

A DAY IN THE LIFE OF A SURGEON

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By: Dr. Jack D. Amis

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Six-thirty a.m.: The alarm goes off - you have been expecting it. When you awakened forty-five minutes earlier, thoughts were already racing through your mind - they hadn't called from the Intensive Care Unit to let you know about the last hematocrit on the GI bleeder admitted late last night. There is uncertainty as to whether or not she will have to be inserted into the already overloaded operating schedule this morning. Mechanically, you roll over and dial the hospital. After three rings, the unique inflection of Millie on the switchboard responds:

"Good morning, Jennie Stuart Hospital."

"Dr. Freund. Intensive Care, please."

Two rings and Ernestine Clouse, R.N., responds.

"Did you get the hematocrit on my GI bleeder?"

"It was thirty-two, doctor," she responds. "It was the same before the last pint of blood; we have been irrigating her and she keeps coming back pink."

"Tell them to set up four more units of blood right away and I will be there." The phone goes on the hook and your feet hit the floor.

The quick prep has become a routine. "Honey, I have got to go" is mouthed while the teeth are being brushed. The Norelco does the shave in no time and is followed by a quick shower. The Bran Buds your wife hands you are soft and can almost be drunk. She protests; that you must drink the orange juice as you go out the door.

You are reminded of the blessings of our technologic age as the automatic garage door opener responds to the push of a button.

The tape player comes on with the ignition and you get four minutes of Audio-Digest Surgery - this time on two stage procedures for perforations of the colon - on the way to the hospital.

Again, the magic response as the gate to the doctor's parking lot yield to your magnetic tape card and you wheel into a parking slot nearest Phase II. Entering the Emergency Entrance, you are greeted by the cheery hello of the clerk at the outpatient pay desk.

There is an accident in the Major Trauma room and you sidestep to let the x-ray tech by as he pushes the heavy portable x-ray machine. People are busy and only one nurse recognizes you with her eyes as you walk briskly by.

You enter the operating room suite by passing through the doctor's dressing room. The assistant head nurse and a few of the operating room personnel who arrive early are just beginning their tasks. A glance at the operating schedule shows that today is going to be one of those days. There were eighteen cases on the schedule last night and there have been three add-ons already - a hot gallbladder, an elderly hip fracture and a post-partum tubal ligation. You and your partner, John Foster, have three majors and a minor. He will be doing an outpatient ganglion excision under axillary block at 7:30 in room 9. Billometto has a colon resection at 7:30 and you and John follow him in room 2 with a highly suspicious breast lump, a routine gallbladder and a thyroid. It will be ten at the earliest before you can start your first major and you have the GI bleeder who has continued to ooze. You tell the assistant head nurse that you probably will be inserting a stomach into the

schedule and head to the Intensive Care Unit.

This time of the morning, the ICU is relatively quiet. The day crew is just beginning to show up and are putting away coats and purses. One aid is depositing a lunch in one of the refrigerators.

"Good morning, doctor" comes from the familiar voice of Ernestine Clouse. Clouse is a good, tough nurse - she is what you call a "nursey nurse" - not too interested in all the sociologic nonsense going on in nursing, but very committed to patient care - temper that is hair triggered, but the kind of nurse that will stay with you all night, if necessary, to get someone out of the woods.

"How is she doing?" Although you have three other patients in the ICU, Clouse knows who "she" is. "She" is the one that is not under control. The others have passed their crisis times and are now on the "downhill slide" to recovery.

"I am not happy, Dr. Freund," confides Clouse. "I have been irrigating her off and on since she came in and although she lightens up some, the nasogastric return is always pink."

"We have got to get her scoped right away" you respond. A quick flip through the chart reviews the problem. A seventy-two year old white female referred by Dr. Rosenbaum from Cadiz with relatively sudden onset of weakness accompanying a large black bowel movement. She had to call for help getting off the commode. She had been initially admitted to the hospital at Cadiz, but was transferred quickly when she was found to have persistent upper gastrointestinal bleeding. Past history of ulcer type symptoms, but no upper GI x-rays in the past. She had her

gallbladder out in 1947 - too far back to get anything of value from reviewing the microfilmed record. Her EKG has been done, but has not been read by one of the internists. The gross pattern looks normal. Admission chest x-ray shows minor evidence of old healed granulomatous disease and a little uncoiling of the thoracic aorta, but no evidence of acute disease. Blood sugar, BUN and electrolytes, as well as bleeding and clotting studies on admission, have been called back to the floor and are handwritten on a piece of note paper taped to the front of the chart - they are normal.

