FORUM

Innocence revisited – 13

This year's first short story, by Dr Debbie Beswick, begins with an innocent and earnest medical student...

Four lessons and a transition

The chosen one

Once upon a time I was very innocent indeed. Even worse, I was earnest. I was possibly the most earnest student who ever donned a white coat, which is no doubt why the professor chose me to examine the trouserless, elderly gentleman during our first ever surgical tutorial.

At that stage of my career, I had only the haziest idea of what circumcision involved, let alone the intricacies of the inguinal canal, so the grossly distorted anatomy of the poor man's scrotum posed quite a challenge.

Blushing furiously, I was coaxed into examining his football-sized 'lump' from every possible angle. I tried to 'get above' the swelling, to transilluminate it, to check for a cough impulse and even to identify his atrophied testis, which was literally resting against his knee.

Finally came the moment of truth. Under the pressure exerted by my trembling hand, the huge mass suddenly reduced with a loud gurgle, while a hitherto invisible appendage presented itself to view.

Then came the question I'd really been dreading all along: 'And can you tell us whether Mr G has been circumcised?'

Unravelling the mysteries of medicine was just as bad. This time, we were gathered around the bed of a young man with 'chest signs'. Once again, I was chosen to do the honours.

'And what is the first rule of examining the respiratory system?' our tutor asked.

I was pleased, for once, to be certain of the answer.

'To fully expose the chest.'

Our tutor motioned for me to proceed.

With great delicacy (and even greater earnestness) I unbuttoned the young man's pyjamas and neatly folded them back across his suntanned shoulders – it never occurred to me to simply ask the patient to undress himself. At last, I turned back to the tutor for further guidance.

'Now that you've won his heart, perhaps we can proceed with "Inspection",' he said dryly.

The most important lesson I learned that day was quite tangential to the diagnosis of pneumonia. The moral of the story is as clear to me now as it was then – 'Always engage the patient in the problem at hand, whether it be undoing a button or coping with a terminal illness'.

'Whoops'

Most, but not all, of my earnestness had rubbed off by the time I graduated. I spent my first rotation as an intern in the casualty department of a peripheral hospital. By the conclusion of my first week there, I had learned two more important lessons:

- 'Never say "whoops" in front of a patient'
- 'If in doubt, ask a resident'.

Resident medical officers had none of the arrogance of your typical registrar, they knew where things were kept, and they were consoling when things went badly wrong. Which was just as well for me…

The triage nurse had decided that the old man's shortness of breath only warranted assessment in 'Cas cubes'. But on taking my usual all-inclusive history I began to suspect a cardiac cause – not that he had any chest pain, sweating, faintness or nausea. That little nagging voice, which I later learned to call

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'gut feeling', prompted me to begin a full cardiac examination.

I carefully laid him on the examination couch at the prescribed forty-five degree angle. Then, I exhorted him to relax, which he did with what I took to be a sigh of contentment. Finally, I started fiddling with the sphygmomanometer but for some reason, I just couldn't get a reading.

I promptly went next door and interrupted my trusty resident, who (luckily) came back with me straight away to iron out the problem. By now, the patient's rapidly deepening cyanosis was obvious even to me. I couldn't take his blood pressure because he had no blood pressure to take.

It was my first cardiac arrest and miraculously, we managed to revive the man and eventually discharge him home. However, I learned another practical tip that day – 'Always treat the patient, not the test result'.

The making of a doctor

Unfortunately, the most needful lessons of all are often also the most painful.

BARRY OLIVE

She was 26 years old and spoke broken English. She was also three months' postpartum – I remembered her face from my student term in obstetrics.

She'd driven herself to casualty that evening with 'chest pains', but these had, of course, subsided in the waiting room long before her turn was called. There was nothing much for me to find on physical examination, although she seemed a bit depressed.

Intuition prompted me to question her gently about her home life. Sure enough, she admitted that the demands of a new baby and an unsupportive husband were getting her down. Naturally, a busy casualty department wasn't and still isn't the most conducive place for supportive counselling but I did my best with my limited experience.

Then, suddenly, she had another attack of the pain. At once, she clutched her epigastrium and began to hyperventilate, while I rummaged around for a shot of hyoscine and a brown paper bag.

She settled within a couple of minutes. I suspected biliary colic and filled out an ultrasound request; what to do for her anxiety and mild postnatal depression was more problematic. I sent her home.

Her symptoms brought her back the next morning but this time she collapsed on the waiting room floor. Truly heroic efforts by the cardiology team – including, in the end, open cardiac massage – failed to reverse her ventricular fibrillation. At postmortem, she was found to have had a rare form of cardiomyopathy.

Could I have made the diagnosis 12 hours earlier? Would she have lived if I had? The commonsense answer to both questions is probably not. But the harsh glare of the retrospectoscope is part of the special equipment of the profession of medicine.

I can't say that the poignant, first death of a patient of mine completed my education – far from it. But more than any other experience, it defined the transition between the loss of my medical 'innocence' and the making of a doctor.

Editor's comment

Learning how to examine patients can be tricky. As I read Dr Beswick's travails, I was reminded of the session in which our student group was taught to do rectal examinations. Somehow, one of my colleagues managed to get his necktie in front of his gloved finger and it went in as well.

He discovered – as he tried to straighten up and address our tutor on his findings – that he was tethered. After some thought, he called for a pair of scissors and extricated himself from the situation. He decided that he was unlikely to wear that tie again. MT

Next month, we bring you a tale of triple jeopardy.