

Chapter 38: The slums of Bronx (2001-2004)

On September 11 2001 we were eating breakfast, watching "Good Morning America" on the TV. Outside the window the sky was cloudless —a perfect early autumn Staten Island day. I emptied my coffee and walked towards the garage stairs, when Heidi shouted from the kitchen: "Look, the twin towers are burning!" I turned back and we watched the smoking north tower and, a few minutes later, the south tower being rammed by the airliner.

"I have to go," I said, "Bronx is far away but the hospital may be receiving casualties, who knows how many of these are there."

My normal daily route to the Bronx Lebanon Hospital would take me across Goethals Bridge to New Jersey, northbound on the Turnpike, over the George Washington Bridge into Manhattan, and finally into the chaotically unbearable Cross Bronx Expressway. But on that morning I found the Goethals Bridge already closed by the police. I had to turn back, to be locked in the island with its entire population for the few next days. At home, from the windows of the second floor, we could see the black smoke staining the otherwise blue sky over the southern tip of Manhattan. The ensuing pandemonium and public hysteria which affected the city and the nation did not steer us much: it happened a few miles away but for me it could have occurred on the moon. It was a tragedy but a small one against the perspective of history— like one or two train loads transported to Auschwitz.

* * * * *

When I agreed to leave the Methodist Hospital, the only full time position readily available to me in New York was at a Bronx teaching community hospital. Here the surgical Chairperson was Dr. Phillip Gerstman. The man, in his mid 70's, who had been running the Department for 37 years was a sly New York Jew, who had noticed, early after moving to Bronx from the Presbyterian Columbia University Hospital in Manhattan, that the only way to attract good quality residents to an area infested with drugs, crime and AIDS, was to import them from India. Thus, throughout his protracted

rule, more than ninety percent of his surgical residents derived from India. Over the years, the entire faculty of the department (as well as of the entire hospital) consisted of Indians, who had graduated from the hospital's own residency programs. The old Jew ruled "his Indians" —whom he had selected, trained and elevated—like a ruthless and harsh, but generous, King. They, his Indians, worshiped him in return, like sons would worship an aging, senile father. They willingly surrendered to his dictatorial rule — benefiting of his gradual decline —in order to gather clinical monopoly and financial perks. The old man had been smart enough to stop performing operations years ago, and thus lost touch with modern clinical surgery. However he insisted on running all clinical meetings including the M & M, like a Russian Tsar. Obviously, I became acquainted with all these facts much later, after spending some time in his department

The reason the old man wanted to recruit me to his homogenous department was stated to me at our first meeting, when he interviewed me in his disorganized, dusty and mildew smelling room: "They are excellent surgeons, I trained and re-retained the cream of India, but they are not interested in academia, they do not write, I need you for the residents, to teach and publish".

"And what will I be operating on?" I asked, "it appears that all these guys here, physicians, oncologists, gastroenterologists are Indians, they've known each other for many years, why should they start referring patients to me, or anybody whose name is not starting with Prasad or ending with Kumar?"

"Don't worry", said the dictator, not even appreciating my sense of humor— later I found out that he had none whatsoever— "I will look after you!" Noticing that I was not convinced he promised: "I will open an additional general surgical service for you—".

"But Dr. Gerstman, I don't think—."

"Call me Phillip, "the old man interrupted, "you and I will be friends, and nothing of what happened to you in Brooklyn could possibly repeat itself here. Please come and join me."

I sensed that the man was a harsh, ruthless and rigid autocrat, and knowing myself I perceived that it would be impossible for me to tolerate his style for long. I knew that taking on this position would be like relocating from a fancy dump in Brooklyn to a rundown landfill site in Bronx; but the professional and financial guarantees were promising, and I had no better immediate alternative—the severance agreement with the Methodist was ready to be signed—so eventually I accepted the offer.

Hence, just after freeing myself from the Brooklyn Iranian medical “mafia” I got entangled with the Bronx medical Indian “family”, and an aging paranoid Boss, who eventually proved a relatively benign mixture of Professor Ferdinand Sauerbruch and Joseph Stalin.