The problem is bleeding. When she came into the hospital at Cadiz, her hematocrit (the percentage of her blood comprised by red blood cells) was 42 percent - normal for her. This cannot be trusted because, with a sudden hemorrhage, the blood volume contracts and the percentage of blood cells remains the same until the homeostatic mechanisms have time to move fluid from the tissues into the vascular compartment. One unit of blood had been hung in Cadiz and was infusing during the ambulance trip here. In the emergency room, Mrs. Smith had appeared a little pale with a slightly increased pulse rate, but her blood pressure was not significantly depressed. Her hematocrit, however, had dropped to 38 percent and she had pink tinged fluid that would not clear with irrigation coming from her nasogastric tube. She had had a subclavian catheter inserted in the large vein beneath her left collarbone through which blood and fluids could be rapidly infused and as important through which the venous pressure could be measured to accurately adjust the volume load administered. History on

admission revealed that she had been a long time user of analgesics, especially aspirin containing medications for chronic arthritic discomfort. She had been having some discomfort in her upper abdomen lately, and on two or three occasions during the past month, had noted very dark stools. She had been admitted to the Intensive Care Unit on ice water lavage through the nasogastric tube, antacids, mild sedation and Tagamet, a new drug that inhibits acid production by the stomach. She had been given a second unit of blood right after admission followed by a hematocrit that revealed the unhappy finding of pack cell volume of only 32 percent which had only been maintained by the third unit of blood evidencing progressive blood loss.

You dial an outside number. "Have Dr. Luan Lia call me at 321, please," you request the answering service. About two minutes later, the 321 button lights up on the telephone and you pick up the receiver as it rings the first time.

"Luan, I have a seventy-two year old white female with upper GI bleeding that is persistent." You tell him the story - "I don't think she is going to quit - I need a gastroscopy."

Luan has problems of his own. It is now 7:00 and at 7:30 he starts his own schedule of cases in endoscopy, but he does what you expect - he will make arrangements for the endoscopy nurse to bring the equipment to the ICU and he will be there as soon as he can.

Twenty minutes later, after explaining the problem to Mrs. Smith and her family, the patient is lying on her left side and Dr. Lia is inserting the long black flexible gastroscope the diameter of one's index finger down her esophagus into the stomach.

Bleeders are a problem because the blood keeps obscuring the view. Luan frets and shifts his body about as he maneuvers the snake-like instrument the twenty inches down to her stomach. He mutters with his Tiwanese accent that her esophagus is clear. The stomach is another matter. Accumulated blood requires twenty minutes of brisk lavaging and aspiration. Finally, he is able to visualize some evidence of gastritis with two small shallow ulcerations in the antrum. The main problem, however, is a penetrating ulcer in the posterior wall of the duodenal bulb with a small spirting artery in its' base.

"This one means business," he retorts, "I doubt it will quit."

By this time, Mrs. Smith is on her fourth bottle of blood and her hematocrit is still low. She is elderly and both of you know that old people do not tolerate exsanguinating hemorrhage well.

"Dang!"

You are in a mess already today. The patient is advised of the problem and the need for surgery and a little later a conference is held with the family. They are advised that Mrs. Smith can be inserted into the schedule and operated upon about 10:00.

A call to the operating room sets up the new schedule. Fortunately, no one is following you, so you won't be holding anyone else up. Your associate, John, by this time, is in the operating room doing the axillary block and will be tied up for the next hour. Appropriate orders and a progress note is made on the chart and an informed consent form discussed with the patient prior to her signing it. Another unit of blood is ordered for

Mrs. Smith.

The charts of the other three ICU patients are quickly evaluated. The rounds in the ICU do not take long this morning. Everyone is doing well.

On the way back to the older part of the hospital, you drop by x-ray to get the official reading on the thyroid sonogram that was done the day before. The cold nodule was evident on the radioactive scan, but it is important to know if the lesion is cystic or solid which can be determined by sonography. It is solid and therefore it needs to come out - maybe cancer. You hurry on to 2-South.

