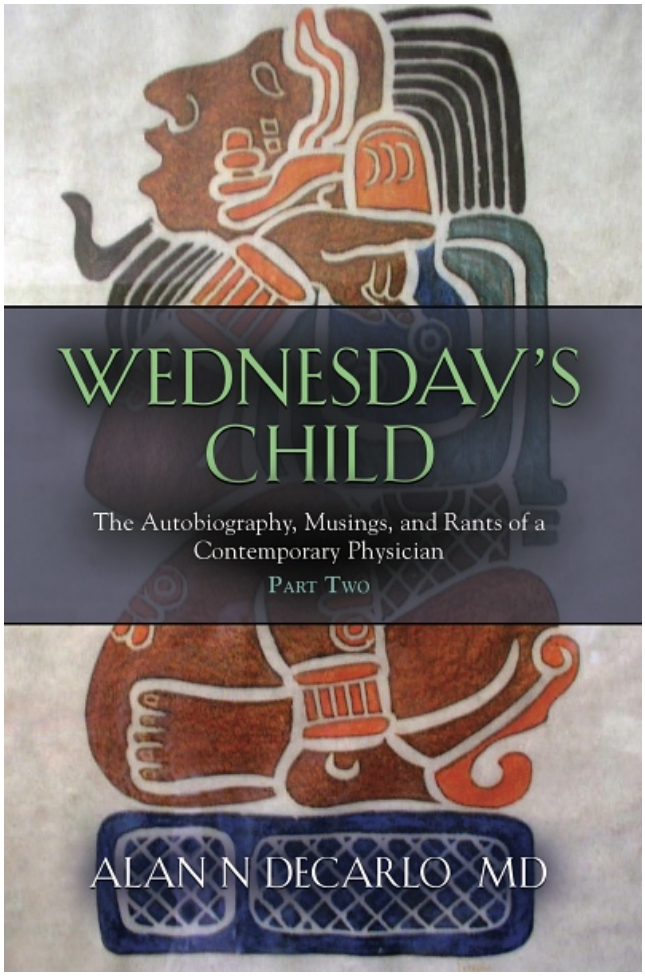


Wednesday's Child, the autobiography of a retired Cardiologist, spans seven decades and is written in three parts: Youth, Manhood, and Old Age. It is an intimate vignette of incidents, personal and medical anecdotes, facts, and opinions.

Wednesday's Child:

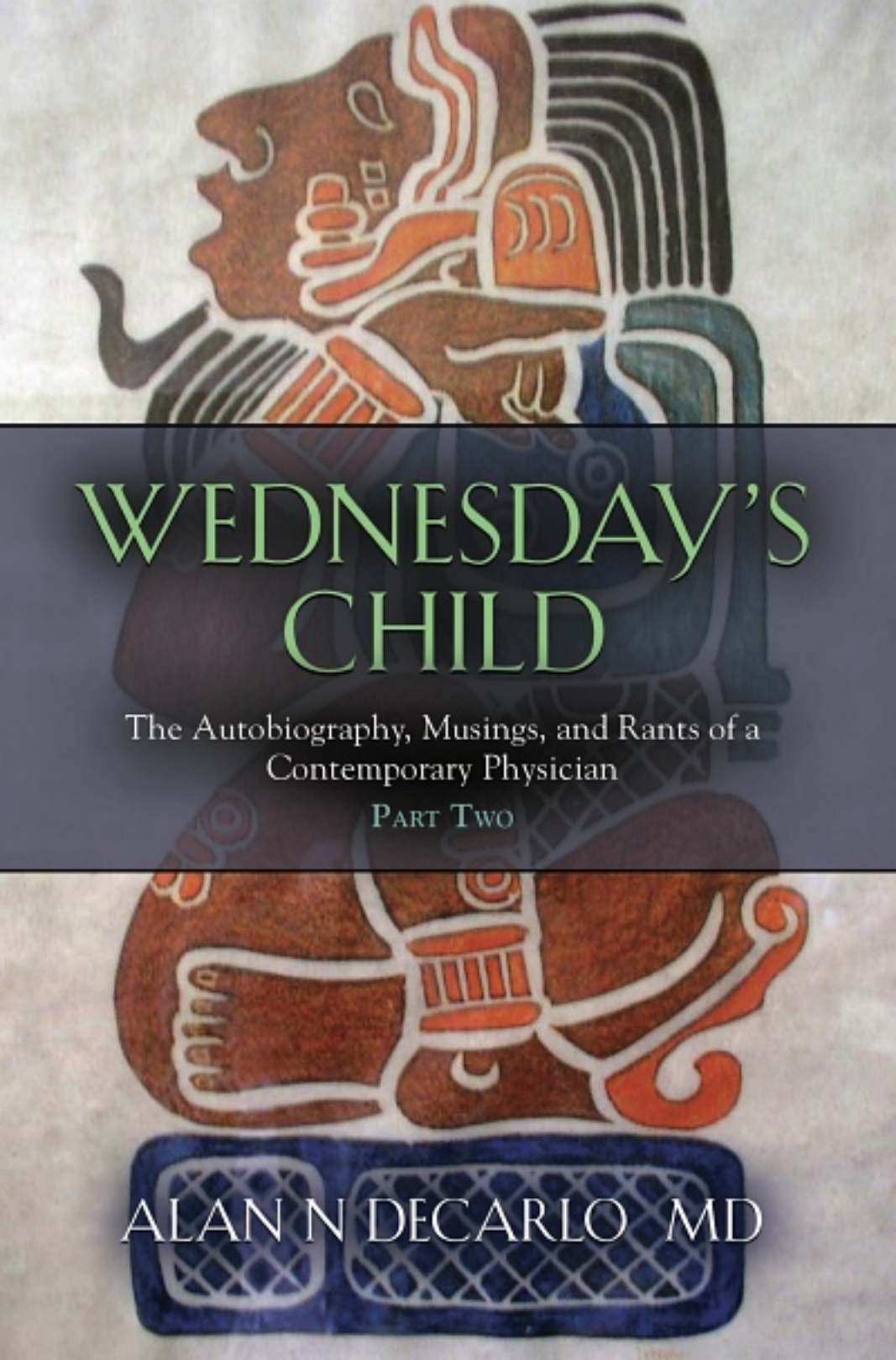
The Autobiography, Musings, and Rants of a Contemporary Physician - Part Two

By Alan N DeCarlo M.D.

Order the book from the publisher BookLocker.com

https://www.booklocker.com/p/books/12162.html?s=pdf

or from your favorite neighborhood or online bookstore.



WEDNESDAY'S CHILD

The Autobiography, Musings, and Rants of a Contemporary Physician

PART TWO

ALAN N DECARLO MD

ISBN: 978-1-64719-908-1

Published by BookLocker.com, Inc., Trenton, Georgia.

Printed on acid-free paper.

BookLocker.com, Inc.
2022

First Edition

Part Two: Manhood

A: Training days

Bar Mitzvah: 1973

Saint Luke's Hospital in New York City is a voluntary not for profit private institution located on the upper west side of Manhattan.

It is also one of several satellite teaching hospitals belonging to the Columbia University Medical School system, whose mother ship, The Presbyterian Hospital of Physicians and Surgeons (P&S) is located further uptown near the George Washington Bridge.

Saint Luke's is nearly adjacent to the undergraduate campus of Columbia University located to the northwest and separated from Harlem to the east by Morningside Park. The surrounding neighborhoods consisted of a mix of university students and faculty, hospital workers, the earliest vanguard of upwardly mobile yuppies, as well as the dregs of slum dwelling humanity.

The most impoverished elements consisted of Hispanics, mostly emigrated from Puerto Rico, and blacks that had emigrated from the Southern plantations at the end of the Civil War. At that time neither Harlem nor Spanish Harlem were holding out any bright rays of hope or promise of better lives for these denizens of New York City's populous infrastructure.

The result was that the local indigent population marginally used medical clinics for long term health care. More likely than not, they only used the hospital when they were forced to do so because of emergencies, crises, critical illnesses, or when they were in extremis. These crash-landing presentations usually fall into the vernacular medical designation known as "The Train Wreck," often requiring an enormous dedication of resources and clinical acumen to get their victims better and back on track.

The hospital owned two rental apartment buildings that availed subsidized affordable housing to the Medical and Nursing staffs. Because both buildings were located directly across the street from the main building this made commuting to work or taking night call safe and easy. At that time, many New York City streets were hazardous at night.

