



Surgical lifestyles

My last stitch

A surgeon must have
The eye of a[n] eagle
The heart of a lion
And the hand of a lady

—*Jessie Ternberg, MD**

I believe every real surgeon is like me. That surgeon wonders all his or her life how it will feel—how he or she will act—when putting in that final stitch and leaving the operating room (OR) for the last time, never to return. After all, surgery for us is an amazing love affair, and our nature cries out for its magnificent obsession. It is a glorious addiction. But addiction, we all know, can breed withdrawal. We have seen our respective forebears preternaturally gray, thrombose good coronaries, and even put an end to themselves, all right after they retire. The worst of these retirees are lounge lizards, dour presences sipping coffee every day in the doctors' room, talking nonsense about the bad old days over outdated newspapers. I swore this was not going to happen to me.

There are only two ways to do this retirement thing. You either cut back on your practice, or you choose a date and you quit. I didn't believe there was such a thing as cutting back on practice. How does one do that anyway? Just care for the patients one wants to and avoid the rest? The late, great chairman Victor Richards, MD, said either a person is or is not in the practice of surgery—there is no in-between. It's really that simple.

So, at age 72, after 40 years in a big, tough, liability-ridden metropolis, I gave six months until retirement and gave everyone the date I'd chosen. On June 15, 1998, I would put in my last stitch and walk away. There would not be a bang, nary a whimper, and that way I wouldn't have to orient a

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whole new batch of residents—all fresh and new as if acute appendicitis was just happening for the first time—who would be coming on service July 1.

The “last” day

June 15 was an ordinary day. I wanted it that way. I had done a lap chole and two or three simple hernias. At home in the evening, my wife served me my favorite meal and excitedly told me about my forthcoming grandchildren. I retired to my study with a little bit of Mozart and the poems of my friend, W. S. Merwin. His breathtaking poem “Ashes” brought me to tears:

O you with no
beginning that we can conceive of
no end that we can foresee
you of whom once we were made
before we knew ourselves
in this season of our own

It was a beautiful poem about each of our lives, what it comes to in the end for all of us. I fell asleep in my deep, black leather chair until my wife came to put me properly to bed at 11:00 pm. It was 1:45 am when the intensive care unit called to tell me I was on emergency room (ER) call and they had a gastrointestinal bleeder for me to see. “The gastroenterologist says come right away,” the nurse said. “No questions, he doesn't have time to talk to you.” I could tell—a surgeon always can—that this was serious. I told my wife as I woke her for the thousandth time in our marriage, as I rolled out of bed, that I had no idea I was on ER call and not to expect me until the morning.

The patient

The patient had been hospitalized on medicine for four hours with a dropping hemoglobin from 10 to 8.3 to 7.5 to 6.8, despite five units of blood. He had been scoped fore and aft, been worked up

for blood dyscrasias, had a chemical panel, received X rays of the chest and abdomen, and two electrocardiograms. All tests were normal. The one thing that had been noticed was progressive swelling in his abdomen, for which a computed tomography (CT) scan had been completed. I went down to X ray to review the films while the patient was settled back in bed. I alerted the senior resident to come in from home and told the operating room to stand by for an emergency laparotomy. The radiologist, by modern computer miracle, was able to read the CT scan data at home while I reviewed the original films. One by one, he described the findings to me over the telephone. We confirmed a normal liver and spleen, a completely normal aorta, no free air, normal bowel pattern, and no soft tissue trauma—nothing. The X rays were no help. Yes, there was massive bleeding intraperitoneally, but there was no evidence as to where it might be coming from.

At the patient's bedside, I spoke with his wife. They were traveling from Scotland and had been in San Francisco for four days when they went out to dinner and her husband, who was 55 years of age, collapsed with abdominal pain. He was always healthy, his wife said. His annual physical—just two weeks ago—was normal. No trauma, no vomiting, no alcohol. When the resident finally appeared, I pointed out the tense, distended abdomen and, especially, the purple, flank discoloration only seen with massive peritoneal bleeding. I asked the resident what he thought we should do. He considered more tests, then suggested a laparoscopic approach. I picked up the telephone and told surgery we were wheeling a patient with massive peritoneal bleeding from unknown source for a crash laparotomy. I told the staff to warn the anesthetist and to get eight units of O-positive blood for starters if they couldn't provide matched blood. I told the wife that her husband was dying from internal bleeding and we couldn't determine where. The eighth unit of blood was running as we entered the OR. Blood pressure was 78 systolic.

The surgery

My hospital has the best residents in the world, with incomparable brio and brightness. They are modern in every sense of the word, and when they are called in from their bed at home, they expect to be allowed to do the case. I love to teach, and it was natural for me to allow the senior resident

his earned position on the patient's right side to do this case.