The nurses and aids are busy taking a report and hardly notice that you have come to the station. You spin the chart rack and pull out your charts. You interrupt their reverie to check on two or three things while running your charts. One of them peels off to make rounds with you. Only two patients on 2-South and they are post-op and progressing well. On to 3-North. 3-North is the pediatric floor. You have a post-operative inguinal hernia on a three year old done yesterday. The parents are pleased he has been up and running around. He goes home today.

The eight year old in 318, however, came in two days ago with a ruptured appendix and is still sick. His mother hovers close to the bed and his father is courteous, but appears anxious. Bobby still has a tube in his nose and some fever and has not yet passed gas. You reassure them, knowing that the overwhelming odds are that he will do fine, thanks to the massive peritoneal lavage done at surgery and the potent antibiotics being given.

3-G is the tough floor - adult surgical - seven patients and the nurse advised you that Mr. Witherspoon, the sixty-eight year old man with colon cancer on the schedule for Friday has just been admitted. He has orders with him so won't be a problem until evening. Charts again are plucked from the rotary rack placed between the nurses station and the doctors cubicle. Most are no problem - patients in various stages of convalescence. Most have been in the hospital only a few days. The average stay for surgical patients now is less than a week. Problems are:

(1) a thirty-six year old diabetic black female who has sloughed most of the top of a foot from a florid infection and (2) a post-operative colon who is slow about passing gas and "turning the corner." No big thing. Rounds take a little longer than you intended because one patient is upset and needs special attention.

Back to the operating room. It is 9:50. John has finished the ganglion and has done a consult for one of the internists on 2-East - a eighty-nine year old nursing home resident with bowel obstruction. The patient has not recognized any of her family for three months and has had to be forced fed. They decide that she should not have surgery.

As you get a cup of coffee in the operating room lounge, you are advised that Mrs. Smith has been brought to the operating room. Her blood pressure is okay, but she still has the blood in the nasogastric tube. You talk with her and have a prayer.

10:30 and room 2 is yours. George Price, certified registered nurse anesthetist and the operating room crew transfer your patient to the table. They start transfusion #5. People move about the

room swiftly, but quietly while George affixes his monitoring equipment and prepares for induction.

Anesthesia induction is similar to taking off in an airplane. It is the critical time when physiologic and pharmacologic changes are swift and everyone is quiet while George deftly goes through his motions. In less than two minutes, the patient is quietly asleep with George regularly controlling her breathing by way of an endotracheal tube. The cardiac monitor reassures us that all is well.

The circulating nurse dons gloves and cleanses the abdomen with Betadine. The scrub nurse has neatly arranged her instruments on the Mayo and back tables and is ready. You and John are scrubbed and gowned. The patient is draped. Suction and the bovie electrosurgical unit are hooked up and you are ready to go.

"Ready, Mr. Price?"

"Ready, doctor."

The number 10 Bard-Parker blade makes a deep thin line from the xyphoid process of the sternum to the umbilicus. John quickly stops the small bleeders with the electrosurgical "bovie." The midline fascia is incised and in two minutes after you start, you are inside.

Your hand explores the abdomen. In order the organs are felt - liver, gallbladder, bile duct, esophageal hiatus, stomach, tight and filled with blood, duodenum - you look at the duodenum as it is being felt. No scars are evident on the frontside, but there is some thickening you can feel on the backside at the site of the ulcer. The whole duodenum and small bowel are purple and distended with blood. The remainder of the abdomen is explored

and found to be otherwise normal.

The stomach is opened between Babcock clamps and we immediately encounter blood - clots, dark blood, red blood - this is evacuated initially by the handfuls and then with suction. It was all coming from the duodenal bulb ulcer which, at this time, is not bleeding. It is funny about duodenal ulcer bleeding. It almost always stops when you operate. It starts again when the patient wakes up if you don't attend to the problem.

The stomach is temporarily closed with Alice clamps and the procedure is continued. It is far easier working with another surgeon than with a lesser trained assistant. John does the maneuvers done best from his side of the table with no loss of time. The greater omentum is taken off the greater curve of the stomach between hemostats and the stumps are tied with 2-0 tevdec ligatures. The gastro-hepatic omentum between the stomach and the liver is divided. With the stomach stretched downward, the vagus nerves that follow the esophagus to the stomach are made taut. The overlying peritoneum is divided and the vagi and sectioned between stainless steel clips.

