

Chapter 16: See one, do one, teach one (1982)

"In this Department, my dear chap, you'll learn how to cut, and cut," muttered, with a fixed smirk on his face, the soft-spoken Professor "Buddy" L., the Chairman of Surgery at Baragwanath Hospital. This was January 1982: my first day of residency in his department, which comprised of five units, each treating up to 100 cases at one time —probably one of the largest academic general surgical department in the world. Prof. L., who looked like a fox, was known to be the first to tie gastric metaplasia and cancer with duodeno-gastric bile reflux.

The Professor allocated me to the surgical unit led by the notorious Mr. "Bokkie" R. —whose other nickname was "the cowboy". This title was founded on his athletic frame, always clad in a white-starched safari suit, his rough military attitude and bearing, and above all, on the huge handgun bulging from his white pants. When I arrived at Bokkie's unit male ward —a hanger-like structure of no less than 80 beds, I found Bokkie, a tall and robust man, with a pink face and bald scalp, inspecting his troops-doctors. I introduced myself and immediately received what was known as his standard welcome speech. It included Bokkie's gospel on surgery which consisted of pearls such as: "you should open the abdomen with a blade and in one stroke", or "in my unit there is no place for closed cardiac massage, I want you to crack open all chests", and "no round abdominal drains in my unit, only flat ones, is that clear?" At the end of his tirade, Bokkie the "cowboy" towering over me, poked me on my chest and concluded: "Hey Schein, just remember, I won't tolerate any Israeli cowboy in my unit, understand?"

I joined the troops, led by the senior registrar Dimitri —who followed Bokkie from bed to bed, with a servile smile on his face, tolerating an ongoing stream of abuse and inane sense of humor, which was also directed at the patients. The only discussion I heard on Bokkie's rounds comprised of "Yes Sir", or "Yes, Mr. R." At ten o'clock sharp, Bokkie looked at his watch and commanded: "Chaps. Tea time." The entire unit retreated for the ritual tea (with milk), which was served with cute little sandwiches of anchovy paste or marmite. During tea, while Bokkie lectured the team on politics,

surgery and guns —“yes Sir” and vigorous head nods were the universal response— while I read a reprint of a surgical paper. Bokkie swallowed another anchovy sandwich, eyeing me suspiciously: “Schein, show me what you’re reading!” He looked at the paper with disgust: “Pericardiocentesis in penetrating heart injury? American Journal of Surgery. Tell me, what on earth do Americans understand about stabbed hearts?” He threw the paper to the floor with contempt, “I don’t want you to read this crap while in my unit. No one can teach us how to treat cardiac injuries— we teach the world. Pericardiocentesis...fools--.” So began my short but memorable stint in Bokkie’s Unit; from the first minute I predicted that my prognosis was grim.

Residents do not like to be told tall tales from the past. It bores them: “Who cares what this old fart did twenty years ago!” For our surgical residents, anything, which does not belong to the present or the future, is ancient history. But even those who would care to listen would find the tales hard to believe. How can they— who undergo today’s tightly supervised residencies— imagine a surgical program guided by the motto of “*see one-do one-teach one.*”

Baragwanath Hospital (we called it “Bara”) is located at the heart of Soweto— a multi-million, crowded, black township. It was an urban battle zone then and probably still is today. The great “wars” would regularly erupt on Friday (payday): with fresh cash in their pockets the locals — promoted by cheap wine or homebrewed ale —would become either victims to violent crime or the perpetrators. The feast of fury, persisting through the weekend, would overwhelm us —the unit on call —with a constant tide of horrendous injuries. The surgical receiving area, locally called as “the pit”, would then resemble a dressing station in Stalingrad: patients on stretchers, on chairs, on the floor, crushed skulls, stabbed chests, shot abdomens, and mangled vessels.

However, it was a semi-organized chaos: those surviving the triage, and the resuscitation room, were wheeled to the nearby operating rooms, which worked non-stop, day and night. What made the scenario there so

different to what we, in the West, are used to now, is not only the unbelievable volume of severe injuries— imagine a night with 7 laparotomies, 4 explorations of the neck, two shot subclavian arteries, 3 stabbed hearts, 3 peripheral vascular injuries, not to mention the bread and butter of emergency general surgery— but the absolute surgical independence we trainees were permitted to “enjoy”, often at the expense of the patients.

The paradox between the day and night was great: during the day academic professors taught us surgery; and then they would depart, leaving us as the kings of the stormy nights. And the chief king of the night in Bokkie’s unit was our senior registrar Dimitri—a shrewd thin Cypriote who had taught himself obsessively, from experience, books and careful audit of his own patients, to become a master trauma surgeon. At nights he was there to supervise, control, teach and assist us, while during the days he was a humble “yes man” to Bokkie and any other South African professor. And this was the secret of his success, which would later make him the Baragwanath Boss, and later one of the most notable trauma surgeons in the United States.

