For some students in medical school, the ultimate encounter with the patient is not essentially new. This includes the few students who were previously nurses or physician associates and the larger number who have volunteered extensively to work in hospital or other clinical settings. But for many if not most, this experience is the most keenly anticipated and most anxious moment of life as a medical student.

Almost all medical students are young enough so that the naive energy of youth overcomes any natural timidity. To extend the analogy of the adolescent crush, contact with a patient, like marriage, is easier to get into when you are young and, if not foolish, then at least confident, even headstrong. The older you get the more you know, and after a certain point you know too much; you can envision the pitfalls, and you feel embarrassed by what earlier might have been a rough but effective brash éclat. I noticed in myself a level of concern about how I would handle patients, how they would react to me, what I might do wrong that, if not exactly inappropriate, was also not perfectly adaptive. I wanted to be the sort of person who would simply dive in, as so many did all around me.

For example, in a moving clinical exercise during the preclinical years, we visited a rehabilitation hospital for a lecture on the subject of paraplegia by a specialist who was a paraplegic himself—the result of an injury that had taken place within weeks of his graduation from medical school. As might be expected, he remarked on many aspects of day-to-day care, the sort that most physicians prefer to relegate to nurses, with a sensitivity and sympathy that few other physicians could have had. Between the
lecture and the patient presentations, we took a break, and as we filed out into the hall to stretch our legs, I saw that one of the patients to be presented—a new quadriplegic—was lying on a portable bed in the hallway. He could not have been more than twenty-one or twenty-two. He was handsome, healthy-looking—his muscles had not had time to deteriorate—and had, as the cliche goes, his whole life ahead of him. Yet he had just lost, permanently, the use of his body below the shoulders. I was one of about forty medical students milling around, spilling out of the classroom into the hallway, all healthy, ambitious and strong; and here, uncomfortably close to me, was a young man about as broken as one could be.

I could not think of anything to say to him. Surely this was a situation in which the wrong words could do damage, and I was highly conscious of the power of my embryonic medical role. I had not been taught the right words, so I was reluctant to say any. Still, the awkwardness of the situation as it was could not be much better than even the wrong words, and I began to grope for some phrases that might be acceptable, that might break the barrier.

During the few seconds that I was preoccupied with this effort, one of my fellow students—a particularly uninspiring athletic type, I thought—walked up to the stretcher, looked down at the crippled young man, and said, "Pretty tough break."

Ouch, I thought. Just the sort of thing I wanted to avoid. "Yeah," said the patient, his face brightening perceptibly.

"How did it happen?" the medical student asked, and they began a conversation in which all the barriers I had envisioned immediately broke down. The emotional topology of the hallway, which for me had been dominated by tension resulting from the lack of communication between the medical students and the patient, had been utterly changed.

I was reminded of the advice I once got as a boy about talking to a girl at a party: if she wants to talk to you, it doesn't much matter what you say; and if she doesn't want to, it doesn't matter either. Unlike the girls of about forty medical students milling around, spilling out of the classroom into the hallway, all healthy, ambitious and strong; and here, uncomfortably close to me, was a young man about as broken as one could be.

And yet it was plain to see that the result of this forthrightness was not always good. Teachers and students alike "dove in" with a brusque, abrupt style that many patients disliked. The laying on of hands was reduced to the carrying out of procedures, and words exchanged with the patient were basically viewed as tools to make those procedures go more smoothly.

At my medical school it was arranged for first-year students to have preliminary clinical experiences in hospital settings. I was assigned to a small group led by an immigrant physician who happened to be a superb if slightly pompous neurologist. He used to say, "Touch the patient."

This, he explained, was a categorical imperative. No matter what, find an excuse to touch the patient, however reluctant you are, however reluctant you imagine the patient is. If necessary, pretend to check for a fever by putting your hand on the patient's forehead. Take an unnecessary pulse. His words made an indelible impression on me.

On this occasion we stepped out of the elevator onto one of the highest floors of a just-finished hospital tower, a surgical ward so new it seemed to glitter. As we turned a corner into the main part of the ward, we saw and became part of a white-coated commotion around a stretcher. My clinical tutor, the neurologist was called, introduced me to a young woman who was a third-year medical student engaged in her surgical clerkship. Moans were emanating from within the crowd of hospital whites. The medical student narrated the scene in a cheery lilting tone with a bright, fresh expression on her face; but I was riveted by the moans, which were now taking the shape of the word "Mama," pathetically repeated over and over again.

The patient was an old-looking woman (I would now characterize her, in retrospect, as merely middle-aged) who was described as an alcoholic and evidently not composit mentis. She was undergoing the procedure of placement of a central line—the insertion of a large-bore needle in a major vein below the clavicle—needed for the pouring in of great volumes of fluid, as well as nutrients and drugs.

The woman did not stop moaning. "Mama, Mama, Mama." (I still cannot get those moans out of my mind. One sees terrible things in medicine, and this was far from the worst I saw, but it was my very first encounter as a student in a hospital; I remember it with the vividness that seems to be preserved for first encounters.) She was frail and small, with a long tangle of orange hair. Curled in the fetal position in a faded yellow hospital gown, she kept repeating her epithet like an uncalm mantra. She was surrounded by large sturdy young men, all handsome and strong of voice. They unfolded her brusquely and efficiently from the fetal curl. Her moans became louder and pierced their moderate, if spirited, professional
exchanges: "Mama, Mama, Mama, Mama." Glancing off these was the voice of the cheery young medical student whose explanatory commentary I found harder and harder to listen to. I had a thought that I was to have innumerable times over the next few years, although the feeling that went with it would wane: _Why doesn't somebody touch her forehead? Why doesn't somebody take her hand? Why doesn't somebody say, "It's all right"?

After a deftly conducted struggle in which the woman's resistance was treated as an annoyance and her cries were ignored, the central line was placed and the residents congratulated one another, as they often and properly do. After all, they are learning, and they deserve and need the praise that goes with new achievement. Also, the central line was for this patient a lifeline, and they could breathe that sigh of relief that comes when, as in a movie, we see a drowning person finally grab hold of a rope.

The patient's body recurred into the fetal position, as the young men stepped away from the stretcher. I was close enough so that without being obtrusive (and they were through with her anyway) I could satisfy my strong urge to touch her. At no point did she stop repeating the plaintive cry, "Mama." "It's O.K., dear, it's all right," I said, taking her hand and stroking her hair back away from her forehead. She made no obvious cry, "Mama."

I didn't know whether the residents' matter-of-fact approach to her entered into her response to these gestures, and I naturally thought they might be useless; but that did not mean I should not be making them. Equally, I didn't know whether the patients' matter-of-fact approach to her entered into her experience in any meaningful sense; in retrospect, with greater knowledge of the neuropsychology of brain damage from alcohol and other causes, I can say with some confidence that they didn't know either.

One could wonder, as I shortly did, whether doctors should not maintain a humane approach to patients not only because of the patients themselves but also because of the students and the residents, always likely to act inhumanely because of the stresses of excessive responsibility, overwork, and sleeplessness; or, for the same reason, because of oneself. This was before I realized that humane acts not directly affecting "care"—a word meaning neither more nor less than medical and surgical intervention for the purpose of favorably altering the course of an illness—are in short supply in the hospital world; that the patient's mental status is only marginally relevant to the effort at helpful verbal or nonverbal communication; and that far from being embarrassed by brusqueness, residents are more likely to be embarrassed by (and to consider not quite professional) acts and gestures that are other than completely instrumental.

One's shock does not last long, but at that point I was still shocked. When the residents were gone and the nurses had removed the patient with her plaintive cries, I looked to the third-year student for some kind of explanation. "What did you think of that?" I asked her.

"Wasn't that great? You have to see a lot of those before you get a feel for them. I'll probably get to place a couple of central lines myself before the clerkship ends."

"Is it difficult to get used to?"

"Oh, it's great, really. The residents are great to you. As long as you do your scut and keep the patients' labs and everything straight. I love it."

I left with a vision of the brightness in her face and with the lift of her voice in my ears, but I was deeply disturbed by what I had seen. On the bus on the way home I met a psychiatrist whom I had known before I began medical school. I told her about my experience, and she was moderately sympathetic to my concern. But I was looking for something stronger, some sharing of my "obviously" just and righteous anger. The incident was not a surprise to her, and although she deplored it, she seemed to accept it and to consider my reaction somewhat immature, surprisingly so, given my relatively advanced age.

"That's just the way things are," was about what she had to offer. When I confided that I might decide I couldn't be a part of this, she did not take me very seriously. "You'll get used to it," she said. "You don't have to become like them." She left me with the sensible advice that whatever was going on around you, you could and should be the way you wanted to be. "Light your corner," she said finally and emphatically.

My corner was for a period fairly dark. Some time during my first year a young woman physician in my community committed suicide. She had been in the obstetrics department, and was not only a practitioner but an excellent lecturer and teacher. Her case became a subject of constant discussion centered mainly on feminist issues. I knew these were central—she had been in what was virtually the first substantial cohort of women coming into medicine. She had forgone marriage and motherhood, and her situation must have been professionally oppressive and personally lonely.

But I thought there were more issues at stake than could be effectively subsumed under the feminist banner. She had been highly competent and successful, and she had been in obstetrics, generally considered the most hopeful and cheering of medical subfields. Yet she had judged her life not worth living. I thought that there might be lessons about the nature of
modern medicine and the awkwardness of the physician's existential situation. In general, suicide risk is higher for men than for women and much higher for physicians than for the population at large. So the death of this young woman cast a shadow over me, too.

At the end of the first year I sat for Part I of the National Medical Board Examinations, and this experience gave me a considerable jolt. For medical students who elect this route to licensure (generally considered the most difficult), three examinations are taken, Part I normally after the second year. It consists of two full days of multiple-choice questions covering anatomy, biochemistry, physiology, pathology, microbiology, and behavioral sciences. The questions are not of the straightforward "choose the one best answer" type, but of the more bewildering "Choose A if 1 and 3 are right, B if 2 and 4 are right, C if 1, 2, and 3 are right" type; and there are a thousand of them (about one per minute) over the course of two days. Somewhere between 10 and 15 percent of the students who take this test fail.