* * * * *

The Bronx Lebanon Hospital was wedged between the Cross Bronx Expressway and the Grand Concourse. Its modern tower dominated the scruffy neighborhood, which was however not grand anymore. The hospital’s interior was shabby and it took 30 minutes to reach the upper floors of the tower in the overcrowded elevators. The hospital was founded at the end of the 19-century on the Grand Concourse; the latter had been modeled after the Champs Elysees in Paris. It had served the middle classes that then inhibited the solid apartment buildings lining the boulevard. But now nothing was left —not even the trees —of the old grandeur: only sealed off Synagogues with decaying Stars of David engraved on its walls told us that the old inhabitants had moved to Long Island or New Jersey and the neighborhood had become predominantly Spanish speaking —a “little Dominican Republic”. And the Hospital’s current claim for fame was the management of HIV disease, transmitted through intra-venous drug abuse, which was (and is) rampant in the neighborhood.

When I begun my sojourn in Bronx I pledged to myself to play it low-key, be friendly and humble and shut up. This was promoted by the Dictator’s welcome greeting: “Moshe, everybody knows about you, you have a bad reputation—.”

"Why?" I objected. "I didn't do anything wrong. What I did was right and I would do it again anytime."

He ignored my comment. "Look, Moshe, all I'm telling you that the CEO has warned me that this hospital does not enjoy being featured in the New York Times. Nor would I tolerate—."

"So why did you hire me?"

"Because I figured out that I know how to control you."

In his favor I have to admit that the old man really tried to be nice to me, to warm me towards him. But our styles, personalities and *weltanschauung* were so divergent that all such attempts would prove futile—such as this one: a month into my stay in his department he invited me for a tête à tête dinner at a cozy upper west side French bistro. Here, with me sipping wine and he sticking to club soda, he opened up a little, telling me —prompted by my habitual curiosity— about his family tribulations and the rather sad and lonely existence as a widower. But the father-son type atmosphere did not last long; walking to our cars he stopped and poked me with his thick index finger: "Moshe, I want you to remember this, and never forget it—I'm the Boss, I make all decisions, I want to know about everything and I know everything."

"Sure, sure Dr. Gerstman, of course." But the coziness between us disappeared instantly, ruining my postprandial digestion.

"So when do I get my own service, like we agreed?" I asked.

"Not now, it'll have to wait, the others won't accept this." The "others" were his Indian puppies that naturally were not too keen to loose even one hernia operation or a breast lumpectomy. The puppies had it well under the wings of their *pater familia*. For allowing him to abuse them at mind-numbing meetings, he granted them absolute clinical freedom and financial perks. Unlike other local hospitals, they enjoyed the security of sizeable salaries and, at the same time, a thriving private practice. And this they tried to defend with their teeth: they knew that when their Guru and protector retires, or is forced to leave, things might change.

Like the Iranian brethren in Brooklyn, the Indian puppies of the Bronx Cedar Hospital controlled the tributaries of referral. Referrals from the Gastrointestinal physician —usually a brother in law, or a cousin; or the oncologist—commonly one who had trained with them 21 years ago. Even when I was on the emergency call list the “money making cases”, such as tracheotomies in Medicare patients, were shifted by ICU doc Patel, or Kumar, to the puppies. But as my salary was reasonable I decided to keep my mouth shut, to do what I was hired to do, and be happy with the sort of cases I had been used to getting in New York hitherto— emergency cases, mostly indigent, coming through the ER or the “service clinic”—a bleak maze of smelly cubicles where impoverished patients were seen.

My first year in Bronx was relatively calm. The commute took an average of an hour each way and occasionally turned into a nightmare on one of the bridges or at the Turnpike gates. My office, like all other surgeons’ offices, was a converted flat, situated in an old apartment building that now belonged to the hospital. In the summer, the ancient noisy AC hardly managed to cool the suffocating room; in winter freezing wind blew through the space around it in the wall. Strong aromas of Indian spices permeated the air, the source of which being the apartments above us, where the residents and their extended families (commonly both husband and wife were residents and grand parents were imported from India to look after their children) were residing. My personal secretary was Margi, a pleasant Dominican lady who looked white; from her I heard about the “pleasures” of living in the slums of Bronx.

I was enjoying the Indian residents whom I found bright, dedicated and respectful. To the puppies I smiled and they smiled back; they had a reason to smile —almost doubling my income. But the dictator was an ongoing irritating factor, and the natural course of events was downhill, heralded by multiple flare-ups.

