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A Day in the Life of a Surgeon

A palpable silence reigns in the operating theatre: the atmosphere is as tense as a taut bow-string. An operation begun three hours ago is going badly. The patient is staring down a tunnel at the end of which the soul leaves the body. He is *in extremis*, at death's door. Everyone else is totally exhausted.

The silence is broken by Dr S, the harassed anaesthetist: We've done all we can for him, he can't last long. Shall we send him back to his room where he can pass what little time he has left in the presence of his family? A compassionate view? No doubt, though at the back of everyone's mind: the thought of a death in the theatre would be troublesome, to be avoided if at all possible.

A death in a hospital ward would require the attending doctor to issue a death certificate, simply stating the cause of death and a few other details. A routine matter. But if the death occurred in the operation theatre a cascade of formalities would follow: a report to the coroner, possible autopsy, an investigation, statements from everyone, administrative headaches. Add to this, even further distress for the family, perhaps for several weeks. A stressful time for the doctor too. He or she must decide: send him back or keep him in the theatre and continue working on him?

What has happened? What has brought about this crisis?

The patient SCL is 45 years old, a jeweller's artisan. He has severe Crohn's disease of the colon. Treatment for twenty years has failed to stop its progression and his colon is now so badly diseased it has to be removed completely.

What is Crohn's disease? It was first described in 1932 by Crohn, Ginzburg and Oppenheimer, as a non-specific inflammatory condition of the terminal ileum (the end bit of the small bowel), though it is now known to affect any part of the gastrointestinal tract, mouth to anus. The inflammation causes severe ulceration of the bowel wall, ultimately resulting in strictures (narrowing) of the bowel, scarring, perforation and fistulation (erosion into neighbouring loops of bowel), possible peritonitis. Serious debilitation and weight loss ensue, perhaps death. The pathogenesis (causation) of the disease is still unknown. Because it so resembles an infective or parasitic process, extensive research had been carried out to verify this. But no causative organism has ever been found. Possibly it is an autoimmune problem where the body's defence mechanism has gone awry, mistakenly attacking its own tissues, which it incorrectly identifies as foreign invasive material. With no known cause there cannot be any known cure. Immune suppression by drugs and steroids offer some help but no cure. Newer research strategies attempt to identify molecular elements that trigger the disease. Once identified, drugs can be designed to target these rogue elements in order to switch off the disease process. Or so we hope.

SCL's colon had several strictures and fistulas, and his intestines had become matted together in a dense mass resembling a state as if a bottle of glue had been emptied into his abdomen, binding everything together. He was at the end of his tether.

The colon was removed with great difficulty. The individual loops of adherent intestine had to be painstakingly separated, sometimes inadvertently puncturing them in the process. Blood loss was considerable and was steadily replaced by transfusion of large volumes of blood previously reserved for this purpose.

In surgery, bleeding from an identifiable source is dealt with by ligation (tying off) of the bleeding blood vessel or by suturing (stitching) if ligation is not possible. The bugbear for the surgeon is when the bleeding is widespread, from all the damaged areas resulting in a generalised oozing from the entire operative site. This type of widespread oozing of blood is usually controlled by applying strong pressure, packing the area with plenty of hot towels, then waiting for the body's natural defences to control the bleeding through blood clotting. If bleeding continues despite this, a serious problem arises. The elements in the blood required to produce the clots are steadily depleted, especially the platelets (tiny blood cells that rush to fill the breach by clumping together, forming a clot that seals the bleeding site). When all the resources needed to form blood clots are exhausted, a serious condition known as coagulopathy (failure of the clotting process) results. The bleeding continues unabated.

The patient by now is almost exsanguinated. An urgent call is put out for assistance. Dr H, an experienced physician and cardiologist, answers the call and works feverishly to keep him alive as his heart begins to fail. Transfusions of fresh blood (stored blood is ineffective because it has lost much of its clotting factors) are given in large amounts. Platelet transfusions. A novel and costly anti-bleeding drug used in desperation. And still the bleeding does not stop.