I was comfortably above that margin and well above the bottom of my own class's performance—not surprising, since I tended to be just about in the middle of the class on most examinations. But I had found the test extremely stressful and felt chastened by my far-from-impressive score. There were many mitigating factors. I was too old for this sort of thing, I told myself, and during the preclinical years this was made most evident by examinations. I had family responsibilities (my daughter was then two and a half, and I used to take her to a sunny little park in the late afternoons and try to memorize preclinical facts while keeping one eye on her wanderings). I had taken some of the basic courses—notably anatomy and biochemistry—six or seven years earlier. Finally, I was taking the exam at the end of the first instead of the second year, so that I could accelerate into the clinical training part of medical school earlier. All this helped to explain why I didn't do better—I could tell myself it wasn't stupidity, or sloth—but the lesson of the exam came home to me. I had made my bed and I was going to lie in it. In at least one sense, the worst of it was over. I still had some preclinical sciences to complete, but I was now empowered to set foot on the hospital floor as a student in Basic Clinical Skills. In my interactions with patients I would now have slightly more than spectator status. It was also the first setting I experienced in medical school in which the class consisted of a small group of students, and after those lecture the-

**Basic Clinical Skills** *The First Encounters*
whatever a doctor does in such a situation, it can be viewed from the outside as having been the wrong choice. It is only by living through the anguish of such choices that we come to appreciate the ethical depths they sound.

I also learned things about myself directly. In one exercise we filled out a form designed to assess our state of health, a form that had proved to be superior to a physician's examination in predicting future medical problems. I filled out the form honestly, and at the end was judged to have a "health age" two years older than my chronological age; all the others in the group had a health age younger than their stated age. Either I was in lousy shape or my fellow students were exceptionally vigorous, and either way I was at a disadvantage—for a medical student, the most ironic disadvantage of all.

We had a number of introductory lectures on clinical topics, and the most important of these concerned various aspects of history-taking and physical examination, in support of the complete histories and physicals we were doing regularly. As I had been before, I was a bit diffident in these encounters, finding it hard to cross the conventional barriers to interpersonal interaction that I had built up over half a lifetime. It was especially difficult for me to ask patients questions about their use of alcohol and about their sex lives, subjects we were expected to probe deeply, skeptically, and efficiently. This was all the more difficult since we were not attending to patient care but were there by suffering; patients had been (quite properly) asked to give their permission to be interviewed and examined by second-year medical students, for the benefit of our education.

My first encounter was comically awkward. Purely by chance, I was assigned to a woman who told me during the brief interview that she was an actress with a local repertory company, the name of which I recognized. She was twenty-two years old, had long auburn hair and large brown eyes, and, although small, carried herself with considerable bearing. She had presence—despite being in the hospital, on a bed, dressed in a drab hospital gown. She was about to be discharged, but her poise was noticeably disturbed by worry. She had been (quite properly) asked to give their permission to be interviewed and examined by second-year medical students, for the benefit of our education.

As in most neurological examinations, there was no reason to intrude on any part of the body ordinarily considered intimate, and of course I did not. But I soon found out that any part of the body is intimate in the sense that it is protected by the customary barriers of interpersonal space. There are cultures where these barriers are fewer or lighter than they are for us, and others where they are more numerous or severe. But they are always definite and somehow are known to every person in the culture, if only subconsciously. A violation of these strictures, subtle as they may seem, can dramatically transform the nature of a relationship—resulting in embarrassment, ostracism, in legal action, or even in homicide. Anthropologists had discovered that diplomatic and business failures—for example, in Japan or in Arab countries—may sometimes be traced to missteps in the frame of personal space.

Yet the physician is supposed to cross these barriers briskly, with confidence and aplomb. And the medical student crossing them for the first time must pretend to the same confidence, ignoring the force and weight of all the previous years of obscure but strict training with regard to personal space. I certainly did try to pretend, and my task was greatly complicated by the fact that I was doing my very first physical examination on a woman who promptly aroused in me unmistakable if fleeting feelings of romantic tenderness and sexual desire. I could not imagine that she was unaware of this, and so another dimension of intersubjectivity was added to an already complex interaction.

I was desperately trying to produce from memory the obsessive protracted sequence of the neurological examination, trying to appear professional, trying to conceal (at all costs!) the fact that I had never examined a patient before (which was probably transparently obvious), and trying to carry forward a stream of small talk, all the while suppressing ridiculous lustful sentiments. The simplest things—looking into her mouth, testing the suppleness of her neck, pushing down on her knee to test the mobility of her ankle joint—seemed almost intolerably intrusive. Touching the neck or the knee of a beautiful woman was something one earned with an appropriate investment of time and sentiment: candlelight dinners, walks in the moonlight, that sort of problem; but it was deemed a good way for me to begin, being the most methodical and meticulous part of the physical examination and the easiest to relate meaningfully to anatomy and physiology. One proceeded literally from head to toe, testing sensation, muscle tone and strength, reflexes, perceptual discrimination and integration, and finally higher coordination of movement and thought.

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thing (or at least, in this age of marvels, a couple of drinks in a singles bar). But to the patient, I was just one of a long line of men and women who had come around to poke at her in the service of various obscure hospital purposes. She understood perfectly well that the rules of interpersonal space are totally different in a medical encounter; it was I who had trouble with the contrast. Understandably, there were moments when the poor young woman almost burst out laughing.

Later I confided my feelings to the group, with the encouragement of the doctor who was leading that day's discussion. He was a very well-meaning man who was appropriately sensitive — indeed almost too much so. (People who say “share” more than twice in one conversation are always suspect to me, and he exceeded this limit by some measure.) He was trying rather desperately to elicit some valuable confessions about our first experience of the physical examination and not getting very far, so I decided to help him out — having been a teacher, I was alert for those moments when panic is setting in because of student unresponsiveness. I said rather flatly that I had had to examine a woman who was very attractive, and that this made me uncomfortable. There was no response from any of my fellow students, who looked at me strangely. “Thank you for sharing that with us,” Dr. Clark finally said, and went on to the next topic. I now knew that this was not to be a forum for discussion about learning to be a doctor, as had been claimed, but yet another setting in which I was expected to treat every health problem as important. Each history and physical took about three hours, and my write-up took even longer, involving me as it did in constant consultation of books for the right word, phrase, or explanation. (In patient write-ups, the order is ritualistic, the phrasing formulaic, and the emphasis and reasoning stringently constrained. If they are not, the already problematic circumstances of medical communication and legal vulnerability become impossible.)

How could this process be reduced to one hour for history and physical and one hour for write-up, which was the standard time spent (at best) by interns in their admission work-ups? Actually, since interns might be required to admit up to eight patients in one day, besides attending lectures and rounds and discharging many other duties, it was easy to see that two hours might not be available. So even as I was making my very first inroads into these basic clinical skills, I began to appreciate how they would have to be compromised.

Some interns and residents I met claimed they could be as thorough in an hour or two as I could in six, and at first I found their arguments convincing. But as I got closer to their stage of training, I could appreciate the corners they were cutting (which I would eventually have to cut as well). They focused more narrowly on the present illness, showed less concern for the patient’s or, certainly, the family’s general health; paid less attention to behavioral and social factors in the patient’s illness; were more abrupt and brusque and less responsive to the patient as a human being. The concept of adequate care was eminently flexible, and the judgment about what was really important to give the patient could become very narrow. Of course, when physicians were constantly beset by demands that they reduce costs, they could not feel encouraged to linger with their patients over details that were not immediately essential. Yet such details could turn out to be life-saving in the near term and highly cost-efficient for the future.

In Basic Clinical Skills I had the luxury (for the last time) of giving each patient the fullest conceivable attention. The patients, almost without exception, seemed grateful, and they provided a very instructive set of experiences. There was a sixty-eight-year-old childless widow who had a forty-five-year history of heavy smoking and was now dying of chronic obstructive pulmonary disease. There was a “morbidly obese” — he weighed 389 pounds — forty-five-year-old man who was hypertensive, diabetic, and suffering from numerous recurring painful abscesses in all the
creases of his enormous body. All his illnesses were directly related to obesity. A thirty-two-year-old mother of seven suffered from direct problems stemming principally from obesity, although she weighed "only" about two hundred pounds: diabetes resulting in kidney impairment, chronic upper abdominal pain, and hypertension. She also had a thyroid problem and chronic asthma, and she was grieving visibly, although it was years past, over her beloved father's untimely death. Her own children had been fathered by a number of different men, and at the time I met her she said she was living and struggling alone.

Another obese man—he weighed 350 pounds—said, "I'm like an alcoholic on food." In addition he was an alcoholic on alcohol. He was now in the hospital, as he had been many times before, for painful swelling in his feet, and this time also in his testicles. His sleep had been sorely troubled by breathing stoppages that woke him—a common problem in the obese—and led him narcoleptic during the day. This had been cured by the surgical opening of a channel into his trachea. But he had been unable to work for about a year due to depression, and he had begun drinking again.

There was a spry seventy-eight-year-old man with a fine wry sense of humor who had just had his gallbladder removed. He had previously had part of his colon removed because of diverticulosis. There was a thirty-four-year-old admirably promiscuous nonsexual, a musician, with a reaper of hepatitis. There was an eighty-three-year-old obese woman with arthritis, hypertension, and leg swelling who had had a bad fall. She was evidently no longer able to take care of herself at home. There was a thirty-nine-year-old man whose lifelong asthma had been exacerbated severely on the day of his separation from a lover. There were cases of cellulitis, thrombophlebitis, cardiac pain, ulcers, cancer, prostatitis, and the question: could have kept them in excellent health in the first place. It was very unusual for any of them to be referred for psychiatric evaluation or even for social service assistance, so they were trapped in a psychological cycle—smoking, drinking, overeating, accident-prone motorcycling, or risky sex—that had brought them into the hospital again and again. Fortunes were being spent on their care by third-party payers, yet these same payers did not deem it suitable to pay for preventive measures or for behavior modification. They would thus never find out whether such methods might be cost-effective—would nothing of whether they brought the best thing that could happen to these patients.

I discussed all this with a psychiatrist I knew—he had actually recommended me for medical school—who was now head of the Institute of Medicine. He was involved just then in a program recommending the investment of more resources in behavioral medicine on a grand scale. My interpretation of my patients was old news to him. This was to be only one of many encounters in which I learned that the opinions of these at or near the top of American medicine bore no relation—or, rather, bore only an ironic relation—to actual practice in the trenches.

At this time I seemed to be what I came to call "medically incidentally", "Arisingly", ironically, and probably not entirely incidentally, I found myself in life situations where my nascent skills seemed to be called for. The first time was on the airplane on the way back from Edinburgh, where I had spoken at a World Health Organization conference on breast-feeding. The pilot's voice scratched over the public address system asking if there were a medical doctor among the passengers. I held my breath for a while, then asked a stewardess what was up. A middle-aged passenger had collapsed, and they feared a heart attack. I was certainly no doctor, but I was feeling the squeeze of responsibility. If I opened my mouth would it do more harm than good? Fortunately, I did not have to answer the question: there were two physicians aboard.