Before Rudi Giuliani took the handcuffs off the police and let them do their work, the city under Mayors Abraham Beame, David Dinkins and Ed Koch was a denizen of thieves, muggers, pushers, pimps, prostitutes, junkies, drug dealers, and professional street beggars. Homeless people not littering the streets squatted and took over public areas such as sections of Pennsylvania Station, bus terminals, or parks.

Certain highly profitable street corners were up for sale on the beggars' underground commodities market, sometimes fetching prices as high as five

thousand dollars. Conversely, any beggar who attempted to encroach on someone else's established territory might risk a knife or a gunshot wound. Even an ordinary citizen taking a casual or accidental stroll either through the Pennsylvania Station Homeless Homestead or the notorious Needle Park could risk buying a one-way ticket to the morgue or an admission to the St. Luke's Hospital Intensive Care Unit.

This was when my brother's advice rang true about how to survive on the streets of N.Y City

- Wear old clothes so that you look poor, always put on sneakers in case you need to run, keep cash in the toe of your shoe, and above all else never make eye contact with anyone. And I mean never.

I eventually learned how to navigate the streets and to anticipate or avoid potential trouble. But after five years of street survival, it took another five years of living in the peaceful suburbs to stop continuously looking over my shoulder or jumping out of my skin if I heard someone running, jogging, or walking briskly on the street behind me.

The teaching hierarchy of the hospital consisted of university appointed Attending Physicians who directly supervised everyone else who was in training as distributed in the following pecking order: Fellows, Chief Residents, Senior Residents, Junior Residents, Interns, and finally P & S Medical Students. The hospital's forte was Internal Medicine and Surgery, particularly vascular and cardiac surgery, with the open-heart program headed up by one of the finest surgeons of the day, John Hutchinson. He happened to be a light skinned black man who could easily have passed for white. In fact, everyone thought he was white. This included the white, redneck Afro-American hating bigot from Easthampton who subsequently crapped his pants when he found out that a black man literally held his heart in his hands when reattaching all the vascular plumbing necessary to keep his bigoted black soul alive.

For the most part the medical staff was required to take care of general ward patients, meaning those indigents who were admitted without private insurance. They also comprised the bulk of the hospital census.

The Medical Intern and Resident staffs had mandatory rotations in general medicine, emergency medicine, intensive care, cardiac care, and the private medical ward. Private patients, mostly from the white upper class, were segregated to another wing of the facility and taken care of by their own physicians. While some of them held academic appointments, and were excellent physicians, there were others who practiced like they had never read anything current in medical advances since the day they left residency.

Although this might seem to mean that indigent care was second rate, in fact the opposite was closer to the truth. By default, these impoverished people

were being exposed to the latest and most current thinking that medicine had to offer, along with daily supervision of care by faculty appointed academic physicians.

In counterpoint, for a few mandatory months we were required to rotate through the private wards. Most of the house officers eschewed this responsibility because they had no control over case management, coupled with being looked upon by both the doctors and their patients as being lackeys or marginally competent nuisances.

- Who are you?
- I'm your intern.
- I want a real doctor. Where is my doctor?
- Probably sitting at home watching TV and into his fourth Martini by now. Want me to call him in?

However as just alluded to, some of the private physician's lack of skill and judgment was typified the day that my Junior Resident found the patient of a doddering old Internist to be in severe congestive heart failure and on the brink of death. He amended the Internist's tersely inadequate handwritten chart note of an hour before from: "Patient is short of breath. Let him rest" to "Patient is short of breath. Let him arrest" by scratching in the "ar" in front of the "rest." What the patient really needed was an urgent transfer to the CCU while the sarcastic forgery was motivated only by the fact that the Resident had become fed up trying to salvage and then cover up other people's less than handy work.

In fact, the only thing this aging monument to cavalier medicine was good for, and the only time I ever heard him speak up was usually during a clinical conference. Without fail he would correct anyone who ever used the phrase "mitigate against" by suddenly piping up to say "Militate. The word is militate." That solitary fact he had down pat.

His terse interruptions reminded me of one of my private patients when I went into practice. He was a noted author and a retired English professor who proverbially corrected my mispronounced use of the term "angina," every time I used it in reviewing his symptoms. This same brief monologue was reiterated. He said,

- The word is Latin, ergo the "i" is a hard "i." It is not like the soft "i" in the alcohol 'gin' but rather like the letter itself, and ergo—an-geye-na. When referring to the female genitalia, you do not say va-gin-a, do you?
- Only if I am falling-down drunk, sir. Then I call it pussy. Derived from the Old German puse vulva, meaning a pouch, a sack, a scabbard or to stuff something.
- What you really mean to say is when you are irrevocably inebriated, yes? And the word pussy is not German. It is derived from the Old English

meaning: warm, soft, and furry. Ergo pussy cat. Referring to it otherwise is vulgar.

- Okay then. When I am irrevocably inebriated, I like to stuff the warm, soft, furry, pouch of a female Homo sapiens with my pendulous phallus. Now let us get back to talking about the immediate problem with your dolorous cor viscus.

Of course, since every other doctor on the planet mispronounces the word, whenever I subsequently said 'an-geye-na' my colleagues skeptically raised their eyebrows, sniggered, and shunned me like a pariah. This type of vulgarity, in heralding the end of the classical Latin period in medicine, was only the beginning of more vulgarities to come that occurred in parallel to the same demystification in the Roman Catholic Church.

- Per omnia secula, secula, seculorum. Amen.
- Huh? What does that mean?
- Forever and ever, Amen.
- Then why didn't you just say so? And what does "Amen" really mean?
- Incontestable truth. No arguments or debates. Written in stone. Final word. Period.

Upon this backdrop, the arrival of my Medical Intern group in July of 1973 was as inauspicious as would be a personification of T.S. Eliot's poetic line "not with a bang but with but a whimper." It was like throwing a new cog into a finely tuned gear system that momentarily groaned and tried to reset itself without stopping to wait for the appropriate mechanical adjustment—but then went on relentlessly grinding, remolding, and incorporating the offensive small kink without having to stop for repairs. That is because illness never takes a holiday or a day off from doing its dirty work.

We were mutually introduced, given a cursory orientation, told what was expected of us, given our schedules, handed keys to our call rooms, and then told to "go to work."

As joyous a day this was for the Interns ahead of us who were now being promoted to Junior Residents, it was equally a sad anxiety provoking day for us neophytes. And even though the medical students who would be assigned to work under us were theoretically at the bottom of the totem pole, it was a false bottom because the real responsibilities resided with us.

These duties would now include: admitting new patients, writing their orders, rounding on existing ones, coordinating care, ensuring complete and neat charts, collecting data, knowing all the pertinent data, drawing blood, starting IVs, staining blood slides. Then worst of all, every third night having to be on twenty-four-hour call, which really means thirty-six hours. All day-all night-next day all day.

Being on call required staying on premises, sleeping in the building, and carrying a pager. Then for either twenty-four hours—or worse—for seventy-two hours straight on weekends—to be available for new admissions, while at night being responsible for problems on the entire ward.

The Junior or Senior Residents provided backup. However, it was conveyed sternly on day one that these individuals were only to be called for legitimate questions of management or if a person was too overwhelmed with work to be able to function.

It was plainly stated that all house officers prided themselves in being able to "suck it up" and that being "overwhelmed" was a relative term one should rarely if ever invoke. Or if so, it had better be truly overwhelming—such as a tsunami of critical illness.

This was suddenly authentic and ultra-serious business. School was finally out for good. But now it was going to be a litany of far more pencils, infinitely more books or journals, and significantly more teachers' dirty looks.

I never felt as inadequate as I did on that first day when the full realization hit home that I now had to be a real doctor with responsibilities for other people's lives. The closest second to that would come later when I finished training and went into private practice. That was with the full realization that even though I had a bit more experience, I now had no one to back up any of my reasonably solid or sometimes meekly tenuous clinical decisions.

I reported as required to one of the general medical wards on my first rotation and was met by a gleeful newly promoted Junior Resident who would be my immediate supervisor. He gave me a patient list that was headed up by an elderly black male who had already been admitted with pneumonia. Then in turning over the pager he said,

- I don't know if you are Jewish or not—but think of me handing off this pager as being your real Bar Mitzvah—because today, my boy is the day that you truly become a man. And by the way, it's bad form to let your first patient die. So, good luck—and welcome aboard.