At his weekly staff meetings Dr. Gerstman, a millionaire driving a 1970 Ford, clad in ageless, eternal, fading, blue blazer, gray flannel trousers and

unpolished brown moccasins—with unkempt long white hair— constantly showering dandruff on the collar of his blazer—did not tolerate any deviation from the protocol. And the protocol meant absolute attention to his chatter about irrelevant paramedical banalities. One would look away, one would stir in his seat, or look at a piece of paper, and the dictator would be upset. The Indian puppies accepted this as a natural phenomenon: he had brought them from India to the promised land and for this they adored him, nourishing that kind of love-hate relationship one has with an older father. But I started to rebel, resulting in repetitive expulsions from the meeting; like the expulsion from class of a misbehaved seven year old pupil: “Dr. Schein, you cannot read newspapers in my meeting, I do not want you here,” the old man would roar.

At the American College of Surgery meeting in San Francisco (2002) the aging leader hired —this apparently was his habit each year—a posh restaurant to entertain the graduates of his program, now dispersed throughout the country. We all sat around a long table, wives included (I did not bring mine), with the *duce*’ presiding over this family like reunion. He made each of the present, when his turn came, to stand up and introduce himself. One after another the distinguished graduates of the grand tyrant rose and uttered something like this: “I am Dr. Rashid Kumar (or Satish Patel). I’ve graduated from the program in 1972 or 1982, currently I’m in general surgical practice in Orlando or Vegas, I’m very much into minimally invasive surgery doing hernias, Nissens and what no—.” Such statements were usually followed with a deep bow towards the imminent chairman: “Sir, I’m indebted to you for the excellent training, you were always an inspiration to me, thank you very much Sir, Dr. Gerstman.”

So this went on and on, a mini speech after a micro one. My wine glass was empty. In desperation I called a waiter to re-fill it. But the observant leader noticed my aberrant movement and called me to order. My glass remained empty. After an hour of the above, the appetizers were served, immediately followed by a dish of overly dry salmon. This provided an interlude of thirty minutes to sip some wine and to chat with one’s

neighbors. But just as the *entrée*' plates were being cleared the dictator resumed the educational activities. Engaging specific persons in some irrelevant medical dialogue he demanded that all the fifty or so people around the table listen to attentively and keep silent. He seemed to need absolute control on this social gathering, exactly like Stalin used to do each night at his Moscow *dacha*. I had enough, I stood up and said: "Thanks Dr. Gerstman for the excellent food and wine. But we are now in San Francisco, not at the hospital. I thought that I was invited to a social function, not a structured CME activity." I stormed out. None of the puppies around stirred in their seats or said a word. The residents gazed at their plates.

From then on our relationship deteriorated rapidly and there were many opportunities that deepened the wedge between us. The dictator demanded the last word on the fate of all publications coming out of "his department", including the list of authors of each manuscript. He instructed me to add to the authors' list attendings (his puppies) who had contributed nothing. "According to the Residency Review Committee", he said, "they have to show a significant academic activity, they have to have a few publications. Add Dr. Grishpatel as the second author." I refused. We stopped talking and communicated through memos.

But the main venue for confrontations was the M & M conference, over which the old man had been fiercely presiding over the last 35 years, and continued doing so years after laying down (wisely) his own knife, and thus being detached from clinical surgery. Now let me state that the Indian mafia in the Bronx was surgically and intellectually more sophisticated than the Iranian one in Brooklyn. A few among them were solid ethical surgeons, but a few were not. Like in Brooklyn, I saw old and terminal patients undergoing futile operations, and younger non-terminal patients receiving death sentences by the wrong choice of operations and faulty treatment of complications. Very rapidly I noticed the pattern at the M & M conducted by the dictator—there were a few rules: *All* operation are indicated, the term non-indicated or unnecessary operation is *taboo*; indication for operations are not discussed because *apriori all* operations are necessary. Furthermore,

all deaths are *non-preventable* and *always* caused by medical complications or the natural course of events. So, for example, when discussing mortality in a terminal AIDS patient, with very poor nutrition, whose anastomosis had leaked after undergoing a gastrectomy —the emphasis was not on whether the operation was indicated or not, but on whether the anastomosis ought to have been stapled or hand sutured.