A week or so later I had been attending an intolerably tedious anthropological lecture in a stuffy lecture hall. I had been on the way home from the hospital and still had my little bag with me—it was the only time during medical school when we actually carried those bags—and I was trying to hide it under my seat. The lecturer droned and ostentatiously turned his pages. The air in the room was so thick it was difficult to breathe. As we filed out, I noticed a commotion and saw that a young woman had fainted. Some people got her to a bench, and I rolled up her coat and put it under her legs. She was soon awake, complaining of a pain in her eye, which I tried to examine gently. "I'm a second-year medical student," I said. "I'm not going to touch your eye, but if you like I can look at it." She said that when she fainted she had scratched her eye on her glasses. The eye was teary but looked intact, except for what seemed to
be a scratch on the surface of the sclera—the membrane covering the white. She said that she had an ophthalmologist in town, and I offered to call him. I told her to stay where she was.

He was not terribly excited by my story. He said he would see her at his office in an hour. I tried to get him to tell me how worried I should be, and he tried to be noncommittal. "Take a history," he said. There was no relevant history, as was obvious from what I had already told him. So I simply stayed with her until she got a ride home with her parents. I had judged that this was not an emergency, and I was right.

The third incident, a week or two after that, involved a "consultation" by the rather reckless twenty-four-year-old son of an old friend of mine. The young man, who in every way still acted like a teenage boy, was using on the other side of town where a patient was waiting to have an lymph node biopsy. Since he was coming back afterward, I asked him if he would mind my tagging along, and on the contrary he was pleased.

The young man teacher—guided me gently through the procedures of sterile technique. As for my friend’s son, they thought I had taken a serious legal risk. He was not terribly excited by my story. He said he would see her at his ence, or a friend. Within and above all those social roles, I was more and more like a physician.

My first surgical experience made a strong impression on me. I was seeing patients one morning with a general surgeon who was conducting his usual clinic, evaluating patients before surgery or following their prog- ress after it. At around noon he said he had to leave to go to a small hospital on the other side of town where a patient was waiting to have an auxiliary lymph node biopsy. Since he was coming back afterward, I asked him if he would mind my tagging along, and on the contrary he was pleased. As we rode together he spoke reverentially of the surgeon he had trained under who had inspired him to become a surgeon himself. What had been only a famous name to me now became real, and I felt as if I were in the presence of an authentic, impressive tradition that comprised emotion as well as knowledge and skill.

And ritual. When we arrived at the little hospital, the surgeon—a plump, middle-aged Irishman with no pretensions to the status of his teacher—guided me gently through the procedures of sterile technique. The hand washing was so methodical and repetitive, so exceedingly thorough, that it was like a ritual confirmation of the germ theory, a self-retreaching of that theory, every day. The gowning and gloving were equally ritualistic but more dramatic, since they involved nurses attending the surgeon—and me, his new assistant—like priestesses who, although subordinated, were responsible for the purity of the ritual and who would pounce mercilessly on a technical blemish. I had to put my hands and arms into the gown without letting my fingers contact any part of the front of it. Then I had to plunge my hands, one at a time, into the tight rubber gloves without missing a finger or touching anything or ending up with the fingers too loose. I did my best, as careful as if walking on eggs, and I did not contaminate anything, but the two nurses’ pairs of eyes scrutinized me with an unrelenting critical gaze.

The young man on the table was conscious, and his shaved armpit had been prepared with a local anesthetic. I was content to stand and watch, with my rubber-gloved hands gripping each other awkwardly, staying in the sterile area just in front of my chest. The surgeon showed me the lump in the axilla, made his incision, and began quickly and efficiently to explore the way the world would now be relating to me. That entailed the ready acceptance of heavy responsibility, with all its practical, legal, and social consequences. I was no longer just a passenger, or a member of the audience, or a friend. Within and above all those social roles, I was more and more like a physician.

As for my friend’s son, they thought I had taken a serious legal risk. He was an adult and was consulting me about a private medical matter. It was a completely privileged communication. For telling my friend his father about the consultation, he could have sued me, probably successfully. These events made me understand for the first time that my role in life was going to be permanently changed—no, that it had already been changed. I had to begin to relate to the world as a doctor, because that was...
the wound with his fingers. Suddenly he turned to me. “Put your fingers in and feel it,” he said. His own fingers pried the wound open to ease the way for me. There was no avoiding this even if I had wanted to. The young man turned briefly to look at us, but he was not really concerned. I put two fingers of my right hand in and felt in the area where I had seen the shape made by the lump under the skin surface. Timidly, I began to move them around. Finally I felt it, a lump about one centimeter across, smaller than I had expected. I nodded, holding my breath, eye to eye with the surgeon, and removed my hand.

I watched the surgeon take out the offending node and prepare it for pathological study. But that was anticlimactic. I was more interested in the blood on my fingers, the lingering mystery, the feeling in my hand. It was like the feeling or even the smell of a hand used in making love to a woman; my fingers had been inside another person’s body, not just in the mouth or the vagina or the rectum, but beneath the protective surface of the skin, the inviolable film set up by millions of years of evolution, the envelope of ultimate individuality. Taking me along with him had been a matter-of-fact random event for the surgeon, but for me it had been an unforgettable experience.

I did not fully appreciate while I was taking Basic Clinical Skills that I was being exposed to two of the best clinical teachers I would encounter in medical school. One was Ross Weinberger, the internist who was my primary supervisor in most of the patient evaluations. He was a socially awkward man with a beak nose and heavy glasses, and an asthenic, slightly stooped frame. He worked for a community health plan with an excellent reputation and he seemed to have no academic ambitions. His general grasp of internal medicine seemed as good as that of anyone I met before or since, but that was not the point really. He was simply with the patients in a way I would rarely see again. He had a penetrating gaze that was medically critical yet full of convincing practical warmth—no “sharing” here. He cared, professionally, about the nonmedical aspects of his patients’ problems—their characters, their families, their living situations, their incomes. Ignorant as I was, I made the mistake of taking all this for granted. I assumed I had had some bad breaks in certain teaching encounters during the preclinical years, and that now I was embarked on an apprenticeship journey under the command of real doctors. Little did I realize with what longing I would later look back on Dr. Weinberger’s simple human decency.

In pediatrics, my supervisor was Ed Gold, who stood out similarly in basic human competence. Pediatricians in general are known for being better people—it sounds silly, but it’s true—that most medical specialists. They have accepted the lowest financial status in medicine in exchange for an opportunity to serve in the most nurturant primary care capacity. Ed’s touch with children was unsentimental and smooth, but as good as his surname in its ability to calm and even amuse them while he carried out efficiently the necessary examinations and procedures. His handling of parents—the pediatrician’s bread and butter—was equally adept. He had worked for a time at the Centers for Disease Control, and he was strongly oriented to preventive medicine.

As a teacher, he managed to confer confidence. He brought out the best in whatever natural skill with children I had, as well as in my experience doing research with children in Africa and my more recent experience as a father. I felt more comfortable with the patients in his consulting room than I had up to then anywhere else in the hospitals and clinics. Toward the end, there was one afternoon when I was closeted for an hour or two with a pair of unusually active ten-year-old twins who were, to use the common expression, bouncing off the walls. I did all that was necessary in interviewing their mother and in observing and examining each of them in turn. I felt in control of the situation and consequently happy.

Ed told me a story that made me appreciate the rigors of internship in a somewhat new and more ominous way. After a long struggle with a deadly illness, he had lost a small child. The parents were grateful to him for the effort—they frequently are—and invited him to their home. They wanted him to be a part of the process of experiencing, and recovering from, their grief. He was touched and was grateful to be with them. They left him alone with a drink in his hand on their living room couch, for a few minutes, while they attended to the dinner they were preparing. He fell asleep, and they left him to sleep, realizing how desperately he needed it.

What struck me was that this unusually sensitive doctor did not have the physical wherewithal to stay awake at such a moment, to serve the function of psychological healing for which he was then badly needed. This was not a man who, in such a situation, would allow himself to fall asleep lightly, and he had felt guilty about it ever since. How bad could the stress of internship be? Worse, evidently, than I had thought.

The parade of exquisitely healthy, normally growing children that came through Ed’s clinic, with their usually minor problems, presented a stark contrast to my memory of Africa. That memory in turn made me fear, as
it always did, for the health of my own daughter, and of my son who was then soon to be born. Life in general seemed fragile, but children seemed more fragile than anything, and I knew that their basic expectable health and safety was a historical novelty. Not only in Africa but in Europe and the United States a mere century or two before, half of all children could be expected to die.

Near the end of my semester in Basic Clinical Skills, this issue came up in a discussion at the home of a physician who was an expert on public health. He had held a powerful administrative position in internal medicine, and had also made a reputation for himself doing research. But he had given up all that to take a leadership role in the field of public health. People were puzzled, and I, like many others before, gave voice to that puzzlement.

He was forthright, even adamant. Public health measures, not medical care, were responsible for all the important reductions of morbidity and mortality in modern times, he said. This was not news to me and I had little trouble with it, but the vehemence with which he defended this position was surprising. Another physician who joined in the conversation was the designer and implementer of a program for screening newborn infants for hypothyroidism, which if undetected can easily cause profound mental retardation. The two of them insisted not only that public health measures were much more important than medicine, but that medicine had accomplished nothing at all.

I protested. Coronary artery bypass surgery? Appendectomy? Antibiotics? Nothing I mentioned impressed them in the least. The treatments were overrated, the numbers of people saved were trivial compared with the numbers, past and future, saved by preventive measures. I felt like an idiot. Here I was, taking my first steps in clinical work, defending the whole enterprise of clinical medicine in an argument with two men who had spent decades practicing medicine at its best and who had abandoned it and insisted that it was useless. There was no getting around the irony of this exchange, or its implications for the journey on which I had embarked.

The official first day of my first "rotation"—two months assigned to a specific specialty at the hospital—coincided with my thirty-sixth birthday. Because of some last-minute rearrangements in my program, as my first clinical rotation ever I drew Galen and surgery. Most students like me drew easier assignments: Galen surgery, considered the most rigorous third-year rotation, was for future surgeons, not for students who had definitely ruled it out and were planning careers in other fields, psychiatry or pediatrics, for example. But for two months—with the exception of a week of anesthesiology—I would be working every day and every other night, living, eating, drinking, and breathing with some of the most high-powered surgical residents in the world.

These were people—mostly men—who ate determination for breakfast. They had no use for the slow, the sensitive, the theoretical, or the timid. They thrived on stress and sleeplessness, they were openly proud of their ability to take punishment, and they enjoyed making moment-to-moment, even snap decisions about matters of life and death. They expected to make the toughest decisions quickly, and they expected to be right. Last but not least, they acted—in the operating room, in the Emergency Ward, on the recovery wards, and in the outpatient clinics, every hour of every day in every way. This was their reputation, and this was the impression I was to carry away from two months with them. For the present, I was frightened as well as excited. It seemed an ironic and paradoxical birthday present, although certainly a big and fascinating one.