Mazel tov

As fate would have it, my veritable bad luck was to draw the lot of being on 24 hour call the first night I worked. I was paired with another Intern in charge of another floor, and we found ourselves assigned as roommates to one of the call rooms.

At about midnight when we had finished enough work to attempt sleep, we opened the call room door only to be met with a spate of truculent curses from the two newly promoted residents we had rudely awakened. Apparently, they had not been informed of being assigned to other rooms. Nicer rooms. Nicer, bigger, and better Junior Resident's rooms.

But because physical possession of the bedroom is 10/10ths of the law, we were not greeted with a soft mattress and pillows but with hard and harsh castigations instead.

- Get the fuck out of here.
- But this is supposed to be our on-call room—and we have the keys.
- Get the fuck out of here. Sleep on the floor. Sleep anywhere. We don't care. Just get out.

We did find a place to sleep. Not on the floor, but as a close second in the hardback plastic chairs located in the patient lounge on our ward—leaning back and using a small table for a footrest hassock.

That was after cleaning up the filthy ashtrays and food remnants that were pocketed about the room, then snarling a territorial warning at any wayward patient who wanted to come in and satisfy his nicotine fit.

Needless to say, we did not get much sleep. Or even if we did nod off, one of the two beepers would periodically beep either beckoning us to retrieve a new admission from the ED, to answer some nurse's call for an IV insertion, or to give an order for a sleeping pill or a laxative. Or worse, for someone whose status had deteriorated and required us to make a personal appearance, an appraisal, or medical stabilization that could easily take the rest of the night.

That was not bad enough, as by the next day the black man with pneumonia died suddenly in his sleep. This left me wondering why I had ever chosen this profession and second-guessing what I had done to cause this person to die. I had no self-esteem, got no sleep, and while now having to face another workday, started it off exhausted and fully believing I was an inadequate involuntary murderer.

But the Junior Resident was compassionate when I told him how I felt. He said it was only a joke about letting my first patient die, adding that the man had such an advanced illness he had little chance of survival anyway and that all physicians lose patients throughout their career.

He said that the best you can do in retrospect is to believe in yourself. Then he added that in always second guessing everything you do for someone; you will always find peace or solace if you can honestly say you did absolutely everything you could. He also said that at all costs you must retain a sense of humor, because this was the kind of business that, above all, required a person to be able to laugh—just to keep from crying.

- This is why we are training you and that is how we will train you. I can also tell you for sure, there was nothing else you could have done for that man. It was entirely up to God and the antibiotics we used. So, in the end it was obvious that for him that neither of the two worked out favorably.

About eight months later when I was assigned to the ICU and got a patient with multiple interacting, terminal co-morbidities, this same Resident ripped me a new asshole when I suggested we should just go ahead and let him die.

- You don't know enough yet to decide about life and death. You have no right to think like that at this stage of your career. Yes, this man has little or no hope. But any hope is enough to give him every benefit of the doubt. And since he is in renal failure, tomorrow I want you to give the group a small dissertation on treating the medical complications of uremia as well as an explanation for the mechanism of renal tubular acidosis. We are going to use this patient as an example of pulling out all the stops in treating every medical complication he might have. This is a major teaching center, for God's sake. Now in the future, I will inform you Mr. "Let Him Go" when I think you are experienced and smart enough to be able to make those judgments. So, while you are studying tonight for

> your uremia presentation, think about whether you would say the same thing if that man was your father.

Even though the man died several days later, the episode served to be both humbling and educational. From that day forward, every terminal illness served to teach me not only the natural history of numerous diseases, but also afforded me the opportunity to do everything in my power to abort or favorably modify the end-game—Meet the Reaper.

Secondarily, it taught me better judgment and widened my perspectives.

Taking care of someone in the downward irreversible spiral staircase leading to death is sometimes like holding back a flood by sticking your finger into a cracked dike. These situations serve to occasionally allow for the earlier interception of a reversible clinical problem in someone else who might die the same way, if not for the physician's personal experience, anticipation, and diligence. As physicians, we never "let people go" unless they are terminally ill, or brain dead.

Terminal illness is defined as having a disease that has been maximally treated to no avail and with no possibility of living for six more months. Drug refractory metastatic cancer would qualify.

Brain death is defined as having absence of brainstem function and two flat brain wave studies taken with twenty-four to forty-eight hours apart. Two physicians then must sign off on the diagnosis. Although as a basic rule, we exhaust all resources to save people, sometimes people simply die, and often unexpectedly, no matter what you do.

One exception to not letting someone go occurred during my training when I was a Senior Resident and finally let a twenty-eight-year-old black man bleed to death. He was a hard-core recidivist alcoholic with cirrhotic liver failure that caused portal hypertension resulting in massive recurrent bleeding from esophageal varices. His liver was dead, and the rest of his body was trying to catch up. It was also before technology had advanced to the point of liver transplantation.

My heart went out to him initially because he had no family or friends, and I fully believed his environment had conspired to provide such little hope in life that he had found solace in booze as his only means of escape.

The real problem was, as it is with most dangerous addictions, that the escape eventually becomes permanent. But in taking a protracted course, as the ship slowly sinks, the addict also sucks too many other people or other valuable resources into the vortex along with it. That is of course unless the addict does everyone a favor by inadvertently taking a lethal overdose.

Being naively enthusiastic, I spent a great deal of time with him, counseled him, got him briefly to go to AA, and arranged for social service support—but to no avail. He always coupled the vacant eyes of a hollow lost soul with the inadequate personality that had already put him beyond reasonable reach. There was simply no humanity left inside the thin remnant of his human shell.

As with any addiction, I eventually came to recognize his look as the same predictive look of recidivism I would encounter repeatedly in clinical practice, especially when counseling against tobacco use, drug abuse, alcoholism, or obesity. When you tell someone that they must stop smoking, drinking, taking drugs, or overeating, their eyes immediately glass over vacantly and either roll up or glance off to the side. Their facial expression suddenly becomes a blank mask. This lets you know immediately, simply because they do not want to, that there is no hope for that person to break the habit.

This man then, had multiple admissions due to relapses of a drinking habit that caused repeated massive bleeds. It finally culminated in a hospitalization that required twenty-eight units of blood and depleted our blood bank. With every treatment option exhausted, the case went beyond even the gastroenterologist's or surgeon's ability to stop the crimson flood. Even the best minds on the subspecialty medical staff capitulated and gave up. They unanimously pronounced that there was nothing else to do. If he kept bleeding, he would eventually die.

His intern called me one night to tell me the patient was going into shock and should we "just let him go?" After I gave him the same lecture that I received two years earlier, then telling him I would handle the rest, I sent the Intern to bed. After he left, I pulled the curtain around the young man's bed, sat holding his hand for the rest of the night, and let him peacefully die. I only wanted him to know that someone cared.

He could not be saved, either in body or in soul, and we desperately needed the bed and the blood for people we could help. It was a judgment made in the context of reasonable experience as well as one sanctioned by the academic staff. It also let my intern off the hook, in a situation where any plea I might have made for help already had a pre-ordained denial by that academic staff. Do not call us—we will call you.

Ironic, I thought, that this man who had nothing going for himself had understandably fallen under the spell of evil spirits, but that the likes of the Grateful Dead's Pigpen Mc Kernan, who had the world by the tail, died the same way at the age of twenty-six. He chronically poisoned his liver with a mixture of Strawberry Kool-Aid and Ripple wine. Believe me. At that young age this is extremely hard to do and requires an enormous quantity of fermented grapes mixed with sugar water to accomplish the task. It was said by some

eyewitnesses that Pigpen started drinking at breakfast, and that breakfast lasted all day.

One of the most difficult problems a physician must deal with is the addicted patient. The cure rate is only about thirty percent and after you do all that you can do, there is still only so much that you can really do. The rest is up to the patient. That is why the first tenet of Alcoholics Anonymous is to admit that you have a problem.

The only thing understandable about addiction is the fact that each type of addiction is the indifferent demon that does not care at all—whom, what, where, when, how or why. Hollywood, the music industry, and Mount Everest are littered with the corpses of dead addicts. Lately in the United States, adolescent and young adult heroin/fentanyl overdose deaths must also be added to that list.

In the lobby of St. Luke's hospital in Manhattan, there is a large statue of the hospital's namesake, standing in front of his mascot, an ox.