For almost six months I suppressed my desire to comment: I buried my head between my hands and tried to control my blood pressure by taking deep breaths. But at one meeting I broke down; I stood up and said: "In this unfortunate case I found seven gross errors which led to the eventual mortality, first, the initial operation was wrong, second...". The Boss, sitting behind his desk on the podium, was thunder stricken. But he reacted rapidly: "Sit down Dr. Schein. You can't talk here about errors, these are your colleagues. We do not commit errors—."

"But this is an M & M meeting, right?"

"Sit down and be quiet. If you have anything meaningful to say we'll listen to you. But we can't allow this meeting to turn into an accusation session about errors."

"Are you shutting me up Dr. Gerstman?"

"Sit down Dr. Schein. Dr. Radinini, you are next. Please tell us about how to mark the operative site to prevent operating on the wrong side."

It felt as if I was back in Brooklyn —where I did not want to be.

For the next couple of months I avoided the M & M, or got my secretary to page me out whenever a "problematic case" was to be presented. Then one week they presented a case of "post diagnostic laparoscopy pneumonia". Usually they would run over such a case in one minute finding "no problems". But as I was there I felt compelled to stop them. And the reason I had to stop them was that the "diagnostic laparoscopy" had been performed in a patient already diagnosed with multiple liver metastases, deriving from a biopsy-proven rectal cancer.

“What was your indication to perform the laparoscopy”, I asked the Associate Chairman —the local self appointed topknife —the most senior puppy who was waiting to become the Chairman once his master would retire or die in his chair.

“Well, we needed to get histological confirmation. The oncologists wanted...,” retorted the second-in-command unperturbedly.

“But you had a CT scan showing a Swiss cheese liver, ridden with tumor, and histologically proven carcinoma of rectum, so why torture this terminal patient with laparoscopy?”

“We have a residency program here, we have to provide the residents with laparoscopic exposure...” the deputy tried to explain.

“What? You performed a non-indicated operation in a terminal patient only to provide residents with experience?” I looked around and added: “This is clearly non ethical.”

This was too much. The dictator closed the meeting hastily. But from that day on I stopped getting patients referred to me even from the service clinic. The clinic doctors told me: “Dr. P (the associate chairman) instructed us not to refer patients to you. This is nothing personal but, you know, he may become our next Chairman.”

* * * * *

I was now almost 10 years in New York but still could not adjust, or accept, the dysfunctional medical system which portrayed itself as being “first class.” Here is an example:

As Heidi’s red Durango seizes the last curve of the New Jersey Turnpike approaching the George Washington Bridge (GWB), I see the electronic sign announcing: “Lower level 45 minutes delay.” *Shit.* I pick up the cell phone and page the surgical chief resident on call.

“Listen Josh, I’m at the bridge, 45 minutes delay, Saturday afternoon traffic. How’s he doing?”

“He’s stable, Sir, we’re giving him blood.”

“Josh, they are stable until they stop being stable and then they die, don’t wait for me, take him up to the OR now, listen to me....” Josh tries to say something but my words merge with his: “By now I mean now and don’t wait, let them put him to sleep. I should be there in fifty minutes, open him up meanwhile—yes, do a midline, move your ass or else he’ll die.”

I hang up and pitch hateful looks at the flood of cars drowning mine, together crawling at five mph towards the mighty bridge— that huge structure across the Hudson River connecting New Jersey with New York, the bridge which controls our lives. I look at the Mercedes SUV on my left: teenagers in bathing costumes, tanned legs, painted toes—stretched out through the windows, sodas in hands, singing loudly to the bass which is loud enough to vibrate my car. Probably back from the Jersey Shore, I think and with frustration hit the steering wheel. *Fuck it. He’ll die...the stupid bridge.*

Forty minutes ago Josh called me at home to announce that the patient is “bleeding again.” The guy had been admitted to Medicine on Thursday night with upper gastrointestinal bleeding. The gastroenterologists had scoped him to find a large bleeding duodenal ulcer which they had injected—“achieving hemostasis”—a term which I had read in the patient’s chart yesterday morning in the ICU. On examination, then, I had found a hemodynamically stable and alert fifty something year old Spanish speaking male. “Recent melena?”, I had asked the ICU resident.

“A few hours ago, seems old blood.”.

“Crit?”