If drawing Galen, and starting the year with it, were not enough, I had
the additional luck to start surgery with the Emergency Ward. I opted for three weeks of it instead of two—I really thought that this would be one of the most important experiences in my clinical training and one that would go a long way toward making me feel like a doctor. We were told that we would be on a twenty-four-hours-on, twenty-four-off schedule, the theory being that on the nights on, we would get at most two hours'sleep (in fact, we almost always got none). But since conferences and clinics were planned during the off days, that schedule seemed optimistic. My one piece of good luck was to start my actual duties the day after my birthday, which itself was spent in preliminary orientation conferences. I got the evening off to spend with my family, which now included a baby boy as well as a little girl. And, luckily, considering what was to come, I got a good night's sleep.

One encounter that day left an unexpectedly strong impression. The six of us assigned to the E.W.—three on each of the alternating days—were briefly oriented by a young surgeon in charge of the Trauma Surgery Unit. He was arrogant, blustering, gruff, not my sort of man at all. And he seemed to take a dislike to me. Because of my (actually very neat) beard? Because my age was too close to his for comfort? I couldn't say. But he decided to single me out for embarrassment. He pointed under my chair at a cherished if new amulet—a beautiful medical bag made of soft Italian leather that I had bought in Florence the previous spring. "You get rid of that thing," he said, snickering at me. "You'll be a fool if you bring that down to the E.W. It'll be gone in no time. And any way, it's useless." His advice was right, and I followed it, but something about the way he delivered the message told me that he and I would not get along.

The next day I was in the E.W. at six-thirty in the morning and met the team of residents and nurses. We were given a little tour to establish the layout of the unit—if in addition to our inevitable clumsiness we should not get along. We were taken to the critical care area, which included a therapy area and a waiting room. Behind the therapy area was a medical emergency center, which included a triage area, a minor surgery clinic, and an overnight ward, an observation unit where patients were temporarily held pending a decision in a day or so whether or not to admit them to the hospital.

Unfortunately the residents would be switching their rotations the following day, so I had only one twenty-four-hour period with this friendly and helpful group. Still, I began my hands-on training immediately. The stream of patients was unrelenting—burns, cuts, partial amputations, abrasions, concussions, fractures, ingestions, unidentified abdominal and chest and back pain, complications of previous surgery, knife and gunshot wounds, and the ubiquitous "lacs" (short for lacerations).

These patients were backed up in the waiting room for waits ranging from two to five hours, hours full of pain and fear. Only the most minimal effort was made to "touch base" with the patients after their arrivals. Many were not seen or talked to, even briefly, for hours. But all of them were screened by a triage nurse as soon as they walked through the door, and the serious emergencies were taken care of immediately. Indeed, these were the cases that most readily mobilized the best and most intelligent
energies of the trauma team. Nevertheless, a patient occasionally—albeit rarely—died in the waiting room.

I spent the first day learning the routines of patient contact, cleaning and debriding wounds and burns, taking the cursory histories typical of the E.W., and learning to cut corners wherever possible and safe, to move patients along more quickly. I held the proverbial retractor on a number of minor surgical procedures and began to get some sense of how to sew a laceration. Although I was not quite ready to try one myself, I knew the lack of action on their side, urged the medical students to go and have a look. When I got to the medical side, the patient had not yet arrived, and the medical residents, nurses, and students were crowding the hallway. Suddenly the E.M.T.'s—the Emergency medical technicians—burst through the doors rolling a stretcher carrying a plump middle-aged man under a white sheet. A handsome young resident from the other hospital—Mount Saint Elsewhere—who had traveled in the ambulance with the patient, came down the hall. He asked who was in charge, was told, and then said, "I'm taking the intubation." He was challenged on this. Suddenly he and the Galen senior resident were standing nose to nose shouting at each other in the hallway about who would intubate the patient who had been rolled in dying. I couldn't believe my eyes and ears—a turf fight at a moment! The Galen residents got the intubation, and I learned a little more not only about handling emergencies but about medical teaching and its politics. As the day and the night wore on, I was too excited to feel tired, and, more important, things were moving too quickly.

During a short lull on that first night—one finally came around two A.M.—I had a chance to familiarize myself with the layout of the very large and multifaceted E.W. There were many interesting nooks and crannies, including a rest area for nurses where I found myself surprisingly welcome and where I surmised I would learn a great deal. Nothing, however, could have prepared me for two other strange discoveries I made. The first was a bulletin board not far from the nurses' rest area, and just outside a room where certain surgical cases were held for observation. The room was dark and quiet, and the hallway was humming slightly with the minimal level of activity that, I would learn, characterized the E.W. in the middle of the night when nothing was happening. A sign above the bulletin board was headed, in careful handwritten letters, "Case of the Week." It was dated a few days earlier, just before the start of my rotation:

**Complaint:** FOR CIRCUMCISION

**Triage Notes:** Self-induced circumcision 48 hrs. ago.

"O", "without," and "sx" meant "symptoms." So the gist was that there were no genito-urinary symptoms, including infection, and there was no fever. "NKA" meaning "No Known Allergies," was scrawled and circled haphazardly. The time was noted as 6:15, the temperature as "gggo"—"per os," Latin for "by mouth." There were no notations in the boxes for Blood Pressure, Pulse, Respirations, or Pupil Size. The last name of the triage nurse was scrawled to the left of a printed "R.N.," and in a space labeled "Assigned to Dr. Southwick," were the letters "M.S." for "Minor Surgery."

This was exactly how a door sheet—so called because it was filled out at the door of the E.W. or frequently hung on the door of a patient's room—would have looked when we pulled one out in minor surgery. This one was a completely typical deadpan triage note, in which the only indication of a missed beat on the part of the nurse was the crossed-out "FOR," probably the beginning of the word "forskin." The absence of notation of blood pressure, pulse, and so on was baffling, but I later realized that this was a sign of a patient so obviously in the pink of health that these measures did not have to be taken, at least at the triage stage.

After a number of empty lines, under a printed "Start Note Here," **fanked** by arrows pointing downward, was the note written by the surgical intern who had examined this patient:

24 yo w. of circumcision himself 2 days ago. Wants to know that it is healing properly.

Pl. shaved pubic area, excised foreskin with a "sterile" razor. Washed the area with alcohol & wrapped it with gauze.

Today he unwrapped it, noted healing. Erection this A.M. 3 complications.

Last tetanus shot date unknown.

PE: Neat circumferential incision at base of glans, with wound edges separated by mm, x x cm hematorna under ventral aspect. No erythema, streaking, induration; only mild tenderness. Nl. sensation distally.

A: Circumcision, healing. 3 sign of infection. Wound was treated with bacitracin wrapped in gauze. To be changed G X daily. RTSD 8d to 14 infection.

After recovering from my double take, I used my growing knowledge of medical language to interpret the case. A twenty-four-year-old white
male had circumcised himself, without complications ("s" was a synonym for "g"). The patient ("Pt.") had consciously imitated real surgery. The intern's physical examination ("PE") showed a properly healing wound with a small collection of blood underneath the head of the penis (nothing to worry about); absence of the classic signs of infection; and normal ("NL") sensation at the tip of the penis beyond the wound, demonstrating that no nerves had been injured. The assessment ("A") was that of a properly healing circumcision wound, and the treatment was topical antibiotic for prophylaxis. "Return to Surgical Dispensary in eight days to rule out infection" was the perfectly bland meaning of the last string of alphabet soup.

Not a hint of surprise was shown. Did they see self-circumcision every day here? No, after all it was the case of the week. More interestingly and significantly, the note showed no indication of the mental status of the patient, indeed did not even show that it had been thought of. I had already learned that certain subjects had to be covered in a note for legal reasons, including stock phrases to show that certain problems were absent, proving that they had at least been thought of ("No erythema, streaking, induration"). I had been sent back to rewrite my own note several times because I had omitted one or more of them. This was a basic lesson of all medical report-writing: in any situation there were certain key symptoms and signs the absence of which had to be formally documented; a default led not to the interpretation that the patient was normal in that respect but that that portion of the evaluation had been omitted—an inference that made the doctor (or medical student) a medico-legal sitting duck.

But as I was gradually and painfully to learn, this note showed the strict duty did not apply to psychiatric signs and symptoms, unless the patient's mental status was so frankly abnormal as to make even a surgeon realize there was a screw loose. There was no indication that a psychiatric consultation for this patient had been recommended, although the best psychiatric emergency service in the region was located a few yards down the hall; nor was there any formal indication that a consult or a referral to Social Service at least had been suggested. Had the intern even thought of the possibility that a young man who circumcised himself might have some emotional problem? Urological surgeons, I knew, sometimes had to remove pens and other objects from the bladders of psychotic patients who had inserted them through their urethras. Surely they called in the Psychiatric Emergency Service? Even the one-line throwaways on mental status—"A & O X 3" (alert and oriented to time, place, and person) or "Responds to questioning with full comprehension"—had not been included.

There was merely the surgical intern's tacit admiration ("Neat circumferential incision") for a fellow craftsman. The job had been done well under poor conditions, by an amateur, on himself, and with (no less) appropriate follow-up self-examinations!

I went back to minor surgery where I found Steve Ray, the young and very friendly senior resident. The bays were empty and dark, and he was taking a rest from the cases in the overnight ward, who were probably mostly sleeping. (I did not appreciate until later how unusual it was for a Senior even to enter the minor surgery room.) It was his last night in Emergency Surgery. He was sitting at the desk, playing with his pen, turning it over and over in his hands.

"Did you get a load of that case of the week?" I asked him.

"Which? Oh, you mean the circumcision. That was Jody Wilson's case." He laughed slightly. "I wasn't here, unfortunately."

"They just discharged him?"

"Sure. Why not? He did a good job."

Steve's beeper went off in a piercing repetitive whistle. He was on his feet as the tape recited mechanically "Call...Extension...seven...two...seven...seven." "That'll be my blood," he said. "Pretty soon, sleep. Maybe." He strolled out jauntily and calmly through the door, stretching his stethoscope rhythmically and jerkily between his hands.

I looked down almost longingly at my own beeper, appropriately but depressingly inactive. Then I realized that the bays were not all empty after all: one was occupied by an intern, John Williams, curled up with a sheet over his head. That was why the room was dark. But there was still enough light to snoop around by. I began quietly to open the closets, trying to sort out where the stream of supplies I had seen all day—bandages, gauze, cotton, scalpel blades, needles—had precisely come from. On the inside of the door a cabinet that held a broad assortment of scalpel blades was a photocopy of a notice typed on official hospital stationery, the name of the director printed at the top:

**NOTICE**

Beginning January 20, 1992, handguns will be issued to all Emergency Ward personnel, along with the following instructions for their use.

Henceforth, patients may be shot, but only after a careful history has been taken and one or more of the following criteria have been met.