Saint Luke, a healer himself, is the patron Saint of physicians and surgeons. He was also a famed iconographer who specialized in portraits of The Virgin Mary. His own iconic mascot is usually considered to be imagery that represents sacrifice, and the ultimate sacrifice made by Jesus. But do not ever tell that to a Hindu. They believe that the cow is sacred—but not necessarily its owner.

The first and last time I saw this statue was when presenting myself for duty on day one. But for some strange reason, I never went in or out the front door after that day. This somehow created an inadvertent disconnect between my call to a supposedly high vocation and its necessary guiding light. From that point forward the hospital only became a generic base for my practical clinical education, as I never again thought of any associated spiritual implications or ramifications.

There were too many situations to come along in the future in which there was nothing fair about who lived or who died, at what age it happened, about who got what terrible disease and who did not, or about who really deserved to die and who did not. There was no logic to it, and no discernable divine plan. There were also no last-minute intercessions from some divine being or Saint for the many hapless people I saw who had fervently prayed but then had their prayers go up with the same smoke of their cremated remains.

By the time I had survived my first day at St. Luke's Hospital I never believed I was going to make it as a physician. Then in taking little solace from the good saint's inspiring statuary and legacy, I concluded by muttering to myself:

- Holy Mary Mother of God, why did I do such a ridiculous insane thing to myself?

As expected, no one answered—and then my beeper went off again.

I then spent the next thirty years of my life sacrificing myself to night call, to the point that not only did it nearly kill me, but it also eroded or destroyed most of my intimate interpersonal relationships. It then secondarily caused me to change my religious orientation as I began to direct all my subsequent prayers from Jesus, instead to Hypnos, the Greek god and patron saint of sleep.

Yes. You can keep your cow, Luke. I would rather take a Valium and a get a few extra REMs.

Saint Luke. Unknown artist

To sleep: perchance to dream, ay there's the rub.
(Shakespeare)

The Revered Ike

Shout, shout, reel, and rout
Turnabout, the gout will out

The Reverend Ike, a black minister from Harlem, was one of the original media evangelist faith healers who typified how easy it is to prey on the misfortune of others—especially those who are ill.

Unlike the few white faith healing evangelists—who at that time plied their trade on television with varieties of voodoo, chicanery, and the slight-of-hand tricks that they use on their shills—the Reverend Ike confined his ministry to

the radio. He then used a simple scam to keep the money flowing—personal testimonies combined with his version of the lottery.

He sold what he called The Reverend Ike Prayer Cloth for $9.95 apiece, with a guarantee that if it were kept under the pillow of a sick person, eventually the illness would abate as the truly faithful would be made whole and well again. It was a small 9 by 9-inch piece of common red cotton cloth, cut with serrated scissors so that the edges had a distinctively official looking jagged border. It was an item obviously easy to purchase for pennies that could be re-manufactured in one's own home.

That is except for the fact that a generic version would not come bestowed with the official blessings like the ones only the good Reverend could impart. That power came only after the cloth had run through the fingers of the factory workers who cut and shipped them out by the thousands in individual officially sealed and stamped plastic jackets.

The way he kept the factory running was by two means. First, he aired the testimonials of the many people who had been cured or healed by the mystical cheesecloth. Then he aired the testimonials of those who had won the occasional car or lump sum of cash that he periodically delivered by random selection throughout the ghetto.

Not only could you be healed, but you could also win money or a Cadillac, too. And everybody knows how good that could make you feel even if you did have something as onerous as diabetic nephropathy. At one point in time, he even began to invite any members of his congregation who owned a Cadillac or a similar status symbol to an annual event he called "the blessing of the cars."

Prayer cloths were not the only things that Ike sold in his coterie arsenal of religious healing artifacts, and to his credit he became one of the richest black men in America.

The only reason I knew what the holy cotton looked like is because I found one under the pillow of a poor elderly black woman who had just died of cancer. Then right as I was getting ready to throw it in the trash, her daughter came into the room pitching a screaming hissy fit about saving the holy relic to be recycled on another sick family member. I said,

- What is this thing?
- That be da Reverend Ike prayer cloth.
- Why do you want this silly thing? It surely didn't do your mother very much good.
- Momma just din' pray hard enough. She had lost her way and had lost her faith in Jesus. That's it. She jus' gave up. I know dis because I got my own cloth, an' da cloth I pray on at home have saved me from goin' stone blind myself.
- Are you sure that isn't only because your cataracts haven't matured?

- You ain't nothin' but a no-good faithless heathen. An' that thing won' never do you no damn good even though yo' sassy ass could use some o' its fine power. Now gimme back my momma's cloth. Hand it over.

The witnessed testimonials, yes. The scorecard of failures, no. And if so, the rationalization for the failures were still linked to the coffers being shorted on the necessary stacks of faith, prayer, and enough dinero to buy many more red prayer cloths.

I do not mean to pick on one specific faith or belief set over the next. The problem resides in making a profit by selling false hope. Unfortunately, however, the ability to pander to false hope crops up everywhere under the guise of a religious sanction that is independent of a person's faith or race. I did learn along the way to always err on the side of offering hope, but to never offer false hope in a definitively hopeless situation. Even then, the truth must be delivered in a compassionate manner.

The Catholics have their cure-all Holy Water along with other specific rituals such as blessing the throat with crossed candles. This represents the day Saint Blaise, who at some undefined point in the early 300s A.D., miraculously saved a young boy who was choking on a fish bone. The ritual has to do with preventing diseases of the throat. However, some fish bones often become unstuck on their own, while others might require the miracle of endoscopic retrieval.

Thus, being sainted for accidental good fortune is only another example of an extreme leap of faith. But then again Catholic dogmatic lore is replete with reshaped versions of supposed miraculous events. The worst example is the fabricated story of the Holy Infant of LaGuardia in Spain, a baby who was supposedly brutally killed by "Conversos."

These were a group of people in the 1400 and 1500s, that were predominantly Sephardic Jews or Muslims who had forcibly converted to Catholicism. It also included any other person who in not being a pure-blooded Spaniard such as a Gypsy or a Moor also converted to Catholicism to conform to state religious regulations.

My mother's Cooper ancestors were included in this lot of individuals who had to become a Catholic or otherwise risk torture, death or burned alive in a public square—the infamous "Auto de fei." Under the guise of national religious purification and a desire for revenge that was condoned by Queen Isabella in the Great Inquisition, these converts were then ferreted out by the sadist Father Torquemada and tortured to death. The rationale was that despite changing their credo they could still not conclusively prove beyond any doubt that they were not "true believers" or still clandestinely practicing their old faiths.

The secondary agenda of how the Church sold the idea to Queen Isabella was simple economics—mutually splitting the assets of the accused deceased. These profits eventually subsidized the Spanish exploration and exploitation of the New World, while simultaneously filling the Vatican's coffers. Result: The Catholic Church became wealthier, Spain was racially purified, ninety percent of the American Indians died, and half the world currently speaks Spanish.

But the real point of the illustration is that the so-called murdered infant never even existed. Then even though all attempts to verify the story or to churn up the corpse hopelessly failed, the effort did not deter the incarceration, torture, and subsequent death of the so-called perpetrators.

The Catholic Church to this day still reveres this holy non-existent infant, while the model of effective state purification by using scapegoats to rally the masses was not lost on such modern heroes as Adolf Hitler and Joseph Stalin. Or even at more subtle levels, not lost on American politicians.

People believe propaganda, such as a murdered then a subsequently sainted baby, because it gives them hope. People also tend to see, hear, and believe things simply because they want to—even if all these "things" cannot necessarily be validated. It makes life easier and more convenient to blindly believe in something than be required to think or apply reason and logic.

Similarly, it would be equally foolish and a clear monument to false hope for some "true believer" in the God of Nicotine to smoke a pack of Camels every day and then use the annual Saint Blaise throat blessing for cumulative warranties as prophylaxis against laryngeal cancer.

Why the Catholic Church does not have more Saints for more body parts is unclear, but then again as an institution it does not excel either in the art of faith healing. That art is exclusively reserved to the more radical spin-off faiths of the Protestants.

Some branches of Evangelical Protestants hold revival meetings in faith healing tent shows where a good smack on the head can suddenly cure a cripple or make him ecstatically throw down his crutches and walk the walk of resurrected Lazarus.

It is a beautiful thing to observe the well-rehearsed dazed look on the victim after the frontal head bash, followed by the poignant pause that comes immediately after—but just before the miraculous cure. In some ways it resembles a good actor having been coached in the art of mimicking a person in status epilepticus.