The dissection around the duodenum is much more difficult. Multiple vital structures are tightly adherent to each other and have to be tediously separated using hemostats, clamping, and tying numerous small bleeders. After twenty minutes of tedious dissection, the duodenal bulb comes free of the head of the pancreas, leaving a hole in the back wall of the duodenum where the ulcer had eroded through. The gastroduodenal artery that caused the hemorrhage suddenly bursts loose and blood splatters

on your mask. It is quickly secured by John's hemostat and ligated with 2-0 chromic catgut.

Now one of the modern wonders is handed to you by the scrub nurse - a TA 30 stapling device invented by the Russians, but perfected by the U.S. Surgical Corporation. It closes the stump of the duodenum in a few seconds with a secure closure that formerly took half an hour to do by hand. The cut edge of the staple line is run with a 4-0 chromic catgut suture to prevent oozing of blood.

You draw the stomach and the attached duodenal bulb with its' ulcer crater downward while John places a larger version stapler across the middle of the stomach, fires it and divides the stomach below the stapler with a scalpel. Again, a fine running chromic suture line is placed on the cut edge to prevent bleeding. A third stapling device is used to make an opening between the stomach pouch and the upper small bowel to reconstitute the continuity of the gastrointestinal tract. This staple line is buttressed circumferentially with 3-0 silk sutures. The abdominal cavity is lavaged with saline to clean out bits of debris and the peritoneum is run with a 0-chromic catgut suture and the abdominal fascia is closed with a row of sutures made of dacron impregnated with teflon. The skin edges are approximated with stainless steel staples.

"How is she, George," you ask.

"Steady as she goes," he replies.

The graphs he has drawn on the complex anesthesia record look good. The monitor on the rack above the anesthesia machine continues to produce a stable EKG tracing and the friendly beep of the pulse

monitor is steady and in the normal range.

"Estimated blood loss?"

"Approximately 400 cc's not counting that aspirated from the stomach."

"Final sponge and instrument count correct," announces the sponge nurse.

A see-through plastic dressing is applied to the incision.

As you retrieve the patient's chart and leave the room, the patient is transferred to a cart and transported to recovery.

The family responds to the patient's name and gather in the small conference room adjoining the operating room waiting room. They are relieved that she did well and that the bleeding is controlled.

It is after noon and your three regular cases have not started. Mrs. Williams is being prepped for breast surgery in the holding area. You speak to her as you go by. The operating room dictation requires a detailed description of the findings and the operative technique, but is done at flank speed because much of it is common to operations of the type. Entry is made in the progress notes on the chart, orders are written and the pathology request card is completed.

As you pass by the glass enclosed control desk, one of the operating room secretaries pecks on the glass and holds a little slip of paper with your name on it. You go around and retrieve it - a call from a post-operative radical mastectomy patient who has a funny sensation in her arm. A phone call reveals that she did not remember that you told her before surgery that she would have an area of numbness on the inside of her arm.

She remembers, seems relieved and apologizes for panicking.

You have a cup of coffee while John does the breast biopsy on Mrs. Williams. The biopsy is positive for malignancy. You can always tell by the quiet way the pathologist walks into the room. "John, you have an infiltrating ductal carcinoma with some inflammation around it - I am sorry, buddy."

So are you, particularly for the patient. While John is closing the wound over a sponge soaked in formalin to destroy the tumor cells, you go out to the waiting room to advise the family that the lesion is malignant and that the patient will require mastectomy.

The patient is totally re-prepared for surgery and new gowns, gloves, instruments and drapes are used. John and you both do a lot of dissection on a radical mastectomy. Ninety minutes later, you are putting in the skin staples for John while he leaves to do the dictation and the chart work. He is late for the office, so you go to speak to the family.

The anxiety of the family is obvious as they gather quietly in the small conference room. They want to know if you got it all. You advise them that you won't know the extent of the lymphnode involvement until the pathology report comes back tomorrow, but that the patient tolerated the procedure well and will probably be out of recovery in an hour or so. They are relieved about the procedure, but are worried about the long term prospects. You reassure them that the pre-operative studies showed no evidence of metastatic disease. You feel reasonably hopeful for the patient and transmit this to the family. They take a little

comfort from this.