The family, anxiously waiting outside, is now informed of the situation which is so desperate that it is suggested that they should be brought into the theatre (suitably garbed in protective scrubs) to have a final view of their loved one while still alive. They come, they weep, they leave, devastated.

Dr S asks again: Shall we send him back to the ward?

The surgeon, dry of mouth, running on empty, replies with a firm NO. My work is not finished yet, he says.

Further pressure is applied, all known medications, devices, manoeuvres continue to be deployed . . . and then . . . *deus ex machina* . . .

The bleeding stops. The final steps of the operation are completed and six hours after the operation began SCL is returned to his room in a serious but stable condition.

A day in the life of a surgeon.

SCL survives, against all odds. He is out of danger after two days and is sent home on day ten. He is alive and well twenty years later. He visits me from time to time, just to say: Hello!

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A Day in the Life of a Gardener

Waking up at six in the morning, the house is quiet; I am the first one up. After some hasty ablutions, I repair to my study for half an hour of quiet time. This time is occupied with communing with my Maker and appreciating the value of silence.

By now Rocco, my dog, is at the door, agitating for his morning walk. We leave through the front door, and there, sitting outside, quiet and composed, is one of my cats, by the name of Patch.

A word about Patch. He was a feral cat that six years ago appeared in my car park. Scrawny and not very clean, with a clipped right ear (indicating having undergone the Trap–Neuter–Return programme of the Hong Kong Society of Prevention of Cruelty to Animals), he called out in a thin voice: Feed me please. This done, he slipped away. After a few days of the same, he decided to adopt us and came to live with us, though he spends most of his time outdoors in the garden and its surrounds.

Then Rocco, Patch and I begin our fifteen-minute morning walk, Patch keeping pace unless there is a bird or lizard that demands his immediate attention. Having dealt with the pesky interlopers, he rejoins us. This unlikely trio is a source of great amusement for some passers-by.

My garden now calls for my attention. It is not an exaggeration to say the garden is different every single day. I walk through it, deciding what needs to be done immediately and what can be left for later in the day. Something to harvest? Today the corn and eggplants are ready right now, the okras perhaps for later in the day. What is past their time is removed, and confined to the compost bin, where over the next three months they will be transformed into sweet-smelling compost, ready to enrich and condition my soil.

By this time, about 7 am, a steady stream of people pass by my roadside garden: early morning joggers, workers making their way to their jobs, street cleaners. Many of these are regulars, known to me, and engage me in conversation. Some are keen followers of what goes on in my vegetable patch. I always keep a supply of seedlings, cuttings and seeds, ready for distribution to anyone that may have use for them. Many are delighted to receive gifts of fresh vegetables, sometimes even invited to personally harvest them on the spot.

The tasks for the rest of the day: garden maintenance, clearing up, cleaning up, pruning, weeding, building a trellis for beans, perhaps. But what I like most is planning for the next few weeks or months. When the present crop is over, I hope to have seedlings ready to step in right away. This is particularly important since the garden is so small and every square centimetre must be put to work without delay.

Sowing seeds. Every time I do this, I am reminded of the miracle of the seed. This tiny structure, embedded with the formula for any and everything needed for its development and growth. A complete blueprint, even with information of when it should fade away and die. Sowing a seed is an act of faith, believing it will deliver what it promises. A tomato seed a tomato plant, a cabbage seed a cabbage.

Weeding. A chore? I once read in a gardening manual: *No one in full command of his senses would probably ever feel that weeding is fun*. I disagree. Weeding is fun, or can be fun. It can be therapy. It is a quiet and solitary activity that leads to an inner calm, soothing away troubling thoughts through a conditioning of the mindset. Some weeds are very attractive and should be left alone: Periwinkles, Russelia. Some weeds are good to eat. To name two: wild Chinese spinach, and purslane. They are constantly available in my garden, even when nothing else is ready to eat.

It has been said that a gardener should have a back with a hinge in it. Since my old back does not have a hinge in it, at the end of a gardening day the back I do have may be stiff, the muscles aching, the sweat running. All adding up to satisfaction of a day well spent.

A day in the life of a gardener.

I have arrived in Ithaka.