These Ecclesiastic jolts from God remind me of the cerebral electroshock therapies administered in the 1960s by the psychiatrists who thought that all depressive disorders could be cured by the equivalent of plugging a person's brain into a 220-volt socket. That is except for the fact that the only real tangible result of this therapy was to create the equivalent of human Head Cheese.

Or better yet as exemplified by my favorite Evangelical trick whereby a malignant tumor is removed from an abdomen—onstage, transcutaneous, barehanded, without anesthesia, with no antiseptic wash or drapes, and with no visible knife marks or blood loss. What a fool I must have been to believe that laparoscopic surgery was a modern-day miracle, when instead I could have had this bloodless procedure done on my own diseased appendix.

Why these healers do not share this exciting technology with modern doctors so that it could then be used for so much greater good is beyond me. It therefore leads me to the logical conclusion that there must be extreme and strict patient selection criteria going on inside the tent show.

Tell it like it is. P.T. Barnum referred to his sideshow accomplices as shills. The same goes for the "innocent" bystander at the street-side game who picks the right card or the right shell as he and the card shark sucks the rest of the audience into playing.

At Lourdes, France, some people have been known to spend their life savings to travel there just to bathe in the water where in the late 1800s some delusional hallucinating fourteen-year-old girl claimed that a woman dressed entirely in white, except for a blue sash, repeatedly appeared to her.

However, Bernadette never personally claimed the vision to be that of the Virgin Mary. Other people did. And although she was cured of asthma, leading to the great myth of the water's medicinally miracle producing properties, the cure may have more been because she eventually moved from an overcrowded dust laden hovel into a clean monastery on a mountain top. What they do not tell you is that the water failed to eradicate the Tuberculosis that eventually migrated into her bone marrow and then, in fact, killed her.

The great irony of the story is that now about five million people a year journey to Lourdes where you can buy some of the holy healing liquid and take it home to your friends in a tiny glassine bottle. That is if you feel like sharing it. If I owned some of this holy fluid, I think I would priggishly save it for something personally devastating like terminal bone cancer, then remotely think about wasting it on someone else. After all: Primum non nocere. If nothing else, it could first do no harm.

I had an Irish girlfriend whose father brought her some Holy Water after he visited Lourdes. She became incensed when I put a few prophylactic drops in my coffee because she too admitted that she was hoarding it for herself. So much for charity; and so much for faith, hope, and love in our relationship, too. Then when she was not looking, I rubbed some of it on my face anyway and went about keeping my blessed fingers crossed and my holy nose clean.

Of course, there is the occasional anecdotal story of a miraculous cure of some potentially fatal disease, although not necessarily linked to religious faith.

The problem being that when anecdotal prayer, icons or visions become involved, the inevitable result is that these events only create hysteria, generate false hope, and produce income for someone or some organization already set up to capitalize on the grief and despair of the faithful, but willfully ignorant flock.

There is no better statistical outcome for throat cancer or any other disease even if you get the candle blessing or gargle with the nasty contaminated Holy aqua in the cistern that everyone puts their grubby fingers into on the way out of church.

On closer scrutiny, some of that liquid resembles what you see if you snorkel in a public swimming pool—snot chunks, hair balls, skin grime or toilet papered dingle berries. Getting it on your hands might even be a good way to catch someone else's cold, or worse an incurable fungal, viral, or amoebic infection.

The same thing applies to drinking communion wine out of the public chalice. You would not go into a bus station and lip-kiss everyone you see waiting in those pews, would you?

I am the first one to admit how great it would be if all these potential cures worked. Then the methodologies could be published in the best medical journals, I would be out of a job, death would be on a permanent holiday, and everyone could possibly live forever.

But the odds of that miracle cure are less than those of winning the Power Ball Lottery—slim to none and based on the same principle that guides these wishfully hoping monetary games: dumb, indifferent, anecdotal, blind luck.

The Prayer Cloth. Your ticket to heaven and everlasting life.
Buy two…and get one free.

An Alternative Plan

The intern I was paired with on that first night of work at St. Luke's was an eccentric little man of Irish extraction named Edward. He was about five feet five inches tall, height and weight proportional except for a peculiar, barreled chest conveying an impression of false upper body muscularity. He also sported a full Santa style blond-brown beard and wore old fashioned granny glasses. For a twenty-six-year-old man this made him look hoary and wizened. Some people even mistook him for being a professor.

There were so many ancillaries stuffed into his white jacket, including a gold pocket watch and fob, that if not for the color of the coat he would have looked like an old-fashioned top-heavy train conductor. The good thing about these accoutrements was that he could always be counted on in a pinch to supply an extra pen or a tourniquet or even a few extra crib sheets. The bad thing was that

he always seemed to fumble excessively to fetch them and always with tremulous shaky fingers suggesting a massive overdose of caffeine.

He had several odd peculiarities including a near perfect photographic memory, a penchant for baseball trivia and a tendency to lapse in and out of a contrived Irish brogue. Attempting to pass himself off as being from Ireland, the accent was one of many small yet innocent fibs that he had manufactured to build a personal mystique designed to mask certain physical inadequacies. This made it amusing to hear him lapse in and out of bad brogue impersonations as if he thought by doing so this would endear him to some legitimate inhabitant of the Emerald Isle.

He was short, nonathletic, and prone to episodes of pulmonary bronchospasm that required reversal by using large doses of theophylline. The drug then explained his tremulous shakes as well as the fact that he hardly ever slept—or for that matter seemed to even have a need for sleep. It never dawned on me until much later that his chronic lung disease also explained the barreled chest that somehow presented a false impression of upper body muscle development.

Asthma was his excuse for never participating in high school and college sports or being handy with the ladies. But he made up the difference by having a massive intellect along with an enduring passionate love for the New York Yankees. His ability to quote baseball trivia was encyclopedic.

The cover story he polished and retold was that of a puny asthmatic little boy, unable to run or play with the other kids, which explained his book-worm reclusive habits. He also repeatedly iterated the fact of having an immune globulin deficiency to explain it all away, then evoked even more sympathy by claiming to be a hapless genetic mutant.

Another tale of pathos he told and re-told was that because he was born on Thanksgiving Day, a day that always falls on a Thursday, but not always the same calendar date, meant that he never had a real birthdate to celebrate. He also said his mother annually reminded him of the fact that she had truly given thanks when he finally emerged from the womb, making the holiday/birthday itself hold only mixed feelings. The question as to why he did not celebrate the real date itself and avoid the holiday issue altogether went perpetually unanswered.

He even went as far as leading all his friends and relatives to believe that he was still a virgin, but only because he was following the Catholic dictum requiring one to save celibacy for whomever became his lawfully wedded wife. The virginity issue was questionably difficult to prove one way or the other. However, when we eventually did share a house, he never had a woman sleep over, making the truth behind his virginity more likely due to his fumbling inadequacy in dealing with the opposite sex.

In fact, if he even did get a date, he would screw it up with ridiculous boring intellectual banter usually followed by turning crimson and then starting to wheeze. Although he said it was always the woman's perfume, it was more likely nervous anticipation coupled with inadequately socialization. Even though the asthma itself was audibly genuine, the real reason for it was yet another lie that eventually turned out to be fatal.

His penchant for drinking included consuming excessive quantities of Guinness Stout, or for that matter any other Irish lager. When he had his hands wrapped around a mug of grog, and with his barreled chest, short stature, and beard, he often resembled a perfect but unintended impersonation of an Irish Leprechaun. The alcohol served not only as an ordinary bad habit but was probably one of the few things that helped him to sleep at night.

It took several years but I finally began to learn the difference between his numerous embellished tales and the truth by a certain tone to his voice, the way he shifted his eyes down and to the right or the fact that those same eyes would often betray themselves because of a devilish impish twinkle.

As it turned out, he was not even born in Ireland meaning that the only things genuinely Irish about him were his last name and his ability to spin a yarn. Sometimes, even our own personal adventures later took on a life of their own that even I failed to recognize. I told him that he must have some Texas blood in him too, because in Texas they never let the truth get in the way of a good story either.

He had gone to Fordham University as an undergraduate and to convey an idea about how bright he was, in 1968 he was a member of one of the few undefeated teams that participated on the TV quiz show "College Bowl." He said that he and his teammates became so bored with the show—as well as running out new material for the interjected polite banter designed to reveal the human side of the contestants—that they were finally asked to leave after one quietly censored interaction with the game show host, Allen Ludden.