1. Patient was caught committing a violent crime and was not sufficiently beaten by the police.
2. Patient was caught committing RAPE or CHILD Molesting and was not adequately injured by victim and family.
3. Patient comes to E.W. by ambulance for suture removal or pain med-prescription refill.

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**BECOMING A DOCTOR**

**EMERGENCY WARD SURGERY: No Man's Land**
I stood with my jaw slack reading this document. Here was the resi-
dents' self-analysis: their hatreds, their fears, the pressures on their lives,
and, by inversion, their hopes and dreams for the future. Here was their
manner when I questioned him was curt and gruff, with a the-world-owes-
me-a-living tone. He did not seem impoverished, intoxicated with alcohol
or other drugs, withdrawing from same, confused, tired, or ill. His story
was that of a typical chronically recurring mild-to-moderate low back pain
syndrome, very much like the one I had had myself for fifteen years. He
was able to sit up on the cot, with his legs dangling over the side, talking
steadily. He was obviously uncomfortable, but this, I knew, was not low
back pain at its worst. More significant, he had had this condition for years,
and this episode had started three days ago. What brings the patient in now?,
a question drummed into me in Basic Clinical Skills as one of the great illuminators, seemed particularly apt in this case. His
answer that it was getting worse did not, somehow, satisfy. The clock said
3:03 A.M.
I strolled out of the half-lit bay and listened to John's snoring on the
other side of the curtain. I could imagine his face coming out of its groggy
sleep, and then snapping out, saying "Low back pain? Lowfucking back
pain? You're waking me up for low fucking back pain?" Fortunately, at
that moment I noticed that Steve Ray was back at his desk, twirling his
pen in one hand, leaning on the other hand with his elbow on the table.
Ray was a puzzle to me. He was a third-year surgical resident in one of

**EMERGENCY WARD SURGERY: No Man's Land**

the vast category of abnormalities for which physicians were held to ac-
count. In other words, substance abuse, failure to keep clean, and child
molesting were purely moral problems and in no sense medical abnor-
malities.

I heard footsteps behind me. Frank, the desk clerk on night shift, had
come up with a new door sheet in his hand. "Do you want it, or should
I drop it in the box?" He smiled coyly when he saw what I was reading.
"Better not let a lot of people know about that." I took the sheet and closed
the cabinet door.

The new patient was a twenty-six-year-old man with low back pain. No
fever, no drugs, no other symptoms, no known allergies. Was I going to
wake up poor long-suffering John Williams for this? I knew I would have
to, since no one was allowed to depart without seeing an M.D. Besides,
after a total of eighteen hours and thirty minutes of surgical experience,
I wouldn't have trusted myself to manage a shaving nick or even a mos-
quito bite. Still, I would have to present the case anyway, so the least I
could do was let John sleep until I had made my fumbling first pass.

Mr. Furillo was a vision out of the "patients may be shot" memo. He was
sullen, slouched, unkempt, and not very clean, even from a distance. His
manner when I questioned him was curt and gruff, with a the-world-owes-
me-a-living tone. He did not seem impoverished, intoxicated with alcohol
or other drugs, withdrawing from same, confused, tired, or ill. His story
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**ALL PATIENTS TO BE SHOT MUST FIRST HAVE CHEST TUBE, CUTDOWN, TRACHEOSTOMY AND CENTRAL LINE UNLESS THE RESIDENTS ON CALL HAVE PERFORMED GREATER THAN 3 EACH.**

**PATIENT MAY BE KEPT IN E.W. LONGER THAN 30 MINUTES BUT NO LONGER THAN 4 HOURS PRIOR TO BEING SHOT.**

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**PATIENT MAY BE KEPT IN E.W. LONGER THAN 30 MINUTES BUT NO LONGER THAN 4 HOURS PRIOR TO BEING SHOT.**
the best programs of its kind in the world at the almost incredible age of twenty-three. He came from the ultimate in urban Mount Saint Else-
where, a medical school based at a nasty big city hospital. To have got where he was at the age he was he must have skipped a couple of grades in grammar or high school and then entered medical school after only two years of college (a possibility in certain six-year programs). He was a walk-
ing, breathing challenge to the argument that breadth and maturity are necessary to be a good doctor. He contradicted every cliche about sur-
geons. Everyone loved him, including patients, other residents, E.W. and O.R. nurses, medical students, even me, and I did not then nor would I ever love many residents. He had done three appendectomies as a medical student—something allowed in certain municipal hospitals—and that was indicative of the clinical experience with which he began his residency. He could charm the pinstripes off the chairman of the hospital board or the haze out of a junkie’s eyes. Half the nurses were in love with his boyish good looks, and the other half wanted to take care of him. He was said by everyone to be a superb surgeon and, despite not being a scientist, to be destined for great things. Still, a key part of his charm was a distinct *épater les bourgeois*: the brash-young-man image subtly graded into a punk de-
fiance.

His cards, for instance. All residents and medical students carried a pocketful of three-by-five index cards for note-taking of all kinds, and it was said that one goal of a residency was to learn how to put all the key data about a patient on just one card. His cards were printed at the top with a ditty he composed, based on his nickname, “The Ace.” (His real name was similar to that of a famous comic book hero with that nick-
name.) The comic-book “Ace” had dominated the imaginations of two generations of American boys, projecting a hypermasculine aggressive image based on a clean-cut rugged face and a bull-like body. Calling Steve “The Ace” was both hilariously wrong and subtly true. He was certainly masculine, but his masculinity was that of the clever hand-
some runty guy who makes out like crazy, leaving the big bruiser in his
figurative romantic dust. And yet he was a hero in the eyes of virtually everyone—and one of the few heroes I would ever encounter in that complex, puzzling world of hospitals. At any rate, he had sat down at the Kardex stamping machine out front, where plastic cards were made up for the new patients with names, addresses, ages, ID numbers and dates of arrival, and had made up a plastic card with raised letters that read:

*The Ace says,
And he ain’t shittin’,
Go fuck yerself,
And do it today.*

Using this card, he stamped up his index cards with the ditty at the top, much the way everyone else stamped the patients’ data on their index cards. He then inserted a stack of them so that the little quatrain poking up out of the vest pocket of his white jacket, facing out, not far from the pinned-on nameplate that said “Dr. Stephen Ray.”

As I drifted out of Mr. Furillo’s bay, Steve did not move from his semire-
clining posture, but he pulled one of the cards out of his pocket, laid it on the table, the pen still in his hand, and said, “What’ve we got?”

“Low back pain,” I said. “Low back pain.”

“Loss of sensation?”

“None.”

“How long?”

“Years, on and off. This time three days.”

He laid his pen down on his card. This was not worth writing about.

“Should I wake up John?”

“No, it’s O.K., I’ll take it.”

“Do you realize that this is in clear violation of Principle Number”—I
opened the cabinet door—“of Principle Five of the Patients-May-Be-Shot
memor

Steve smiled tolerantly. I went on, “I don’t believe this guy. He comes in at three A.M.—exactly—with low back pain that he’s had for days, not to mention having it on and off for years. These guys must think there are shifts here, or something. Like we’ve been home asleep all day and we just showed up to take over, all fresh like. He’s up, so he figures we
should—”

“That’s the E.W.,” was Steve’s placid summary interruption. He lifted
his head from his hand and his elbow from the table. “Let’s see him,” he said.

“Hello, Mr. Furillo,” he said. “I’m Doctor Ray.” Steve shook hands with him. The doctor, pale and thin, with sleepy eyes, looked worse than the patient. He had been operating all day long. “Can you tell me what’s been bothering you, sir?” This was not the “sir” that I would soon get used to
hearing, the openly contemptuous one, transparent to patient and student alike. This was real.

Mr. Furillo began, "Like I told him . . .," and started again on his story, glad to be seeing a more important doctor but annoyed at having to waste his time repeating himself. He had the same presumptuous tone he had taken with me. Steve went on questioning him in a way that was both polite and gentle, interested and respectful. He said "sir" often. "Sis, can I ask you to step down here? Are you able to do that?" He put a footstool in place and helped Mr. Furillo climb down. He asked him to bend forward a bit and then examined his lower back, pointing out to me the place where the spasm was. Then he helped him back onto the cot and examined his mobility and sensation in his legs.

"Is there anything else you want to tell us, sir, that we might have forgotten to ask about?"

"No. Just if you could give me something for the pain."

"I can't give you anything other than Tylenol for this, sir."

"Well, O.K., I'll take Tylenol. And need a note? For work tomorrow?"

"What kind of work do you do, sir?"

"Warehouse work. I got a lot of lifting, and I don't see myself doing it, not in this shape I'm in."

"I'll give you a note, sir."

We walked out of the bay, and Steve remained placid. I could hardly believe my eyes and ears. I had seen patients insulted and mistreated all day under much more favorable circumstances. I thought I'd had the whole brutal system figured out. "How can you be so nice to that guy? What does he want, just pain meds or something?"

"Well, it didn't faze him when I said no to that. He wants the note for work tomorrow, for what he was supposed to do. He even lanced a boil that had recurred and packed the wound. But how he thought he could truly check up on this varied group of post-minor-surgery patients in such a short time was beyond me. It was not because he was so pressed; he and I and a nurse sat through of a dozen or so patients that I had seen before or would see since. He spent just two or three minutes each with most of them. I guess he did what he was supposed to do. He even lanced a boil that had recurred and packed the wound. But how he thought he could truly check up on this varied group of post-minor-surgery patients in such a short time was beyond me. It was not because he was so pressed; he and I and a nurse sat around chatting for half an hour or so after his patients had been put through. During that time the nurse, an overweight, pretty Brunette with a pleasantly professional manner, took out the books and announced that John had set an all-time record for monthly earnings by an intern in that clinic. This was proof that his speed was off the scale, but it was no more than an exaggeration of what was expected.

During one encounter that morning, a sixty-year-old man who looked older came in for a check of a leg infection that had been incised and drained. John did the check in less than a minute, since the dressing had already been removed. The leg wound did not look good, but presumably it was better than it had been. The man asked how often he should change the new dressing. "The nurse will explain all that," said John, in a tone that said, Don't let's get involved in such trivia, it's not for tough guys like us, and don't ask me any more questions.

The man said, in a tentative friendly way, "I had this other operation," he said, pointing into his lap. "On my privates. They cut off the end of it, how they fixed it up, and started again on his story, and don't ask me any more questions.

Other residents, I knew, found many other ways to be, none of them nice. Perhaps Steve did not see the gulf between his own bedside manner — somewhere between genuine courtesy and a heartfelt simulation of it — and their listlessness, condescension, or patent fakery. He had devoted his whole young life to achieving excellence as a general surgeon, and yet was reflectively decent to an insolent man who was not really sick and who was wasting his time — and this in a context that encouraged the worst in everyone, in which insult and impudence was the dominant mode. How he managed this — how he had become what he was, in the system as it was — puzzled me for a long time.