29 %, no change since last night, no blood transfusions since, got 4 units since admission.”

I had irrigated the nasogastric tube: clear, *good*. A finger into the rectum: dry melena, *good*. “OK, guys, he stopped bleeding, but watch him carefully, when they re-bleed they can pour. Should he re-bleed he’ll need an operation”. I had entered a note in the chart and left. That was Friday morning, more then 36 hours ago.

Now as I approach the *EZpass* toll booths I see in my mind the gastroduodenal artery at the base of the duodenal ulcer, pumping a jet of

fresh arterial blood almost to the ceiling, like I had seen on numerous previous occasions, that is, after the duodenum is opened and the ulcer is exposed. *Stupid internists, why didn't they call us last night? Why re-scope?* He should've been on the table many hours ago. We are late; and now this disgusting bridge.

I cross the Hudson River, deep and blue, calmly glistening under the early afternoon sun. I keep to the right, fighting incoming vehicles, vehemently pushing from Manhattan's Western Highway. Finally, beyond the intractable deep potholes, comes the Cross Island Expressway: one of the most clogged traffic arteries in the universe, a cemetery for stalled cars—one of which is now hindering me for another five minutes. But now, nearing my destination, I become calm and fatalistic, resigned to my fate on which in turn depends the fate of the patient. The exit, traffic lights, a turn under the elevated train, another turn and into the doctors' parking lot. I leave the Durango with the attendant and run into the hospital, up the stairs and into the OR. I grab a pair of disposable scrubs and shout to the first OR technician I see: "which room?"

He shrugs his shoulders. "Doc, the patient is in the ICU, we've been waiting for you—."

"Just set up the room, get anesthesia ready and wait. We'll be back in five minutes." *Idiots.* I don't waste more words and rush up to the ICU where the main entrance is blocked by a wooden screen and signs of "Construction Site. Use alternate entrance." I break through the screen and storm through the dusty corridor into the nursing station. "What do you think you're doing," snaps at me a tall, quasi-morbid obese black nurse, "didn't you see the signs?" I ignore her. My eyes are searching the cubicle where my patient is probably exsanguinating to death. I see Josh— tall and calm in his green scrubs. "Sir, good to see you," he smiles, "the OR refused to accept the patient until you've arrived, the regulations, you know, can't start without an attending." I see drops of sweat on his forehead.

My anger makes me almost speechless. "For God's sake, Josh, this is not an elective hernia repair... this is like a penetrating heart injury, couldn't you convey that simple message to them?"

An apologetic smile. "I tried; they said no' anyway, he's stable. Meanwhile we inserted another line and gave more blood."

"OK. Let's go now." I enter the cubicle where two nurses play with the patient's lines and tubes. A tube hangs out of his nose, blood stains on his face, which is white like the bed sheets. He appears obtunded; his chest wall oscillating in acidotic respirations. I insert my hand under the blankets to feel for his moist groin: femoral pulse rapid and feeble. *He's empty!* I pull on his bed and shout, "we are going to the OR!"

"Wait Doc, what're you doin?: says one of the nurses, "the Patient's not ready, we must take his vitals and the forms, consent not ready." I ignore her. I disconnect the monitors' leads from the patient's chest and hiss to Josh: "Don't pay attention to them. Where is the intern? Let him get the elevator." Five minutes delay in front of the elevator. This is Saturday afternoon visitors rush hour and the "service elevator" is stuck somewhere in the unknown caves of the hospital. Bystanders look at us with indifference.

We roll into the OR and unload the patient on the table. The anesthetist on call walks into the room as if on his Sunday afternoon stroll in Central Park. He is a middle-aged Philipino gentleman—more suitable to administer anesthesia for ingrown toenails surgery than resuscitate bled out patients. He looks with disinterest at the "case" —*Did it interrupt his afternoon nap?*— and starts clumsily disentangling the spaghetti of tubes and lines.

"Don't play. Just put him to sleep. He's bleeding actively. I want to open him now!" I command.

We scrub rapidly. When we re-enter the room the patient is asleep, prepared and draped.

