The Real Doctor Will See You Shortly

Matt McCarthy

ALSO BY MATT MCCARTHY

OddManOut:AYearontheMoundwithaMinorLeagueMisfit

THE REAL DOCTOR WILL SEE YOU SHORTLY

A Physician's First Year

MATT MCCARTHY

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Author’s Note

This is a true story and the people I’ve written about are real. However, in order to ensure patient privacy and maintain the confidentiality of others, this work has been carefully vetted to comply with the Health Insurance Portability and Accountability Act (HIPAA), and throughout the book, names, dates, and personal identifying details have been changed. In one instance, a composite character has been used.

Prologue

It started with a banana peel.

After years of quiet study in the libraries, laboratories, and lecture halls of Harvard Medical School, I finally made the tectonic shift to hospital life in the summer of 2006. The third year of medical school marks a startling departure from the academic fantasia of study groups and pass/fail exams, and I was flooded with anxiety. I valued sleep. I wasn't sure how I'd handle destructive criticism, and I was known to have an irritable bowel.

The first assignment in my rotation was surgery, a three-month slog of 120-hour workweeks at Massachusetts General Hospital that was designed to identify the handful of future surgeons in our class of roughly 165 students. On the first day, I was assigned to a team with a desiccated fifth-year surgical resident named Axel, who had piercing periwinkle eyes and an implausible Adam's apple that caused my eyes to bounce when he spoke. Axel could fairly be described as a member of the Undead; he had traded the better part of his youth for world-class surgical training and wasn't sure it had been a fair swap.

Shortly after I was introduced to him in the cafeteria, Axel held up a banana peel, tore it in half, and said, "You may not lay a hand on any of my patients until you've sutured this back together." He reached in his back pocket, handed me a needle and thread, and banished me from sight. "Go wherever you want to figure it out," he said, "and please stop grinding your teeth."

At first I didn't know what to do; surely none of the other medical students had been given this assignment, and I didn't know my way around the place we called Man's Greatest Hospital well enough to find someone who could help. I cradled the peel like a wounded bird and started wandering up and down the long corridors, peeking into rooms at random.

Eventually I returned to the room where I'd started the day—the surgical library—where an administrative assistant had given a dozen of us folders with an outline of expectations. There had been no mention of banana peels.

As I scanned the room, which was dotted with portraits of men I should have recognized but didn't, I recalled something a frustrated professor had recently said to me: "When a patient is having a heart attack, a Harvard student's instinct is to sprint not to the patient's bedside but rather to the library, to read more about the nature of chest pain. Don't ever do that." Yet here I was, surrounded by books instead of patients.

I pulled one off the shelf and flipped through the pages. What were my classmates doing right now? Learning to scrub in? Assisting with appendectomies? Removing gallbladders? That's what I'd thought this rotation would be about: actual surgery, not fumbling with fruit. Was all of that really on hold until I figured this out? I looked down at the banana peel and sighed.

I could probably patch the thing back together with some basic shoestring knots, but that wasn't the task. Suturing involves a specific set of techniques to make knots that leave very little trace of their existence, as would be necessary on a patient who required them to close up a wound. But the instructions I found in books weren't helping. The pages were filled with detailed descriptions of arcane anatomical structures and artists' renderings of complex intestinal surgeries, stuff that was far too advanced for me.

Based on my incipient attempts, the banana peel would have been grounds for a malpractice suit. An olio of solutions bounced through my head: *Pay a frazzled surgical intern to show me how to suture? Superglue the peel back together? Claim I'd used dissolving stitches?*

I heard a knock at the door and closed the book. A voice outside the library called, "Hey, a little help?"

I opened the door and found looking up at me a man with a receding hairline and wire-rimmed glasses seated in a wheelchair.

"Hello," I said, as though receiving an uninvited dinner guest. A lost patient, I presumed, until the man wheeled himself past me into the room and flipped on a second set of lights. "I'm Charlie," he said. "You must be…"

“Matt. One of the new medical students.”

His face brightened, and he took off the glasses. “Charlie McCabe,” he said. “Pleasure to meet you.”