I see a huge complex of one story tin roofed, WW II era, military barracks converted to patients’ wards, like the barracks left behind by the British all across Africa and the Middle East. The barracks are interconnected with paved passageways, roofed with galvanized tin but open to the elements. I see patches of grass between the barracks, where under the shade of tall eucalyptuses groups of young patients in torn pajamas —tubes dangling from their chests —exercise under the command of blond physiotherapists. Inside the barracks —freezing in winter and scorching during summer —one can smell the clotted blood, dried pus, spilled urine, lost feces, rotten flesh, unwashed sweat, cigarette tobacco, Lysol, human breath, and food. And the food provided to Bara patients was appalling: bread, jam, lumpy porridge, thin soup, an occasional piece of hard meat, tea or coffee which tasted the same—a far cry from what white patients received, from the same hospital administration, but at the “white hospitals”.

I see chilly dawns —the barracks immersed in smog emitted by millions of fires burning in nearby Soweto. Groggy, blood stained, and weary down to our bones, we would round on the numerous last night patients in the Surgical Admission Ward. The critically ill would lie on stretchers near the nursing station: we had nowhere else to put them because intensive care was always full. Others laid on beds and mattresses, between the beds, and even under the beds. Those with “minor” injuries, such as a simple puncture of the lung, would spill into the corridors. They would sit patiently on hard, wooden benches, smoking hand rolled cigarettes made of coarse, black Zimbabwean tobacco, coughing and bubbling air into the water bottles connected to their chest drains. For hours we would move from patient to patient. Sometimes we’d find a corpse under a bed: a “missed injury”. But where the utmost atmospheric action took place was the notorious “pit”.

I see a line of stretchers along the long and shabby corridors leading to the doors of the pit’s shock room. On the stretchers are slouching stoic, young males to whom suffering is no stranger. Most of them are semi-comatose, if not from intoxication, then from loss of blood. At first I run from stretcher to stretcher to see which of the victims, wrapped in thick stained woolen blankets, is gasping to death from a thoracic wound— forming a red pool under his stretcher. “But Moshe,” Sam B. —a middle aged, experienced ex Russian surgeon, now an abused lackey to Bokkie —admonishes me, “you can’t save `em all. Don’t waste your time. First come, first served.”

Here in the *pit* we would pick our stabbed hearts or bleeding subclavian arteries and wheel them to the nearby OR shouting “stabbed heart”, or stabbed something, to compel the OR team into frantic action.

See one, do one, teach one. Yes, this is what we did, and how we learned, but it was an abnormal learning process. A normal, conventional course of learning would be to first do a couple of hernias, or varicose veins, under supervision, but here the first operation I did was a repair of an acute diaphragmatic hernia, with Sam B. standing behind my back and shouting in

his Russian–English mixed with some Hebrew, “*chort*, take bigger bites, *kadima*.” After assisting on numerous stabbed hearts, and *doing one*, helped by Dimitri, I started doing them on my own—I saved a few but lost some, which most probably could have survived —if operated by Dimirti himself. I enjoyed the exhilarating freedom, but already then realized that our independence was immature and harmful to our patients. I remember being sent to do, alone, a highly specialized and technically demanding arterio-venous fistula for hemodialysis after only *seeing one*. And I noticed that those who *teach one* after *doing one* often teach it wrongly. I cannot forget watching a third year Portuguese registrar teaching a junior on how to repair an inguinal hernia —the repair they did perform was wrongly placed in front of the spermatic cord, and not behind it as it should be.

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My career in Bokkie’s unit did not last long because, predictably, as my personality was inherently opposed to any ruthless dictator, I did not comply with his commandments. And even when I did comply— things turned out wrong.

Thou shalt use only open cardiac massage.

This was one of his crazy rules that I took too seriously, and the consequence was such that even I find it hard to believe that the following event really took place— but it did. One morning as I was strolling through the messy recovery room, a nurse pointed to a man lying on a stretcher with a bandage over his abdomen: “Doc, he’s not breathing.” The guy still had a tube in his trachea, obviously waking up from some abdominal operation. I felt for his femoral pulse— nothing. Carotid? None. Monitors? Not enough for everybody. He has arrested, I thought—*needs cardiac massage*. I looked around for help but only saw a few nurses. Well— *thou shalt use only open cardiac massage, Bokkie said*. “Give me a knife, nurse...come on, keep bagging him,” and she handed me a blade. It took 30 seconds for my ungloved hands to expose his heart which, my right hand felt, was full of blood and pumping beautifully.