"I can't read his blood pressure," the anesthetist mumbles under the mask, which is hanging below his nose, "he needs more blood." A midline incision. The knife slices through pale and bloodless layers, *like an autopsy* -

-like a pre-mortem post mortem. We enter the peritoneal cavity. As expected the stomach is hugely ballooned with blood, extending well into the lower abdomen. "Here is where his 'stability' is", I comment sarcastically to Josh—whose perspiring forehead touches mine. A right hand between the left lobe of liver and the diaphragm, searching for the aorta, which is hardly palpable. "He is empty," I say to the people behind the screen, "we'll compress the aorta while you guys fill him up."

We wait five minutes with the fist pressing the aorta onto the spine until we sense the large vessel invigorating. "I get 70 systolic", the intern informs us, "this is the adrenaline drip." We place a longitudinal incision in the scarred cap of the duodenum, extending it up the pylorus and into the stomach, and suck out a few liters of freshly clotted blood. And down there, at the back of the duodenal cap, lies a 2 cm' whitish ulcer, with a red, elevated dot decorating its center, from which a pitiful stream of red blood is spilling, like a desert water spring in the aftermath of a draught. "It's an eroded gastroduodenal artery," I tell Josh, "when his blood pressure was up it bled like a tap."

We under run the artery with a few sutures and close the duodenum. "In his flimsy condition he is not a candidate for anything definitive," I tell Josh. In my heart I know that he won't make it, that the temporary revival of his cardiovascular system is agonal; that his tissues were ischemic for too long. When we close his abdomen the wound edges are pale like those of a cooked chicken, denoting intense peripheral vasoconstriction.

In the ICU, poisoned and inflamed by the by-products of ischemia, tissue re-perfusion and massive transfusions, the patient swells like a wet spongy balloon and develops multi-organ failure. He expires a few days later.

A week later we sit at the weekly surgical mortality and morbidity meeting. The usual theoretical discussion: that bleeding ulcers are treacherous, that one has to diagnose and treat promptly any re-bleeding. A semi-retired surgeon comments that such patients should be admitted under Surgery —not Medicine. And as always there is somebody to stand up and suggest: "gastrectomy would have been more appropriate." Finally I rise

and say: “This was a relatively young patient who bled from his duodenal ulcer. GI attempted endoscopic treatment that initially appeared successful but then failed. Clearly, we were... or better to say *I was* too late, allowing him to exsanguinate to death.”

I fall back into my chair. In my mind I have prepared a long and painful speech which for obvious reasons won't be uttered: that patients are admitted to the ICU for *intensive* observation, that the patient was bleeding throughout the night between Friday and Saturday —this is when we should have been notified and would have taken him to the OR; that re-scoping him without alerting us— the surgeons— delayed us further; that surgical chief residents should be allowed to start life-saving operations while the attending surgeon is on his way; that there was miscommunication between the services; that the GI team should have been present in this meeting; that the anesthetist on call was not able to cope; that this tragic-preventable death of a young and salvageable patient reflects a total dysfunction of the system; that our systems are constantly dysfunctional and hiding behind the veil of credentialing, and approvals, and committees, and self congratulatory claims of excellence. I say nothing. Instead I dry my wet palms on my white coat while sensing muted outrage in my pounding head and heart. I should have been used to the scenario...

That day, as I crossed the George Washington Bridge, homebound, in the other direction, I smiled to myself bitterly: at least in this case I can blame it on the George Washington Bridge. Too many patients around me were harmed and damage due to the dysfunction of the system, a system which I was powerless to modify, a system which had been dysfunctional and, I knew, would continue to be so. How long, I asked myself, should I endure it?

* * * * *

Two and half years into my Bronx chapter we were told that “administration” has hired a “consulting firm” to assess the function of the department.” We guessed that the hospital’s CEO — a prominent local Latino politician—wanted to get rid of our aging Chairman. Our weathered dictator

immediately understood the CEO's plans and after not speaking with me for a year he suddenly summoned me to his office. "Listen Moshe," the old man said, "the consulting firm should be here next week, and they'll interview each member of our staff. They'll interview you. Do understand that although considered confidential, these interviews are never truly so. I'll know who is saying what about me. They want to get rid of me...I know it...but they'll fail. And I promise you, I'll know what you tell them, so watch your tongue. I'm going to stay on here and I WILL protect you—as long as I'm here your job is secure. Beside, Moshe, we need to get you more patients."