The schedule is way behind. While the room is being prepared, you slip over to the coffee shop for a quick lunch. On returning, everyone is impatiently waiting. The anesthesia cannot be induced until after a brief prayer with the patient. The Pentothal is being injected by the time you get to the door to scrub. There won't be a fully trained surgeon assisting now. It will go well, but will be slower.

The patient is already draped by the time you get back. Everything is ready and the right subcostal incision is swiftly made. You reflect on how you couldn't get the blade to go all the way through the skin the first time you tried as a resident. The exploration of the abdomen is the same. As you begin to pack off the bowel and expose the gallbladder, your beeper goes off requesting you to call Dr. Blackford. You hit the button on your beeper with your elbow to cut it off and the nurse requests through the intercom that the secretary call Dr. Blackford.

Gallbladders are fun. They are tricky, but after the twelve hundredth they are old friends, well understood and yield to your advance. The nurse does not have the right angle clamps on her Mayo - why doesn't she have the right angle clamps on her Mayo? We always use right angle clamps on gallbladders - was the instrument card used as is regulation in the instrument room? The operating room supervisor responds to the call on the intercom. "Yes, doctor, I know you have had this problem several times before. I am trying to get these young people to

always use the instrument card, but they sometimes don't do as they are suppose to."

You remind her that there is no excuse for the maintenance man who fails to fill the fuel tanks on the transoceanic jet. You cool down. The smooth progress resumes as the freshly flashed right angles appear from the autoclave. The operative cholangiograms take only a moment as contrast material is injected through the stump of the cystic duct into the main biliary system and x-rays are made. During the brief interval while the films are being developed and read in the x-ray department, the gallbladder bed is oversewn. A needle biopsy of the liver is obtained and the appendix is removed. The films are normal and closure is routine as is the post-operative ritual.

Dr. Blackford has a child with an acute appendix waiting to be seen in the emergency room. You call ^{him} Niven and he gives you the particulars. You quickly speak to Mrs. Gorman who is ^{your thyroid patient} in the holding area and apologize that she has had to wait so long. They have told her about the bleeder and she understands. You take off your scrub cap and shoes and don a white coat and head for the emergency room. The seven year old boy is sick. He has had symptoms since supertime yesterday and although he doesn't have signs of rupture, you are concerned because time is running out. You have the nurse call in the admission, rapidly dictate the history and physical with the mother listening to correct any errors, call the operating room to let them know the appendix will follow the thyroid and spend five minutes explaining the informed consent to the parents. They sign.

Mrs. Gorman is asleep when you get back to the operating room.

They are prepping her neck. You scrub. The thyroid is routine. Dr. Christopher, the pathologist, has been kind enough to stay until you get the lobe out. It is a benign adenoma without evidence of malignancy.

The crew has decided to use the next room for the appendix so there will be no delay between cases. You are rushed to get the paper work done by the time the child is asleep. The appendix is hot, but not ruptured, everything will be fine.

You look at the clock - 8:00 p.m. Another Athenaeum missed. You suddenly realize you are tired. You go with the patient to the recovery room and sit with your feet propped up on the desk while you dictate the record. One of the girls gets you a cup of coffee. George Price is tired, too. He advises you that he has just checked on the thyroid and she is doing fine.

It is your day at the hospital. The doctor who has the office goes home. It is a long road yet to go this evening, but you do not envy John because you know he has the same problems while you are at home. Rounds in the ICU don't take long - everyone is doing all right. The x-rays from the day must be viewed and this is done on the way to the older part of the hospital. One set of mammograms bother you and you put them back to discuss with the radiologist tomorrow. 2-South doesn't take long. There is only Bobby in 318 on 3rd North. He is unchanged from the morning. Mr. Rogers with the colon cancer will require a complete history and physical so you put him off until last. Three of the 3-G patients are today's post-ops and are doing satisfactorily. The remainder of the rounds is routine. Mr. Rogers takes an hour to evaluate. His general

medical problems are under good control and he is on his bowel prep for colon resection on Friday.

Finally at 10:30, you get home. Your wife has faithfully put your supper in the oven. The family is just going to bed and kiss you goodnight. Your wife gives you the news of the day as you scan the New Era over supper. The mail is stacked in your study, but you won't look at it tonight. At 11:15, you retire.

2:30 a.m., the phone rings.

"Dr. Freund, this is the emergency room. We have just gotten a gunshot wound of the abdomen."