When he asked me where I wanted him to make the incision, I said urgently, "From outside in," as I outlined a generous xiphoid to pubis incision. The resident did this, and suddenly there was blood and huge rubbery clots everywhere—a volcanic faucet bled somewhere down deep. The patient's blood pressure dropped to zero, and visibility was zero. I dove for the aorta with my dominant right hand, felt it, and crushed it against the vertebrae just beneath the diaphragm. I didn't know what else to do.

Surgery is not an intellectual pursuit. Rocket physics, the permutations and combinations of the deoxyribonucleic acid helix, and the decussations of Plato's Republic are infinitely more difficult for the mind. All surgery requires of the mind is average superior intelligence. Nothing special. But there is something else, something that is seldom mentioned anymore, let alone emphasized, that is required: In a day and age when time away from work is mandated for youth, when home life is valued above all else, when efforts are afoot to shorten residency years, it is not de rigueur to proclaim to the world that surgery is essentially an emotional discipline. But the fact is that one can learn the 12 cranial nerves in a night, but it takes a lifetime to understand and control feelings. Where I received my training, only the psychology residents who underwent Freudian analysis were committed for as long as the surgeons. A person cannot control feelings in surgery in three or four years—it takes six or seven, followed by a lifetime. And when I dove for that aorta and crushed it against the vertebrae to save a life—something I had done because, 30 years earlier, someone had showed me that that's what to do automatically in a case like this—I was suddenly alone, without an assistant. The cool head of the trained surgeon is nothing more. It is that same surgeon who just now feels alone in the middle of the night on the wrong side of the table with a third-year resident and only a free left hand to work with.

With my left hand, I continued to scoop blood and huge clots from the abdomen. The bleeding seemed to be coming from a tense lesser sac, which I urged the resident to enter quickly. He did this, though much too slow for me, as my right hand was rapidly tiring as the anesthetist poured unit after

unit of blood against my aortic pressure to bring the patient's blood pressure to 60. If I relaxed even slightly, the blood immediately welled up in the mid-abdominal area and obscured the field. I asked for a Satinsky clamp and knew I would have to place it blind across the infradiaphragmatic aorta. This I did, with only partial results. The belly filled up with blood again, so I replaced the Satinsky, hoping to get a more complete cross-clamp. I quickly helped the resident enter the lesser sac, but the exam was negative for any bleeding source. And once again, the abdomen filled with blood. Once more, the anesthesiologist was without a pressure. I began to feel helpless and hopeless. I looked at the liver and the spleen, in case the CT had been wrong.

Desperate, I recalled a case from my early days of a metastatic chorioepithelioma to the liver that had spontaneously bled into the peritoneum. I fantasized that that case had returned to haunt me. Then I suddenly realized I might be losing it. We had now replaced the patient's total blood volume twice over and had begun our third. The Satinsky was not holding, and the resident was fading fast.

At 3:00 am, I decided that if this patient was going to die, I wanted the chair of the department by my side to witness what I had done. When the nurse asked what she should tell him, I said to only tell him I needed him right away, which was something I never did.

I crushed my numb right hand against the aorta again, as it was the only thing that was having any effect. It seemed like an hour, but help arrived within minutes, and I can't think of a time I was ever so happy to see a person in my entire life. I replaced my hand with the resident's hand, and together the department chair and I were able to lift up the fatty apron of omentum and begin our exploration up along the aorta. As we came to the root of the midcolic artery and traced it out, there was an apparently large A-V formation in the right colic area that had ruptured. When pinched off with release of aortic pressure, the gushing bleeding was controlled. The department chair backed away, and as I held pressure, I invited the resident to oversee this area and we'd see if a right colectomy was necessary. He oversaw the area and in doing so, his spirits perked up a bit, as my own anxiety over a completely new experience had been hard on him.

Together, the resident and I watched the bowel for a long time and saw that it was viable. The resident closed the abdomen with aplomb, as all good residents do. As he put the serial steristrips in place to approximate the skin edges from below upward, I suddenly made him stop in the epigastrium so that I could place the last one.

The last stitch

I do believe a surgeon has only so many cases like this in him. Yet, despite everything that had gone wrong with this patient, with his multiple near-death experiences, we surgeons had done it right. This patient was my postoperative lifetime miracle. I expected disseminated intravascular coagulation, acute respiratory distress syndrome, renal shutdown, paraplegia, sepsis, hepatitis, atelectasis, pneumonia, dead bowel, evisceration, blood dyscrasias, and so on. But this patient never turned a hair. He returned to Scotland after two weeks, and his wife sent me a reassuring card three weeks later with understated thanks and appreciation as if nothing had happened in the U.S. that night.

"It was expected," she said, and that's all I ever got—but that was enough, more than enough, because I was able to put in that last stitch, a steristrip, all by myself.

I have never returned to the OR since that night. But somehow I think that if I had to, there's a part of me that could do it again. Sometimes I wonder why I still feel that way, but in my heart I know. I'm a surgeon. □

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