Ludden discovered that one of the students on the team grew up on a farm. Then after running out of the usual inane pedantic streams of personal questions, asked him if it was sometimes a boring lifestyle. Then if so, what had he done as a child for self-entertainment on some of those enervating occasions.

The insouciant answer gave credence to the failsafe concept of delayed taping censoring in the telecommunications industry.

- Why Allen. Especially on nights when the moon was full enough to light our way, my brothers and I would sneak out to the back pasture and take turns screwing a randy old sheep.

However, it was precisely because of Edward's intellect and his quirky personality that I gravitated to him, and we eventually became close friends. I always had a penchant to be attracted to oddballs anyway, principally because

I found ordinary people to be mundane, excessively boring, or far too insular in their beliefs and habits.

Not that I was a rebel, but at least I wanted to know that the people I was interested in were somewhat alive and breathing as opposed to half dead Zombies living in stodgy predictable cookie-cutter worlds. Or worse, human robots bound down by religious beliefs that stifled their humanity, their ability to think objectively, or worse, their ability to have fun.

One thing never made clear to anyone entering medical school is that predictably for the rest of their lives they will have to take night call. If there was an orientation program that included a warning about this drudge—accompanied by a reality check as to what it really means—I believe that half the entering classes would drop out before they started.

There was only one incident during my training in which I suffered enough sleep deprivation, after been awake for seventy-two hours straight, that I hallucinated. Bright colored little balls flashed as they orbited my head, and my logical thought processes came to an abrupt stop.

After sleep deprivation was blamed for a mistake made by an intern at New York Hospital, medical training programs now limit to eighty hours per week the total shifts that Residents and Interns can work. While caring for an eighteen-year-old college student, Libby Zion, she died after an intern gave her meperidine which reacted with another drug, phenelzine, that she took for depression. The family successfully sued, and the Libby Zion law forced the cap on call hours.

The countervailing argument to limited training hours is that the restriction may also limit critically needed experience.

- So how was your Residency program?
- Great. Slept right through it. Didn't learn a blessed thing, either.

So, after about three months of taking night call and sacrificing many hours of sleep, Edward and I came to the simultaneous conclusion that doing this for a lifetime would undoubtedly play itself out by shortening our own lives. There had to be a better way. Unfortunately, however, we were too snobbishly cerebral to take the easy way out, like signing up for a Residency in Dermatology. Intellectual medical snobs believe that Dermatologists only need to know two things about rashes. If it is dry, wet it—and if it is wet, dry it. Just about anything else medically challenging, except for Psychiatry, would require night call. Most suicidal patients just go ahead and kill themselves and do not call for help anyway.

In those days we were also too short sighted to know how lucrative Dermatology, Radiology, Anesthesia or Plastic Surgery would become or we might have happily traded forced insomnia for mountains of cash.

Whatever the case, Edward took it upon himself to contact the Dean of the Harvard Law School and made a discreet inquiry as to whether there might be a chance that the two of us could get in.

His letter of inquiry was answered by a personal phone call from the Dean himself.

- Let me get his straight. You two just finished Medical School at Columbia and Tufts. You are both M.Ds doing an internship and you want to come to Harvard and go to our Law School. Correct?
- Yes, sir. So, what are the odds of getting in?
- No odds whatsoever. You two fly up here tomorrow. Not only will I interview you myself, but I will personally guarantee you both a spot in the next class. Are you kidding? Doctors who want to be lawyers? After Law School you can write your own tickets.

The Harvard Dean was savvy enough to know that a bright future lay ahead for a nasty subdivision of the law as the hey-day of medical malpractice litigation was just beginning to blossom. Either that or corporate pharmaceutical liability had a significant need for physician lawyers. Edward and I talked it over, but decided we were too burned out on schoolwork to consider another three years behind a desk. Then there would have been the cost.

I suppose we failed to realize the possibility of scholarships or alternative funding, such as some prestigious Law firm giving us the tuition in exchange for a future commitment to work. In the end we committed ourselves to follow in the footsteps of our Patron Saint and in doing so not prostitute ourselves to the Devil himself.

It certainly might have been lucrative. But in expertly helping to sabotage the careers of would-be colleagues and peers, not only would we never have saved a life, but in the process would have lost our own souls while destroying a few others.

The final irony was that although Columbia University Medical School had given me a flat-out rejection on admission, I was now going to be tutoring their medical students. Also, that same Harvard, where even entertaining an interview for a medical internship had been pointless, would now ultimately and with immense pleasure, put me into a position to potentially crucify their own Medical School graduates in a court of law.

More often than not, it truly is a crazy world.

Edward
What goes around usually tends to come back around again.
(The First Law of Newtonian Planetary Elliptical Orbit Physics)

Rounds

"Rounds" is the morning ritual whereby the medical team in charge of a group of patients discusses the past twenty-four hours of the patient's progress—or lack thereof—plans the next twenty-four hours and next steps of care and affords time for the senior staff to tutor the people under them. The word "Rounds" is preceded by a qualifier such as Surgical, Obstetrical, ICU, or Medical, which lets you know if you are in the right place, at the right time, or if it is paged overhead, lets you know where you must go.

An Attending physician, usually on the teaching staff, attends this function formally. However, before he shows his face a more informal process may have already occurred in anticipation of his visit, such as teaching or advance criticism by the Junior and Senior residents.

I am not even sure why this ritual is called "rounds" in the first place except for the fact that the team goes from bed to bed as each patient is discussed, which makes nothing round about it at all. The only time we did go around was when we had to visit the patients in a large open gymnasium-like ward in which the beds were laid out against the walls in one large circle. When nurses meet at shift changes, they refer to their discussions as "giving report." This makes much more sense.

There is also an exercise called Grand Rounds, whereby instead of walking around a ward, everyone sits in a room where an unusual or rare case is presented. Then we all beat ourselves over the head to come up with the

diagnosis that only the presenter knows ahead of time. It is kind of like the quiz show Jeopardy where the clues come first, and the answer is posed as a question.

- Answer: Persistent hypokalemia, dark skinned pigmentation, muscle wasting, and X-ray evidence of splenic calcifications characterize this disease.
- Question: What is Addison's disease, secondarily caused by withdrawal of steroids or tubercular infiltration and then bacterial destruction of the adrenal glands?

The most erudite of all Grand Rounds are the CPCs or Clinical Pathological Conferences held at The Massachusetts General Hospital in Boston that are subsequently published in the New England Journal of Medicine. These are held in a large amphitheater that is packed to the rafters with doctors, students, nurses, house staff and faculty. The cases are not only contemporary and real but are also designed to be arcane sophisticated brainteasers.

Because a medical student or house officer—with his hands behind his back—is made to present a case from rote to a visiting professor, and this is followed by the professor discussing a long differential diagnosis before paring it down to his definitive answer, the exercise would better be called Ground Rounds. This is because all the prospective players undoubtedly feel as though they are being literally put through a meat grinder.

These professors rarely miss the boat and even if they do not get it right, they usually have one of the correct answers in their differential diagnosis. Much personal gloating, backslapping and all-around hurrahs accompany the pathology report when the corpse proves that the professor is one hundred per cent on target.

But on occasion, the MGH faculty likes to throw out a perverse curveball as typified by the case of a man who died of recurring heart valve infections. The infections got progressively worse as a sequence of newer and deadlier bacteria, in keeping one step ahead of each newly added antibiotic, relentlessly chewed at his heart tissue as well as seeding and destroying all his other organs.

The man finally died of an overwhelming fungal sepsis after all the bacteria had been eradicated. It became a race between drug toxicities killing vital organs while attempting to cure what was now an athlete's foot of the heart. The differential diagnosis centered on recurrent incessant endocarditis, but only the pathologist knew why there was no ability to offer a cure.

Apparently, the man had eaten a club sandwich, as well as half of one of the toothpicks holding the layers together. The toothpick then speared and lodged itself into the wall of his small intestine where it formed a nidus for a continuous bacteremia that kept shedding microbes into the blood stream.

Every doctor knows that if a foreign body causes an infection, there is little hope for a cure unless the object is first removed. My feeling was that this case, more than anything, illustrated the principle that you are what you eat, and one that even Saint Blaise might have lost his halo over for a failed cure. More than a situation requiring a candle blessing, this was more a case for simply lighting one.

