification and requirement of deadly force.

And as for all my fellow travelers thrust into that crucible, I pray that in the twilight of their lives, they can breathe easy with their decisions.