The "consulting firm"— a few middle aged ladies, probably ex nurses— arrived from Atlanta. It was one of those consulting companies that would evaluate the function of a hospital, or a department, for anyone who is willing to pay a 100 grand per assessment—yet another scheme to milk the holy cow of US health system. The ladies received an office at the administration section where they were interviewing, separately, each member of the department, including the faculty, residents and administrative staff.

When my turn came up I told them that "the Department is excellent, but could be better"; that it needs "some fresh blood to counter the thirty year old process of inbreeding." I declined to comment about the old dictator and did not mention even his name. Let his demise be brought upon by others, I told myself, why should I insert nails in this old Jew's coffin?

Then the old spinsters left and after a few weeks a 230-page report landed on the CEO's desk. What was in it nobody ever found out but the dictator was put meanwhile on ice, which sooner or later had to be defrosted. He, who knew that his fate was near, blamed it on me; according to him it was "Schein who had organized everything."

After a few months of the status quo, the announcement was made that Dr. Gerstman would step down after a distinguished service of 38 years. But the dictator, like a dying old lion, did not accept his fate. "I am going nowhere", he declared to his confused puppies— now bracing themselves to

unpredictable changes—and barricaded himself in his shabby and dusty room, brooding on revenge.

One day he called my previous chairman Professor Winestone of the Methodist Hospital in Brooklyn. Dr. G., one of Winestone's lieutenants, had been present when Gerstman called and thus could later reconstruct for me their approximate dialogue.

"Winestone, this is Gerstman. How're you doin'?"

"Hello, as a matter of fact, I'm doing fine, very fine. My program has been approved for five years, my own contract re-issued for three years; and how about you Phillip? Is Schein causing problems?"

"Actually, this is why I'm calling you. It seems that Schein managed to put a knife in my back."

Now each of the old surgeons had a personal reason to seek revenge on me. The dictator for his own imminent demise and Winestone to pay me back for "*Behind the Green Wall*" in which Winestone had featured as one of the lead characters.

And here is what the two old Jews decided to do: I had left Brooklyn with an appointment of a full Professor of Surgery at Cornell University, with which our Department was affiliated. In Bronx, the dictator had promised to "transfer" my appointment to Albert Einstein —the local Medical School. Forms had been completed and a new set of supporting letters produced. And just around when the above events were taking place I received a letter from Albert Einstein Medical School with an invitation to attend an orientation meeting for the "new members of the faculty". I called Albert Einstein and was told that yes, "according to our list you were appointed as a "professor of surgery."" Two weeks later another letter arrived claiming that there was some administrative error and my name was added to the list by mistake and "please ignore our previous invitation to the orientation meeting."

My letters to the Dean and calls to the deputy Dean were bounced with the same excuse: administrative errors— "your application forms were not in order, please discuss with your chairman how to re-apply."

"But we do not have a Chairman—he has been fired."

“Well, then you have to wait until the next one is appointed and start again.”

A few weeks later another letter arrived from Cornell University: “We were notified by Professor Winestone that as from 31 December 2004 your privileges in his department will expire. Thus, your appointment as a Professor of Surgery at our University will terminate on that date.”

This is how the two old New Yorkers joined hands and succeeded, by whatever administrative means, to strip me from my academic appointment. And so, after 25 years of an academic career, with over 400 publications and twelve books on my record, I was left without any “active” academic title.

Towards the end of 2003 Dr. Gerstman vacated his office. One Saturday afternoon, when I left the OR I saw the old man shuffling around, carrying boxes to his car; by himself—alone. Where are his puppies now, I thought, why don’t they help the poor bugger? I felt like approaching him, taking the load off his weak arms; but I knew that he might spit at me —so deep was his misguided resentment.

Now the Department was cruising autopilot, each puppy on his own. The hospital vice president, a charming, patriarchal African American and a talented surgeon, was nominated the acting director. He let me take over the surgical outpatient department; now being able to refer cases to myself (and sent the minor cases to the puppies) I realized how they had been shunting away cases from me during those three years. When the administrators announced the appointment of the new Chairman—another aging Jew from New Jersey— I knew that the puppies were now weakened, that my situation was improving, but by that time I was already committed to leave New York, its medicine and pseudo academia. I wanted nothing more to do with it.

* * * * *

See pictures below



Bronx Lebanon Hospital



George Washington Bridge.....



each morning on the way to Bronx...