Medical School, Part II

by Carl Nelson (May 2025)

A Hospital Ward during the Chief Physician's Round (Luis Jiménez Aranda, 1928)

As mentioned, I've often joked that I saved more lives by quitting medicine than a lot of doctors have by continuing. Following Covid-19 this might have become more true than not. At the time, I took the strict moral ethos of the medical profession very seriously. But after the Covid experience, in which medical institutions and doctors were unwilling to treat patients who had not been vaccinated, this shattered their persona of virtue for me. Before then, I'd always had a lingering guilt for quitting medicine—as if I had reneged on a moral obligation, even if it promised better outcomes for both parties. But nowadays, after the harsh light of human nature

has shown on the medical profession, I feel more reasonable, like I just quit a job which I wasn't suited for. Just like any other career move.

The Surgical rotation was a bit like war, moments of fright interlarded with vast stretches of boredom. When something went south, it had to be addressed immediately, but most procedures were repetitive and routine. And holding the body wall (fat, mostly) retractors while standing still for seeming eons was tough duty. Young surgical wannabees should practice by holding a spare bobbin or bolt of cloth, while their moms assemble a shirt on the sewing machine from a pattern cut-out.

Open-heart surgery at the time involved cracking the chest wall and isolating the beating heart from its blood flow. Things needed to move quickly as the longer the patient was on "coronary bypass" the worse chances for a reasonable outcome. Post surgical treatment in the coronary care unit made for some crazy looking eyes in the skulls of these intubated insomniacs. The fluorescent lights glowed 24/7, the machines wheezed and beeped constantly, nurses moved in and out, doctors came and went, groups on rounds gathered 'round, moving from bed to bed. Urine output was examined. Patient responses and wound drainage were noted. The intubated didn't say much. Their charts hung on the foot of the bed like toe tags.

Too long a time on the surgical table can lead to such cellular damage that the patient can begin oozing from the capillaries. This can be difficult to staunch. Often, when they begin to fail, they might be taken back into surgery on the hope that perhaps a 'bleeder' was missed. Platelets can be given, but it can be like rolling down a steep hill after the brakes have faded. I worked up one such case on the wards the night before surgery. She was a nine or ten year old girl with a congenital heart defect. Her lips and fingers were a shade of blue. As I got to know her, her mother was there watching. The resident had told me that though these patients looked

generally stable, their demise into the inevitable heart failure was not pleasant to witness, and that it was best to correct the defect before the general health was too impaired. So that’s what was to be done.

Post surgically, she began to ooze. I believe they opened her up twice (but maybe it just seemed so), hoping to find a bleeder. She died on the table. Leaving the surgical suite I must have taken too long and missed the other doctors and took the wrong exit. They had all gone one way, and I went the other, walking right out into the waiting room of the poor waiting mother. So I had to blurt the bad news. She was just a wall of tears. I’ve never thought these things affected me much, as I don’t respond much emotionally. But the fact that the memory has stuck with me over fifty years must mean something.

Internal medicine can be like archeologists pouring over unearthed hieroglyphics. The writings are compared with other unearthed specimens, papers are reviewed, all of the recent literature is discussed, arcane analysis is undertaken. It all takes a long time with lots of tests and revisited thinking. The patients’ beds are huddled around. Surgery happens much more quickly. The operation generally is a success and the patient heals enough to be discharged—or they go downhill fast, and are gurneyed off to the cooler with no more word than a squeaking wheel. It can stress the system when those getting worse won’t die when they are supposed to. They hang around like a ghost, (who can’t die either), of some loathsome event, embarrassing everyone.

I remember standing on rounds while one older surgical patient was discussed who had been hanging on for over a month. We were discussing the matter out in the hall, but I could see the patient lying on his bed in profile, as we did so. With an iron grey handle-bar moustache, a yellow cast, and a cadaverous aspect, he resembled one of those loggers resting in the notch of a huge tree with a crowd of others in a vintage early 20th century photo.

What was being discussed was whether or not the patient should be "coded." "We've tried everything, and frankly we're at the bottom of our bag of our tricks," the head resident initiated the discussion. The attending nodded. But as the intern next agreed and we continued around the assembled group, the head nurse wasn't agreeable and began tearing up as she made her plea. She was a comely blonde with a withered right arm.

"We've all put our hearts into this fellow's recovery. The whole staff has really gone to the wall over this, and it will just be devastating to have us give up now."

When patients are deemed terminal, it's generally seen as the most caring to not resuscitate the person if they have a heart attack—as this is seen as the their easiest way to go. They are not "coded."

As we all shared out opinions, the doctors reluctantly sided with the Head Resident while the staff supported the nurse.

Finally, it came down to me, the lowly medical student.

I stole another look at the patient. Though he seemingly had drains and tubes coming from every orifice and IVs to squander, he didn't appear intubated.

"Can he speak?" I asked.

The Resident nodded.

"Could we just ask him?" I hesitated.

It was decided they would do just that.