Most of what I experienced on the surgical rotation was quite different from what I saw with Steve Ray. For example, the next morning, after the shift changed and our twenty-four hours in the E.W. were over, John Williams and I went to his follow-up clinic. We practically ran over to the ambulatory care wing, and he introduced me to the nurses there; they were having doughnuts and cake to celebrate the residents' last day. We lingered over this for about five minutes and then began the fastest run through of a dozen or so patients that I had seen before or would see since. He spent just two or three minutes each with most of them. I guess he did what he was supposed to do. He even lanced a boil that had recurred and packed the wound. But how he thought he could truly check up on this varied group of post-minor-surgery patients in such a short time was beyond me. It was not because he was so pressed; he and I and a nurse sat around chatting for half an hour or so after his patients had been put through. During that time the nurse, an overweight, pretty Brunette with a pleasantly professional manner, took out the books and announced that John had set an all-time record for monthly earnings by an intern in that clinic. This was proof that his speed was off the scale, but it was no more than an exaggeration of what was expected.

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you'll be really well soon." I bolted out so as not to lose John, since I had been told in no uncertain terms that I was to be his shadow, and he was as informative as a bottle of iodine about what he was going to do next.

I caught up to him as he zipped past the door of the nurses' conference room, where they were again eating cake and doughnuts. He waved good-bye and said "Thanks," over his shoulder. His hand came up to his mouth in a characteristic gesture. All ten fingernails were bitten below the quick.

At six-thirty on the morning of my next day on, after a good talk with my wife and a good night's sleep, I came into the minor surgery room to find, as expected, a new set of residents. Margaret, Bill, and I, the three medical students, sat down in our corner to fill out forms. There were ten copies each of about six forms: requests for blood and blood products, for urinalysis, for arterial blood gas measurements, for toxicity screens, and for routine biochemical measurements in venous blood, among others. We filled these out in advance so that we would be ready when a trauma patient — like Madeline Fine, the young woman with the collapsed lung who had been repeatedly stabbed by her boyfriend — needed these fluids without delay. No degree of emergency would get us to square one with the labs if we hadn't filled out the forms.

This tedious clerical task done, we awaited the arrival of Jack Parker, the respected and feared Director of Trauma Surgery, the one who had told me to get rid of my Florentine leather medical bag. He arrived on the dot of seven, muscular and well-rested, and sat down and began talking.

"Trauma is a surgical epidemic. There are a hundred and fifty thousand trauma deaths a year in this country, and sixty percent of those didn't have to die. Fifty thousand are motor-vehicle accident cases — more than the trauma deaths a year in this country, and sixty percent of those didn't have to die. Fifty thousand are motor-vehicle accident cases — more than the number of Americans lost in the whole Korean War. Twenty-five thousand are suicides. In 1965 somebody did a study that showed that fifty percent of U.S. ambulance drivers were morticians. That wonderful setting for teaching had been my bread and butter for years, and I had eagerly participated in them for years before that. Their..."
function was to encourage thought, exchange of views, even temporary error. A good graduate seminar became itself like a thoughtful mind, beset with ambiguities, arguing generously with itself, teaching itself, learning. But there was no such thing in medical school. If Dr. Parker's "seminar" could be likened to a single mind, it was a rigid, authoritarian one, intolerant of ambiguities and constantly searching for certainties: reliable rules, unchallengeable procedures, incontrovertible facts. This could not be justi

fied on the grounds that in medicine there was only one right way; it was, rather, that physician-teachers and residents preferred to believe that there was only one right way. The more constricting the rules were, the more easily they could be memorized and, more important, the more comfortable you would feel—regardless of the outcome—when you had followed them.

Out of the corner of my eye I noticed that the door from the waiting room into the minor surgery room had opened about six inches. A man in a dark suit and tie, with black curly hair, was holding his head and looking around tentatively, evidently in pain. Neither Parker nor any of the residents or other students had noticed him, and I wondered if I should speak up. K.M.S., I repeated to myself once again, K.M.S.

Half an hour later the man with the hurt head had poked his head into the room three more times. I wrestled with my conscience. Could it really be that none of them had noticed him? It did not seem possible. Yet it seemed equally impossible that they would be ignoring him. Surely one of us could talk to him for a few minutes?

I remembered a time in the first year of medical school when a clinical professor was lecturing on the mechanism of the blood pressure cuff. His beeper rang three times over the course of half an hour, and each time he turned it off and went on lecturing. I remember not being able to concentrate very well on his technical points, wondering instead what problem, what danger, what pain was waiting for his attention at the other end of that persistent, ignored beeper. And if he had had some reason to concentrate very well on his technical points, wondering instead what else he was missing?

My first experience in "the Saturday Night Knife and Gun Club" turned out to be very quiet, yet I got a chance to do some work. Just before nine o'clock a middle-aged woman came in with a painfully swollen finger. She had obviously gained a good deal of weight since first putting the rings on, and they were now impossible to remove. The finger was clearly infected, and the tissue under the ring looked ischemic (oxygen-starved); it was purple. She could lose the finger. I injected the local anesthetic Xylocaine at the base of the finger on both sides. Then I went to work sawing at the rings with a small tool expressly designed for that purpose. It wasn't working. After ten minutes or so I asked the intern, Freddy Robertson, if it was supposed to take that long. "Of course," he said. "You're just afraid of work. Keep turning it. It'll saw through." I was working as hard as I could putting pressure on the instrument. My hands
by now hurt badly. The situation was oddly intimate. This very nice, patient, but clearly upset woman, in considerable pain despite the Xylocaine, tried to control her reactions with her face a few inches from my own. There was no visible progress, and after another twenty minutes, I asked Freddy again. He gave me the same assurances, this time even more annoyed with me for bothering him.

When I became thoroughly discouraged, I didn't go to him. I went to Bob McIntyre, the junior resident, who told me to ask the "orthopods"—the orthopedic surgeons—for advice. I went next door and told them the story, which gave them a good laugh. They said, "It ought to take about a minute and a half." One of them opened a drawer and took out an identical but shinier ring-removing tool. Armed with that, I returned to the unfortunate woman, set to work again, and removed the largest ring—the first one, which I was still working on—in about a minute and a half. I was furious at Freddy, and yet I had learned a lesson. His arrogance was ignorance, and this was true of many residents in many situations. Yet he was every bit as self-assured as if he were talking about something he really knew. The patient had suffered an extra forty-five minutes of unnecessary pain as well as risk of losing a finger, and she would have suffered much more unless I had explicitly disobeyed his order and gone over his head. It was a good lesson to have learned early. After we sent her out, Ted Webster, the senior resident, arrived in a jacket and tie. After checking in briefly, he went off to change. "I didn't recognize him," I said, attempting a lame joke. "How come he looks like that?"

A resident I didn't know said, "That's because he's the senior. When we grow up and get to be the senior, we'll get to look like that too."

There was nothing major until the early morning, but we were kept up all night by small problems. At six A.M. a woman with serious spinal damage was brought in on a stretcher. She had only fallen off a bed, but she had metal rods in place to stabilize her spine from a previous injury; the unfortunate woman, set to work again, and removed the largest ring—the first one, which I was still working on—in about a minute and a half. I was furious at Freddy, and yet I had learned a lesson. His arrogance was ignorance, and this was true of many residents in many situations. Yet he was every bit as self-assured as if he were talking about something he really knew. The patient had suffered an extra forty-five minutes of unnecessary pain as well as risk of losing a finger, and she would have suffered much more unless I had explicitly disobeyed his order and gone over his head. It was a good lesson to have learned early. After we sent her out, Ted Webster, the senior resident, arrived in a jacket and tie. After checking in briefly, he went off to change. "I didn't recognize him," I said, attempting a lame joke. "How come he looks like that?"

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I stood near the door beside the policeman and policewoman who had brought the patient in and who were intently watching Ted try to get going. I said, "Two minutes ago he was fast asleep and now he's completely in charge of somebody's life."
plish that goal. But I could not really get angry, since his characterization was uncomfortably close to my own view of why I was dressed in white.

On the way in for my next shift, on Labor Day, I ran into Bill, another of the students on emergency surgery, and we walked while walking up from the subway. He was normally taciturn but now was in a complaining mood. He wondered aloud why we had to be at the hospital so early—before seven—and I said we needed the overlap with the team ending its shift. He also resented the residents' cryptic talk, not the technical jargon, but the inside jokes, slang, and abbreviations they never tried to explain. This I agreed with completely. Then his next complaint was about his loans. He was grinning under his burden. I wondered whether, if he calculated even the lowest income he could be certain of in the future, and the number of years he would have to pay them back, he would realize that it was not really something he had to worry about. Bill did not buy this argument at all. His final point, for emphasis, was, "You know, I'm even beginning to think that my choice of where I'm going to live may have to be conditioned by financial considerations." This stunned me; it said more about the ideas doctors have of their privileges and expectations than any sociological treatise could. What profession's members did not have to consider such mundane human matters as money?

When we walked in the three residents were standing around in the minor surgery room making fun of patients. This was a regular part of the morning ritual. Since nothing was happening, they had nothing to do, and instead of policing the overnight ward or waiting for a patient in one of the trauma rooms, they took over our corner in minor surgery. They rarely entered the room to help when patients were piled up outside, but now the only part of the place that could be considered ours, Ted, the senior, also took my newspaper. I bought another one.

In the late afternoon a charming old Italian woman came in with a nasal fracture after a fall in the street. Her solicitous, handsome husband was with her. She was very worried. She'd been preparing for a party later in the week. Was the nose broken? Would it be reset? Would she still be a bandage by next Thursday? There were many other questions. She and her husband each had an intense and implicit concern: his was to show his love for her and his guilt at having allowed this to happen; hers was more specific and more difficult to discuss, but she gradually revealed to me that she was hoping to have a prettier nose after the fracture was corrected and healed. Her two daughters had had elective rhinoplasty as

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**Emergency Ward Surgery: No Man's Land**

teenagers, she told me, having inherited her rather beakish nose. She wanted keenly to know if the accident might have given her a chance to have a similar alteration. Her husband, insistently doting, told her several times that he liked her nose "just as it is." I made a point of getting a "roadside," or informal, consultation on this from Steve Ray. It would not be possible, he said, but he would have a talk with her and offer her the rhinoplasty after her recovery from the fracture. This made me a little sad, since I doubted that she would do it then.