“What the hell are you doing?” asked another Greek sounding surgeon,

whom I never had seen before.

"An open massage, he arrested, your patient, eh?" I said laconically as if what I had just done was the most commonplace thing to do.

"Um, he has a normal pulse now; what's his BP, *mama*?"

"One hundred twenty over eighty," said the fat *mama*.

"Strange," the Greek shrugged his shoulders, "nurse, continue to bag him, give him some Morphine, he's waking up, I will organize a theatre, we have to close his chest."

I left. I knew that I had done a stupid thing and was awaiting the repercussions, which luckily never arrived.

Thou shalt not be a cowboy.

A statement I agree with, although the system forced me to be one. One morning after tea, Dimitri ordered: "Moshe, they asked for a trachesotomy in the ICU. You did a few, right? So take an intern and do it." I selected an intern; I forgot her name and how she looked but I remember well how we both killed that young girl who was just starting to recover from Tetanus, after two weeks of mechanical ventilation and muscle paralysis. "Moshe, can I do it?" begged the intern on the way to the ICU.

Teach one! "sure", I said, "you'll do it." We performed it at the bedside under inadequate lighting. Everything went well until I committed a classical error: the intern opened the trachea — a spray of air and blood rushed out —exposing the endotracheal tube. "Withdraw it", I commanded the nurse, not instructing her to do it slowly, and leave the tip of the tube above the hole in the trachea. Instantly, the tube was out in the nurse's hands; the intern inserted the trachesotomy tube, but it did not enter the trachea. "Come, let me do it", I hissed. Now the tube was in the correct position but the monitor was already showing a flat line. The poor girl's heart did not tolerate the short period of inadequate oxygenation.

I will never forget the bearded face of the Director of the ICU when I came out the cubicle and told him that the child—the girl for whose life he had fought for two weeks—was now dead. He turned white but said nothing.

I could read the despise and hatred in his accusing eyes. Then he turned his back on me and I was left speechless and humiliated. Repercussions? None. When Dimitri told Bokki about this, the latter mumbled something about the silly, fat black nurses.

Thou shalt not use round drains.

Late one chaotic night, two months into my residency, I took to "theatre" yet another abdominal gunshot wound. Knowing by then the rule that any organ has a potential entry and exit wound, I repaired the anterior and posterior wounds of the stomach, the fourth part of the duodenum and transverse colon. The body of the pancreas appeared bruised so I left a large, round "sump" drain in the lesser sac. Why did I use a *round* sump, ignoring Bokki's dictum? Because of what I had read in one of the American surgical books which I was then devouring: for the pancreas— use "sump" drains ! To the patient, who eventually did well, the operation was a great success but for his surgeon it brought only misery. The next morning during rounds I observed Bokkie's face turning red: "what's that?" he asked Dimitri. All eyes were on me: "A sump drain Sir."

"Leave my unit immediately. Go and wait for me in front of the Prof.'s office."

I stood at Professor L.'s office listening to Bokkie's ranting about my impudence and *chutzpa*. "He has to be thrown out of the residency," Bokkie demanded. When Bokkie left the Prof. fox-smiled at me: "Moshe, as of today you are working in my unit, on probation." My surgical career had been saved.

I could go on and on and write a separate book about the remaining months of my Baragwanath's year. About young surgeons, local and from abroad, who came to Bara to get "superb cutting experience" before moving on to private practice or returning to Europe. I could tell you about Miss A., later Professor A., an Australia born lady surgeon who spoke and dressed like Mrs. Thatcher, and accepted to her unit only lesbian females, and Greek surgeons. In Bara she became a self-proclaimed guru in esophageal cancer

surgery, publishing a large series of her experience in the international literature. However, those of us who perceived the realities of life in Bara could not believe her reported extremely low morbidity and mortality rates. Only her registrars, many now professors of surgery in Greece, know how these “scientific” studies were conducted and documented.

Yet again my viewpoint sounds negative so perhaps I should mention that what took place twenty-five years ago can be viewed as history and history should not be contemplated solely through today’s perspective. Obviously, the “see one, do one...” practice I described has to be denounced but at the same time we must not forget that twenty-five years ago the pattern of teaching in certain American inner city hospitals was not the same as today. Whatever critics may say, the surgical care provided to the masses of Soweto in those days represented one of the best available then in Africa—to the blacks...

On the day I left Baragwanath, to continue with the second year of residency in another affiliated hospital, I felt almost an accomplished surgeon. But was I? Our residents today would not believe my Bara stories; looking back I cannot believe them myself.

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See pictures below



Baragwanath Hospital, Soweto



After a night in the "pit" at Bara