The next day the Head Resident reported on rounds that he had had just that sort of conversation. He appeared quite moved. He said that the fellow was very ardent that he "wants to fight."

And the next day, he died.

The take away I got from this is that we all want some say over what is done for or to us. We want our agency—and we're willing to postpone dying to get it.

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One of my externships in Family Medicine was in Kodiak, Alaska. Hypothermia was one of the most common emergent afflictions as fishermen wobbled home late at night from the bars and fell off the icy wharf into the saltwater or down the hatch into a hold of fish. They were rolled in from the aid car hypothermic, smelling of fish, or also puking out all orifices (as seawater is an emetic and a cathartic). What a mess!

When there was an emergency, residents would lift from their pillows to hear the Coast Guard helicopter thumping past overhead and know that likely some fishing vessel was in trouble. A night I was not on call, there was a diabetic

emergency on a freighter passing and the other medical personnel (and intern, I believe) left Kodiak harbor on a Foss tug and plowed through fifty foot waves to administer medication by passing the properly prepared instruments by line between vessels in the night. Wheeeee!

They also came in, pulled from the sea by helicopter. The waters around Kodiak are sprinkled with treacherous rocky outcroppings and winter storms are frequent. One evening a fishing boat captain had been plucked clinging to the side of a rocky bluff some miles north of town. It was believed he had headed his boat back out of the harbor, alerted to imminent arrest by the fishery police, in order to dump an illegal catch and had capsized a few miles north in heavy seas.

The capsized fishing boat captain was the only survivor. There had been two of them who had made land, clinging to a cliff side for several hours. Eventually, the second had said that he couldn’t hold on any longer, let go and fell back into the surf. When finally plucked off the cliffside our captain presented with what was deemed the second lowest core body temperature (of those who survived) ever recorded. First place had gone to a drunken woman found frozen in snow on a wintry park bench in Chicago.

Our handling physician was a romantic lover of chaos. He was a Columbia educated Internist with a big ego and an apparently strong skill set. He thrived on the delicate business of defrosting these fragile cases. The big problem was cardiac arrhythmias due to electrolyte imbalances and conduction abnormalities due to temperature changes. One had to maintain an electrolyte balance to achieve a steady cardiac rhythm while warming. Warming the extremities too quickly could draw away warming blood from the interior and send them into fibrillation. The Doc placed him in a cold water bath and monitored his warming all night. He survived—with all of his fingers and toes even.

This doc had been a collegiate wrestler who was currently fairly hefty. I had the impression that he dominated the medical community there both intellectually and physically, like an eagle from his remote aerie. (He allegedly shared a solitaire (cliffside?) home with his beautiful wife and spoiled child.) He and I had reservations about each other. He didn't like the fact that I was staying at the home of one of the nurses (a struggling single mother), who I'd met in the bar my first night or so there. "She keeps living with these medical students who come here and then leave. Time and again." He shook his head towards the outside as he slowed. "What say you and me walk out into that field there and wrestle?"

Kodiak received a fresh snowfall about two times a week winters, it seemed. Everything looked pristine. Then during a thaw, all of the trash, junk, children's toys and dog poop appeared. I made the mistake of turning my faucet all of the way off (a natural mainland habit) when I was gone and the pipes froze. I had also been given the keys to a pick-up truck for transportation along with the apartment unit.

One evening the roads were especially icy and heading up a steep incline several blocks long I stopped moving forward and started sliding backwards about halfway up. As I began gaining speed, to complicate matters another car had appeared coming down the hill towards me. By turning the wheel and using the brakes I was able to do a 180 while sliding backwards, so that when the car passed me we were both still sliding but headed downhill and glancing at each other. It was some serendipitous choreography, I'd thought. Once I had cleared bottom and drove up the other side, I turned the truck around, made a better run at it, and made my destination.

If you watch TV, you'll often see people fall from heights, or get beaten up and punched in the head repeatedly. Then they hurt a bit and pop right back, but this isn't real. More often than not there are sequelae and disabilities. One night while

on call, a young woman came in with a rifle shot to her calf. Apparently she had been living with a drug dealer who had pissed someone off, who then shot up their trailer from the ridgeside with a high power rifle. The idea that when the bullet passes right through, you just put a patch on either side, crunch some antibiotics and you'll be fine wasn't the way it worked in the surgical suite where I found myself. I watched, rather horrified, as the surgeon carved away (debrided) more and more of the calf muscle to eliminate the chance of necrosis. You could have passed a baseball through the hole when he was done, excepting for the nerve bundle which luckily was left intact, but hanging in the air there like a white telephone wire. She was a very attractive and friendly woman, but a bit rainbow-headed. I didn't think she fully realized the extent of her coming disability and was enjoying the change of venue and well-wishers during her recovery on the ward.

(to be continued in Part 3)

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Carl Nelson's latest book of poetry titled, *Strays, Misfits, Renegades, and Maverick Poems (with additional Verses on Monetizations)*, has just been published. To have a look at this and more of his work please visit Magic Bean Books.

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