At the ten o'clock meal that night—the hospital provided a nightly all-you-can-eat so-called dinner for all staff members in the house—there was grim dinner conversation about patients who had been brought in dead and yet had had to be coded—slang for being put through a full-scale attempt at resuscitation. Each resident had a story. One man was brought in dead and "coded" for half an hour. An elderly woman with a ruptured abdominal aortic aneurysm had been brought in from a distant suburb. Her chances would have been slim even an hour earlier, but now she was dead and cold; still she was coded. A college student had jumped off a dormitory window and lain dead on the street apparently for hours—a rat had eaten part of his eye, but since the students who had found him in the morning had dutifully started C.P.R.—cardiopulmonary resuscitation—the E.M.T.'s had felt obligated to treat him as a code, and so, in their turn, had the residents. Expensive resources were being lavished on the not-too-recently dead, and the residents, trapped by rules not of their making, could not do anything but laugh.

At around two that morning, a street drunk named Sam Bigelow came in with a report of a head injury. He had been pushed or had fallen down a flight of stairs. He did have a bruise on his head, but it did not look serious. In fact no one thought he needed a skull film. However, he was trembling all over. He was clearly not drunk, and he spoke to me politely, recounting his repeated attempts to get and stay dry. This latest, he was two days old, and he somehow convinced me that he wanted to stay with it, that he was not merely looking for a place to spend the night. He was in distress, nauseous, flushed, unable to eat. I spent some time trying to calm him down, and then stalled for a couple of hours so that he could continue to occupy a bay in minor surgery where he could at least lie down. Freddy Robertson and the other surgical residents showed no interest. His head injury was not serious—and it wasn't—he had to be turfed to the street. If I was serious about treating his withdrawal, I should wake up a psychiatrist.
So, according to protocol, I went to the triage nurse to ask her to page the psychiatrist on call, so that Bigelow could be transferred to their service (and if surgery were quiet enough I could help with his treatment). The nurse, a hard, pretty brunette, looked at me unbelieving. "You want me to wake up a psychiatrist at four A.M. to take care of Sam Bigelow?"

"He's a patient, isn't he? He's sick. He's in withdrawal. The surgeons are going to turf him back to the street. Isn't it the job of the psychiatrists to take care of a patient in withdrawal?"

"Sure, but... Her face softened, and a distant look came into her pretty brown eyes. I later imagined that she had been trying to think back to a time when she had had the sort of faith that I was now demonstrating. "How long have you been here?" she asked. She did not wake the psychiatrist, and I told Sam to come in to the detox clinic the following day. But, through various excuses, I managed to keep him in a bed in minor surgery—there were no patients who needed it, at least not as badly as he did—until after seven o'clock in the morning.

That day was the official day of publication of my book about the biological constraints on human behavior. I dragged myself out of bed after three or four hours' sleep to give a not completely coherent two-hour interview to National Public Radio, focusing on the "dark side of human nature." I was not so tired that the irony was lost on me. Neither my years in Africa nor more than a decade of rather cynical study had quite prepared me for the darkest shadows of the Galen E.W.

The following morning I awoke at five, as usual, but this time, with a clear mind, not wanting to go. As I struggled to figure out whether it was Tuesday or Saturday (it turned out to be Wednesday), I remembered Freddy Robertson's remark on the first day we had met, "You'll forget what day it is." As my train progressed toward the hospital in the dark, I realized that I would miss the superb dawn skylights that had greeted me in the past week. Winter was closing in. For the rest of the term I would come to the hospital and leave it—often thirty-six hours later—in the dark, having never seen the light except through a window.

I was able to skip Dr. Carter's lecture that morning, because I had an appointment with a senior surgeon, Dr. Maple, who would be supervising my presentation on breast cancer. I sat for a while in the waiting room of the radiation clinic trying to collect my thoughts. The waiting room was a wonderfully pleasant space, with soft, curved, continuous couches upholstered in a warm dark orange color: they had only round shapes without corners, and even the armrests were soft and round. A wall of handsome fresh red brick, also without corners, rose to a clerestory of glass. Large potted trees stood in several places, and an inoffensive abstract bronze sculpture in the center of a spiral staircase. There was a constant fall of soft natural light through the clerestory.

On the wall high in the atrium was a round naive painting of an exotic tropical bird flying across candy-colored mountains. Around this painting on the frame it said, Sarah J. Winlow, 1972. These Waiting Rooms Established Through Her Generosity. Had she done the painting? Had she helped to design the room? Had she been a breast cancer victim herself? I wanted to think all this was true; that she was someone who had really thought, as few people did who were not touched by it, about what it was like to be a woman with that particular disease. This was by far the nicest place I had discovered in the hospital—with the possible exception of the chapel. It was a fit place, if any was, for a woman to sit for a long time, repeatedly, in substantial pain, and to think about disfigurement, deterioration, and death.

Dr. Maple told the two of us who were presenting that week that we should take a day off to prepare properly. "It will be the single most important determinant of your grade in surgery, which will be one of the most important determinants of what residency you get." Knowing that Freddy Robertson would not like our disappearing, I pressed Dr. Maple to make sure he would support me.

"Who's down there?" he asked.

"Freddy Robertson is the intern."

"No. Who's older?"

"Ted Webster is the senior."

"Good. Tell him to come to me if he has any questions." Seeing my uncertainty he added, "You're already developing a medical neurosis. You think you're needed. It's not true." Of course, he was helping to encourage our other neurosis, the one about "the most important determinant..."

Webster said, "That's reasonable. Come back tonight if you can. Use your judgment. They'll be glad to have you back if you can get back. Freddy."

I went to find Freddy in the surgical follow-up clinic, where I was supposed to be working with him. Freddy reacted as I knew he would. When I was a student, he grumbled without looking at me—he was talking about two months ago as if it were ten years—"we had to give presentations without taking days off. But the names of Maple and Web-
ster quieted him. At least my age was worth an understanding of how to make the hierarchy work, if only occasionally, in my favor.

On my way out to the library, I ran into Stephanie Walker, an intern, who had the same job as Freddy on the same shift, but in the other wing of the hospital, and I was on good terms with her.

"Where's your medical student?" I asked.

"Not here, she said, sounding surprised. "Does Freddy make you come to his clinic after your shift?"

"You bet. Including days off."

"Days off?" she said. "Tell him to stuff it up his nose."

So I looked up Keflex in the P.D.R. There was nothing remotely like such a side effect. I called the emergency psychiatric service and the psychiatrist agreed that he should be seen. I got him over to her on the pretext of documenting a new side effect of this widely used antibiotic. The psychiatrist, a small, thin, harried woman—her hospital name tag was upside down—with long, frizzy, red-blonde hair, gave him a half-hour interview that seemed to me competent, if also dull and lacking in individuality.

Outside in the hall afterward she said, "He's very crazy." But she thanked me for "helping to get him plugged into the medical health network." I wasn't absolutely sure that he'd be better off.

We, the medical students—had two conferences back to back that afternoon, one on pathology with the director of the morgue, and one on transplantation with one of the great pioneers in the field. We'd been out of minor surgery for more than three hours, and when we came back we should have begun working as soon as we stepped in the door. Instead I was stopped short by a pretty, dark-haired young woman elegantly dressed in a pink-and-purple party dress, with two different pink-and-purple barrettes—one a flower, one a bow—in her long straight hair. Steamlining down from her eyes were two great shiners, each drawing down to a point, the left slightly longer than the right, each a play of pinks and purples like her colorful dress. She was not in a patient bay but in the residents' and students' corner. She was sitting up in a chair, happy and animated, talking to Freddy Robertson in a way that amused him. She was plainly well.

"What happened to you?" I asked, when she had stopped for a moment and turned toward me.

"You know that stone wall outside the hospital? I drove it into it at fifty miles an hour."

"You look pretty good, considering."

"Well, it was a couple of months ago. I've still got these black eyes."

She thought it was fine. "They're not black. Actually they look nice. Match your dress."

Some time after this conference, around noon, I saw a handsome Irish-immigrant carpenter with a charming florid brogue. He came in with a hand wound, having come in some days earlier with another. He reported a strange reaction to Keflex, the antibiotic he'd been given—a fifteen-minute powerful "rush" followed by a whole night of auditory hallucinations. He had heard the voices of his friends, he said, who were having a party in a suburb a few miles away. The voices were coming through the chimney, and the unfriendly remarks mostly pertained to him. He was frightened by but also rather proud of these new powers.
who had been writing at the desk, said to me quite properly, "Are you gonna socialize or are you gonna work?"

"Work," I said, regretful but ready, "What do you want me to do?"

"See the lady in that bay," he said, pointing across the room. "Hemorrhoids." The patient, an obese person who apparently bathed only rarely, gave off an odor detectable from at least half way across the room.

Later that day, Freddy and I were out in the hall when the nurses' shift changed, and we saw one of the friendlier ones leaving. "You guys are supposed to be back in minor scource," she said, "What are you doing out here?"

"We came to flirt with you," said Freddy unconvincingly.

"Where's Bob Gross?" Gross was a senior medical resident assigned that month to work with the surgeons—a budding superdoc, humorless, arrogant, self-centered, no doubt destined for the chairmanship of a major department of medicine, someday, somewhere.

"Right over there, on the phone," said the nurse pointing. "Beat him up for me, will you?" She was not smiling.

"Sure," Freddy said. "Should I put your name on the bruises?"

Now she smiled. "Every one," she said and was out the door.

Freddy asked me to check with Gross about a patient, and so I waited the few minutes until he was off the phone. He gave me his answer with his usual contempt for students, as we walked into the "doctors' lounge," an ugly room with a few chairs and a coffee maker. I thanked him, and as I was leaving he said to a junior resident, "Wanna go get a drink?"

"That's right!" the junior reminded himself. "Happy Hour." This was news to me. I followed them as they tore out of the "lounge" down the hall. "Wait... hold it," I said, in what must have been a comical way, struggling to keep up with them. "Wait, please tell me about this Happy Hour." I didn't need a drink, but I wanted to be included in whatever was going on.

Cross, turning back for a second without breaking his stride, said, "It's for the hospital staff."

"Does that include medical students?" I asked.

He hesitated. "Sure, come on."

"I can't come right now—I have to check back at minor surge. Just tell me where it is, so in case I can get away... ."

Cross turned back again, just momentarily. "Flagg fifteen," he said matter-of-factly, and they were gone.

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Now she smiled. "Every one," she said and was out the door.

Freddy asked me to check with Gross about a patient, and so I waited the few minutes until he was off the phone. He gave me his answer with his usual contempt for students, as we walked into the "doctors' lounge," an ugly room with a few chairs and a coffee maker. I thanked him, and as I was leaving he said to a junior resident, "Wanna go get a drink?"

"That's right!" the junior reminded himself. "Happy Hour." This was news to me. I followed them as they tore out of the "lounge" down the hall. "Wait... hold it," I said, in what must have been a comical way, struggling to keep up with them. "Wait, please tell me about this Happy Hour." I didn't need a drink, but I wanted to be included in whatever was going on.

Cross, turning back for a second without breaking his stride, said, "It's for the hospital staff."