At bit more fortunate was the construction worker who was brought into the emergency room in unexplained anaphylactic shock. His foreign body illness was immediately cured when epinephrine shots made him so sick that he vomited up the Yellow Jackets that got into his beer can while his back was turned. After a single final chug-a-lug, they began to repeatedly sting his stomach lining.

- Don't worry, guy. We have no intention of building a nest down here. We just want to get out. So, take that, and that, and that.

Speaking of beer, and to make the matters of rounding nomenclature even more complicated, there are the customary Friday afternoon "Liver Rounds," announced as such on the overhead paging system to cleverly disguise their real intent.

Any of the nurses or doctors who are not on call knows that this means to meet in one of the conference rooms and then drink themselves silly while they mingle for chats or mutually try to score sex. It saves having to go through the trouble of meeting strangers in a bar and would be the equivalent of having an office Christmas party every single week.

Finally, at times when the wards are packed and the overall severity of illness is acute, the whole scenario becomes more chaotic as everyone abandons protocol and then more or less frantically runs around in circles. But most often, rounds are for grass roots teaching and because various Attending Physicians rotate on all the floors throughout the year the medical teams become exposed to various personalities practicing their various specialties.

It goes something like this. A medical student or Intern presents either all the new cases he got in the past day or gives complete updates on the existing ones. The first part of the grilling comes with knowing every factual detail of the case. For raw data and updates there is no excuse for the response: "I don't know."

After that, the academic exercise begins with a spate of questions about the disease, its etiology, diagnosis, co-morbidities, and treatment. The higher up the ladder you go, the more you are expected to know. The only thing marginally compassionate about the process is that the queries start with the students and move up the intellectual assembly line from there. Bad form is to have a Senior Resident say: "I don't know," especially when it comes to a Board level question.

However, because a hierarchy handles the queries, the system automatically protects the senior people while simultaneously allowing the senior most

person to show off his knowledge. Ergo, even if the Senior Resident then says, "I don't know" the Attending Physician will get his shot at humiliating everyone else with his profound knowledge and experience.

The atmosphere fosters both an elevated level of patient care as well as a genuine desire to learn. It only backfires if the team is cursed with a pain in the ass know-it-all who enjoys practicing the dirty academic game of "one-ups-man-ship."

He is the same kid in grade school who raised his hand at every question or shouted out the answer before the teacher even called on him. The same kid whose shoelaces you tied together, put glue in his inkwell, or if it was a girl, cut off her ponytail.

On the medical wards, because it usually happens to be a smart-ass medical student, we could even the score later by assigning this person the job of doing rectal and pelvic exams, drawing blood, and inserting IVs on all the new admissions.

Attending Physicians will finish each case with their own opinions, insights, or imparted knowledge, then give guidance as to where the treatment or next set of tests should go. If you disagree, you can present the logic behind your opinion. You may try. But you will hardly ever win. Then you had better know when to just shut up, zip your lip and go do what the mentor says, because just like the rising sun, the Big Kahuna is going to come around at the same time tomorrow to ask the results of what he told you do yesterday.

But as with anything there is always an exception to the rule, and I did on one occasion see an Attending Physician excuse a less than adequate case presentation from an Intern. It happened one night when my friend Edward was on call and was beaten up by having to take about ten admissions. Edward, being the perfectionist that he was, always wrote his notes in perfect Gothic script with an old-fashioned ink pen, but hopelessly fell behind in his paperwork.

This penchant for perfect penmanship was great for anyone wanting to read or easily comprehend his chart notes or orders. However, it always took inordinate amounts of time for him to complete his scroll and was non-conforming with the rest of the profession—not to mention the ink breaks needed to re-fill the pen cartridge.

I told him his legible handwriting was a bad habit that he should work on breaking—especially since it was making the rest of us look so bad in comparison and setting potentially newer undesirable standards for doctors everywhere.

Pharmacist:

- You cannot possibly be a doctor.
- Why?

- Your handwriting is perfectly legible, and I am calling the police on this narcotics perception you just wrote for yourself.

On this night, Edward said he was so fatigued from lack of sleep that both he and his last admission, number ten, which came in at about six a.m., mutually fell asleep in the middle of Edward's intake interview. A nurse awakened Edward as the less than critically ill patient snored on into the morning.

Edward frantically raced to morning rounds, but there were no chart notes and not even a differential diagnosis on this man, and minimal written data on patient number nine. This was something that under ordinary circumstances would not go over well with the Attending physician.

Scrambling to get his act together, Edward was able to present a brilliant sequence of eight case presentations until he got to admission number nine when he simply stopped talking. He handed a terse note, in beautiful Gothic script to the Attending physician. It stated,

- This fifty-seven-year-old white female, admitted through the Emergency Room, was too stupid to give me a good history, so I have no idea what she thinks is wrong with her. She also did not know what medicines she was taking. Next, she was too fat for me to do a decent physical examination, so I have no idea what could possibly be wrong with her. In summary, my diagnosis is: Too dumb for history. Too fat for physical. Please refer to the lab data and X ray reports.

The senior doctor laughed so hard, that he almost cried, as the usual formality of teaching rounds disintegrated on the spot. Our Junior Resident covered everybody's rear and omitted even telling our Attending about Edward's last incident case of the peacefully sleeping pair of beauties. Since the doctor and the patient had both fallen asleep, that person had undoubtedly been poorly evaluated in the Emergency Department and therefore became a dump admission. "He's sick, but not really that sick. However, I am exhausted, so I'm punting. Field goal—and you lose." Hopefully, it would only be someone who might later be a same-day discharge, meaning the case would not find its way to tomorrow's patient roster. Here today and gone tomorrow—as if the case never existed in the first place.

On a personal note, I only had one situation that required me to confront an Attending physician. He was an imperious, condescendingly arrogant, know it all British Wasp Gastroenterologist who was taking his obligatory turn by rotating on the general medical teaching floors.

This case involved a man in his fifties who had emigrated from Italy decades earlier and presented to the hospital with severe hypokalemia, (persistently

low potassium levels), emaciating muscle wasting, profound weight loss, and dark pigmented skin.

This illness had been slowly progressive before he finally came to the hospital where he was admitted to my service. He looked like a death camp survivor who was so weak he could barely raise his head off the pillow. Beside the emaciation, his wife added that his dark skin color was something new.

There were no medications or any other potential etiologies to be implicated, but he did have speckled calcifications across his upper abdomen on a plain screening X-ray film, which were felt to be in the spleen. More specific CT scanning was decades away.

There were some other lab abnormalities and the Attending decided that the man's problem was probably due to occult pancreatic cancer. He would not entertain any other possible cause, even though I raised the possibility of Tuberculosis having destroyed the adrenal glands. This would have been a rare wild guess, except for the fact that the patient was born and raised overseas where TB is common, and the very unusual fact of the probable splenic calcifications.

The Attending argued that my diagnosis was impossible because the calcifications must be in a different place and then enumerated about seven other reasons why he was right, and I was wrong. Then he made us inform the family that the diagnosis was likely terminal cancer, that the prognosis was grim and forbade me from calling in an Endocrinologist. Exploratory surgery was scheduled to establish a sure diagnosis.

When I kept pushing back and made a final pitch by asking "what about the dark skin pigmentation," the closet bigot responded with a comment to the effect that all Mediterranean people "are dark anyway—especially when they go out in the sun." No matter that the man worked inside, or that it was also the middle of winter. The investigation was to proceed along other lines, while I was subjected to a severe tongue lashing about impertinent behavior and overstepping boundaries.

But I had already been taught that if one has reasonable justification to entertain an etiology, especially if the situation was unusual or rare, that all diagnostic stops must be pulled out in a search for the truth.

It was fortuitous that this admonishing conversation had occurred on a Friday. In knowing that the Attending would not be back until Monday, I went over his head, worked the man up for latent T.B., called in the specialist I needed and, in the end, turned out to be correct in my deduction. He had secondary Addison's disease.

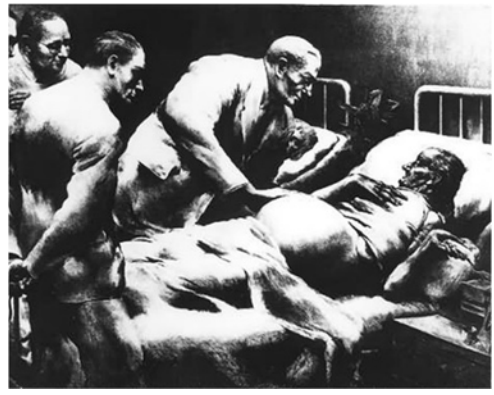
Instead of being consigned to a death sentence in six months, the man was cured by tuberculosis antibiotics and steroid therapy. He eventually walked out of the hospital instead of going to the operating room for an unnecessary exploratory surgery. When I saw him months later, I could not even recognize

him for the improvement in his physical status, including the fact that the mysterious suntan was no longer present. He was the best-looking corpse on the planet.