"Does that include medical students?" I asked.

He hesitated. "Sure, come on."

"I can't come right now—I have to check back at minor surge. Just tell me where it is, so in case I can get away... ."

Cross turned back again, just momentarily. "Flagg fifteen," he said matter-of-factly, and they were gone.
The following week my mother had an appointment with Peter Engelmann, a Galen cardiologist who was my adviser in medical school. During minor surgery at a hospital in Florida she had been diagnosed as having evidence of past heart muscle damage and had been placed on a new cardiac drug. I did not have confidence in the hospital or in the physician, who, I gathered, had made the diagnosis on the basis of one routine electrocardiogram. I convinced my mother that we should bring to bear the power of Galen medicine.

But Engelmann was more than just Galen. He was a prince of a man, reserved and formal but generous in the extreme, and he struck me as completely trustworthy. He was a clear and elegant lecturer, a helpful adviser, a capable administrator, and—it went without saying at Galen—a clinical scientist of considerable reputation. He was a Viennese Jew who had come to the United States in the 1930s, and he spoke with a charming accent that, like his bearing and formal courtesy, seemed more Austrian than Jewish.

My mother was handicapped by severe lifelong hearing loss, and so she presented more than the usual challenge to bedside manner. Engelmann was more than I had hoped for. His patience in talking with her, his courtesy, his lengthy, careful history and physical, his personal administration and reading of the electrocardiogram—all this, after weeks at Galen, nearly brought tears to my eyes. He ruled out, or at least failed to confirm, the abnormality identified by the Florida physician; indeed it was very equivocal even in the EKG tracing she had brought with her from there. We threw away her pills, which had had some unpleasant side effects, and she emerged from the mistaken category of cardiac cripple.

At the same time, I emerged for a while from the category of discouraged medical student. Engelmann represented everything I had imagined a doctor could be. Part of me wanted to grab hold of him and insist that he tell me why he and the rest of the faculty assigned us to places like the surgical emergency clinic, when we needed was to see more of people like him. But instead I wrote him a grateful note calling attention to the contrast; and went back to the grotesque version of medicine that was practiced by Freddy Robertson and the others.

Sunday morning there was little happening, and the residents were sitting around in minor surge chatting and laughing. Freddy said to Ted Webster, who was reading the funny papers, "My dream used to be a Cadillac Eldorado." He paused and then laughed, "Now it's a Porsche. But I have to wait until I get out West. Can't you see me tooling around New Mexico in a Porsche?" This was the first time I had heard him allude to any vision of the future. He had been a prep-school English teacher before entering medicine and was one of those whose humanistic background was supposed to make him a better physician.

Another resident, a smooth Ivy League type with a neat bow tie, a man who often bragged about his investments, was leaning over the shoulder of a new Vietnamese intern, trying to explain an article about financial planning in Money magazine. The Vietnamese intern's banter was hilarious, even to him.

Meanwhile Freddy and Webster were exchanging stories about security guards they had sicced on patients. Freddy, who I must admit, was funny, did a routine comparing the guards to trained attack dogs: "Whoa! Down boy! That's a good boy!" and after they disposed of a particularly obnoxious "sleaze-ball" he rewarded them "with a slab of raw meat."

Things heated up a bit that Sunday. A young Chinese man, apparently quite crazy, came in with a self-inflicted, moderately serious arm injury. What with the inevitable hours in the waiting room, with cleaning his wound and sewing his arm, with the psych consult that even the surgeons realized was necessary, he was with us from morning until midnight—a regular fixture with intense and wary eyes, a taut thin body, and a suspicious angry voice. Another completely crazy patient came in having swallowed a handful of small sharp pieces of metal (this was soon documented by X-ray). But since no one took the time to talk with him during the hours he spent in the waiting room, he walked out without treatment—a potentially life-threatening circumstance. A third patient was a big, belligerent black man who smelled stately of whiskey and who had been found unconscious on the street by the E.M.T.'s. He had been badly beaten and was suspected of having a skull fracture. "Don't move, John," Freddy said to him as we wheeled him to X-ray.

"I won't move," he said with a bad slur, "I move for my kids. That's the only thing I move for. I move for my children."

The steam of patients went on all day without a break. At three minutes after midnight a nineteen-year-old named Joseph Mazullo, large, slow-moving, and gentle, came in looking confused and hurt. His door sheet said, "Back injury. No medicines or allergies. Assaulted by pizza trays." It wasn't really funny. He worked in a restaurant, and his boss had assaulted
him with pizza trays. But after fifteen hours or so of nonstop patients, no one found it easy to keep a straight face.

After he had been examined and been cleared and left, we finally had a lull. Ted lay on a stretcher in one of the bays, Freddy ate some old yogurt, and Bob McIntyre was reading the funny papers. We sent out for Chinese food. Freddy and Ted did one of their favorite routines, which they called the Wheel of Pain. The Wheel of Pain, like the big wheel on a T.V. game show, would be spun to determine which pain medication would be prescribed. Any sort of patient would do, but addicts and other undesirables who were faking symptoms were especially appropriate.

The imagined wheel, invisible on the wall, was spun. Freddy followed it, building up the suspense. “There it goes, there it goes, Perca—, Perca—, Perca—, no sorry, but you do get a choice: enteric-coated aspirin or Tylenol.”

“Can I have Tylenol with codeine, at least?” Ted asked plaintively.

“No sir, you may not. Next. Perca—, Perca—, Perca—, where will it stop? Where will it stop? Yes! Congratulations! You get Percocet! Next! You say you have a terrible pain in your back? Headaches too? Well, let’s see what we can do about this! Spin the Wheel of Pain, where it stops nobody—Perca—, Perca—, Perca—, No! Sorry sir! You get Pez! That’s right, Pez! What a shame, folks! Better luck next time! But you do get your choice of flavors and the handy little dispenser! Enjoy it sir! Next!”

Ted, still on the stretcher, laughed himself literally blue in the face.

A couple of days later at morning conference Dr. Carter took the residents to task for the waits in minor surgery that Sunday. “A five-hour backup in minor surge is not acceptable,” he said. Freddy explained that there were some complicated lacs to sew that day—like the Chinese boy’s self-inflicted tendon injury.

Carter said, “Those go to plastics. I know that takes away some of your fun, but you’re not here to have fun.” I wondered what he would have made of the much more complicated tendon surgery Freddy had done a few days earlier. I also knew that five-hour waits were not at all unusual. K.M.S., I reminded myself, and stayed with him—for three hours while he sewed. I watched the lovely face come slowly back together again—it would be weeks before it was clear how well he had done—and hoped for the best.

On my next shift, in the evening, I looked after a rather grand, upper-class woman in her nineties, who had sustained some leg abrasions after walking into a garbage can. She was a delightful woman, in almost perfect health, courageous and pleasant in the face of pain—a perfect example of the best Yankee tradition—stoical, good-humored, and exquisitely polite as I dressed her leg.

I was shaking my head admiringly as she walked out when a nurse we all knew well walked in, in obvious distress. Her eyes were red and moist, and three residents turned from their patients to converge on her.

“Princess Grace—she stammered, a sob welling up in her throat. “She's dead! Cerebral hemorrhage...fifty-three years old!” She sobbed again.

Ted was mildly sympathetic. “Oh gee, that's really too bad.”

Freddy was less concerned than curious. “How'd she get a cerebral hemorrhage?”

The nurse began to explain, but was too moved to continue. She handed Ted a newspaper article describing the accident.

Freddy began his inevitable ribbing. “Did you announce that minor surgery is closed to commemorate Princess Grace’s demise?”

Ted was reading the article. “She was lucky to live as long as she did,”
he said, without looking up. "The car fell a hundred twenty feet into a ravine. Some farmer heard a crash and came out and found a car upside down in his garden overlooking the Mediterranean. In the car the two princesses were trapped. The younger was saved first."

"Come on," said the nurse, obviously hurt. "I really feel bad." She turned and walked out.

"Yeah," said Freddy with a look of mock concern. "I really liked some of her movies. Some of 'em were really great."

"I don't get it," I said. "That nurse watches people box around here every night. She never bats an eyelash. Then she reads a newspaper story about Princess Grace and she's crying."

"Sure," said Ted without missing a beat. "It's the difference between a legend and a nobody."

The stream of nobodies continued without abatement. A man had somehow been run over by a truck while eating breakfast and drinking a beer. Another had been shot in the side by a .38 caliber bullet that improbably penetrated almost every abdominal organ. Another had sustained a garing injury—these were common in rural areas where farmers strung wires between trees so that motorbike or snowmobile riders would encounter them at neck level. Another had come in with a routine diaphragmatic hernia. "Go upstairs and enjoy it," Dr. Carter had said. "It's easy to fix, and it's fun."

An engineer—tall, fair, handsome, broad-shouldered, with wire-rimmed glasses, confidently friendly—came in with a scrotal lump. Under his arm was a worn and extensively underlined book about cancer. He was convinced that he had the dread disease, though this was not likely, and he was terrified. And a sweet, intelligent old man came in with a broken neck. He had been picking apples and pruning his orchard when he fell out of a tree. He was paralyzed from the shoulders down. He kept trying to reconstruct the event that, he knew, had destroyed his retirement and the rest of his life, the part he had waited fifty years to enjoy.

On my last night in the E.W. there was no major trauma, but there was news of trauma that touched me. The novelist, teacher, and critic John Gardner had been killed riding his motorcycle to work. He had once read a story I sent him, responded kindly although I was unknown to him, and eventually published it in his magazine. I had never met him, but I was in his debt. Furthermore, I loved his writing, which should have gone on another twenty or thirty years. The accident was so typical of the ones whose victims we were seeing every night that I could picture all too vividly just what had happened. I kept seeing him roll into the E.W. Dead on arrival, the news report had said. I hoped there'd been no attempt to resuscitate him.

I went sadly through the motions of my work that last night. There was a man with a cut in the webbing between his fingers. I suspected Freddy of assigning it to me purely for practice. The man was by far the most irritating patient I had had. He virtually jumped off the stretcher at every mere cleaning gesture, and then I had to inject lidocaine in several places and put in the superfluous stitch. It was depressing, and I was glad when it was over.

After this, at two A.M., there was enough of a lull so that I could find some peace. I went to the chapel, which always provided a wonderful respite—cave of emotional safety that I had come to many times. It was quiet, dark, pleasant, and empty, with a pretty pane of stained glass and the glow of both soft orange electric lights and candles. I sat for a long time, very grateful that the beeper did not go off. I took out a card I had bought earlier that day, a painting of a flight of geese low over a pond, all in soft dark blues and grays, and composed a little note to Gardner's widow. In these few peaceful minutes I battled on the epic of trauma, and my sense of personal loss echoed back through my mind over the dizzying array of patients I had helped to take care of.