But instead of congratulating me, the Attending physician, was ungracious enough to never speak to me again and from that day forward never brought himself to look me in the eye whenever I saw him in the hallways. He was rooted in the thought that his status obviated any need for questioning his authority and was bitter about his bruised ego— none of which had to do with the patient's welfare. Humility and a willingness to admit to error—additional qualities that go into making a good physician a great one—did not even enter the equation.

What he had failed to understand was that I was not imperiously smug about myself or even happy he was proven wrong. I was only doing my job, part of which involves the training that tells you to sometimes think outside a box that is ultimately directed toward saving lives.

It did not matter. The patient's wife was so grateful she sent me a bottle of Galliano. Then for the next five years, she also sent a Christmas card containing the annual family portrait—always posed with her arm wrapped around her healthy, happily smiling husband.



Rounds. Great minds do not always think alike.
(Lithograph by Robert Riggs 1941: Woodmere Art Museum)

Happy Birthday, Baby

Speaking of anniversaries, one night when I was screening calls for Surgery as a medical student in Springfield, Massachusetts the switchboard operator routed a frantic woman to my phone. She stated that it was her boyfriend's birthday and since he liked to have things inserted into his penis, she had taken

two birthday candles, fused them together end to end, then stuck them in his urethra. However, they disappeared, and she could not retrieve them.

Knowing that some S&M activity involves hot wax, I refrained from asking her if she intended to leave some of the wick end showing so that she could light it up and sing. But no matter how bizarre the story or the situation, a physician must do his best to listen, but not make value judgments. Otherwise, patients will tell you nothing.

This of course does not abrogate our responsibility to offer advice about self-destructive habits and behaviors. But this one, although marginally dangerous for some secondary potential consequences, was amusingly kinky—the St. Blaise blessing of the urethra.

However, the point of the call was not so much her concern for the missing candles as it was for advice about what to do about it. She said,

- All I want to know is if I jerk him off, will that make the candles come out?
- Not a good idea. They are probably somewhere in his bladder and will have to be extracted by a Urologist. Bring him to the hospital right away.
- Oh. Okay. Thank you very much.

She never did bring him in. But this situation paled next to the case of the homosexual male couple that celebrated a birthday by one of the men pushing a small Mason jar into his partner's rectum. Why a jar when there are so many other less innocuous and more professionally designed sex devices available out there, no one knows. Perhaps this was the only available tool during a late-night spur of the moment sex-frenzied idea.

Again, this is where an unnecessary value judgment came into play and was like the situation my brother found himself in, when as a restaurant supervisor, one of his gay male employees wanted to go to the kitchen to "borrow" a turkey baster for anal sex. He was in a panic because he was running late for a last-minute hot date, had left his own baster at home and did not know what to do.

- I don't know what to do. I need a turkey baster. I don't have my turkey baster. Help me. Help me. I need a turkey baster.

My brother did not ask what, if anything, this employee put into the baster first. But not wanting to be held liable for a broken glass rectal shredding catastrophe, told him he could only take a plastic one, and then added,

- And don't worry. You won't even have to bring it back. Keep it.

Nonetheless, after that my brother had great trepidation about eating any basted food products while he worked at that restaurant.

It is axiomatic that every medical student is aware that the vagina is a very accommodating and somewhat elastic organ. After all, a baby must fit through

it on the way out. This relative elasticity also explains why both large and small things can also go the other way—meaning back in—which also accounts for the most part why, penile size usually does not matter too much or why some women can even enjoy having sex by vaginal fisting.

I guess the one exception to this rule would be when both my wife and another close personal female friend independently told me about separate prior encounters with men who had an erect penis the size and girth of a small pinkie. They both independently, but also politely, declined to even try it out. That was after excusing themselves to go pee where they laughed hysterically in the bathroom.

I asked my friend if she had bothered ahead of time to look at his shoes or asked him to compare his hand size against hers. She said,

- What possible difference would that have made?
- You know the old wives' tale. Small hands, small feet, petit meat. If you already knew about that it would have saved you a lot of wasted pre-ambling verbal foreplay.
- Well, maybe and maybe not. Because after I got over the initial shock, I felt sorry for the guy. Then my perverse curiosity got the better of me, so I gave him a blow job just to say I experienced it.
- Just like a woman.
- Huh?
- Invariably contradicts herself and then all reasonable logic breaks down. You know. Curiosity and what it did to the cat.

Who knows? Maybe it was even the same guy. In any event we do know for sure that it was probably not Tom Thumb.

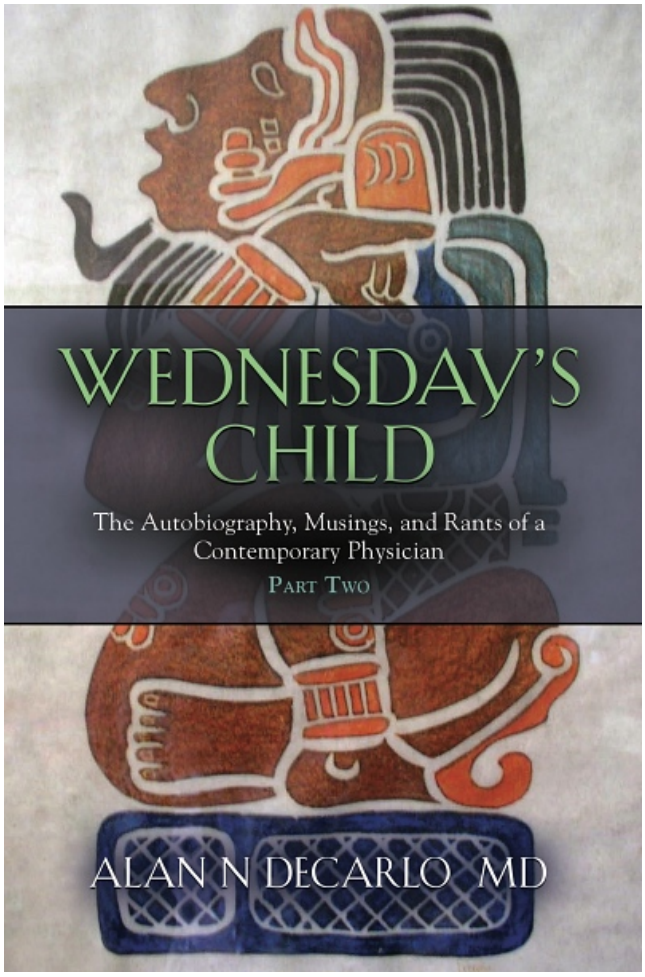
But the rectum and lower colon is another story because the designed purpose of this organelle is different. As far as I know, when even though on the way out it might sometimes feel like an eight-pounder, no one, not even Ripley, has ever documented the delivery of a human baby sized turd.

Being naïve at that time, I only found out about a year later that some gay men and female porn stars work assiduously on anal stretching procedures. It becomes an ongoing effort to thwart Mother Nature and ignore her implicitly unwritten sign that reads: "One Way. Do Not Enter."

However, that couple with the Mason jar then found themselves in a quandary when, low and behold, the jar went in… but would not come out.

After a few futile and extremely painful self-help attempts, they presented to the emergency room where an X-ray confirmed the diagnosis of "Retained Jar." After that, the object was successfully delivered in the operating room, under anesthesia, with obstetrical forceps.

- Congratulations. You are now the proud parents of a bouncing baby urn.



Wednesday's Child, the autobiography of a retired Cardiologist, spans seven decades and is written in three parts: Youth, Manhood, and Old Age. It is an intimate vignette of incidents, personal and medical anecdotes, facts, and opinions.

Wednesday's Child:

The Autobiography, Musings, and Rants of a Contemporary Physician - Part Two

By Alan N DeCarlo M.D.

Order the book from the publisher BookLocker.com

https://www.booklocker.com/p/books/12162.html?s=pdf

or from your favorite neighborhood or online bookstore.