I flinched when I heard the name. McCabe had been one of the most promising surgeons of his generation when he began his residency at Mass General in the 1970s. At the end of his training, he was accepted into the cardiothoracic subspecialty training program at MGH, but just before graduation, he developed a tingling in his hands. In short measure he was diagnosed with multiple sclerosis and was left unable to operate. After the diagnosis, McCabe began teaching surgery to medical students and now ran the surgical rotation at Mass General. He had been named the Harvard Medical School teacher of the year on several occasions, and we all knew his heartbreaking biography.

“You’re a few minutes early,” he said. “I was about to have you guys paged. We’re going to go over some of the basics of the rotation.”

As I sat down I looked for a place to put the peel.

“Need a trash can?” McCabe asked, motioning with his head toward the large receptacle in the corner.

“My, uh, resident gave this to me today to—”

“Axel and his banana peels.” McCabe’s head shook from side to side.

“Yes.”

“Give it a shot, and if you can’t figure it out I’ll show you.”

“Really?”

“Give it a shot.”

—

For the next three days, I reported to the surgical library at 6:00 A.M. to spend hour upon frustrating hour mutilating the ever-darkening, softening banana peel. At the end of the third day, I bumped into McCabe near the hospital’s entrance.

“Success?” he asked. I held up the tattered peel, and he winced and said, “To my office.”

When we got to his office, I took a seat and he handed me a suture kit that he kept on his desk. “Technique is crucial,” he said. “Are you right-handed or left?”

“Left.”

“Southpaw!” he said. “All right.”

The last time I’d been called that was on a baseball diamond, when life had seemed to be pulling me in a very different direction. Before I met McCabe, I’d spent four years on the Yale baseball team, daydreaming of life as a professional athlete. A week after graduation, I was drafted in the twenty-first round of the 2002 Major League Baseball draft by the Anaheim Angels and joined a minor-league team in Provo, Utah.

It quickly became apparent, however, that our hero was not destined for a career in pro ball. And it was during that soul-searching summer in the minors that I acknowledged something my sister had said during our childhood in Florida: I was one of the very few athletes who just didn’t look good in a baseball cap. So as my brief but memorable stint in rookie ball drew to a close, I applied to medical school. Harvard accepted me the same month I was cut by the Angels.

McCabe’s hands shook as he positioned mine above the banana peel and approximated its edges. The sensation made me shiver, which I tried not to show; he seemed as delicate as the peel. But despite the shaking he moved with remarkable certainty. His confidence and expertise were undiminished, and I could imagine in that moment how good he must’ve been. “Don’t take too big of a bite,” McCabe said, referring to the depth of the needle insertion. “But be confident, be assertive.”

I made a swipe, and he shook his head. “Not bad. Not good. Again.” I retracted the needle and considered my next path. “You’re thinking,” he said. “Don’t think. Do.” I took another swipe, and the peel cinched together. “Perfect.” I was briefly reminded of the pottery-throwing scene from *Ghost.* What felt clumsy at first quickly became comfortable. The peel was sutured up in minutes. “You’re a natural,” he said. “I think we might have a budding surgeon on our hands.”

The compliment stilled my roiling stomach. To have picked up something so quickly gave me a hint of the confidence I’d felt in baseball,

before I peaked short of the big leagues and suddenly started hearing from coaches and trainers that I didn't quite have what it took. Granted, I had a long way to go in medical school, but this sort of stroking coming from someone like McCabe opened up a window on a possible future.

I admired the dank, battered peel and presented it to Axel the next morning over a predawn breakfast. "Very nice," he said, daintily holding the peel over his plate of pancakes. "You're almost ready for the show."

As I took in the compliment, I thought about the operating room and "the show." I imagined myself extracting a bullet from a victim of senseless violence and calmly suturing up the wound.

"Let's lay some ground rules." Axel mumbled while devouring his food. "One, you should always be the first one scrubbed in. Two, do not speak unless spoken to. Three, wear a clean pair of scrubs every day and keep a shirt and tie in your locker for the days when we have clinic."

"Got it." I started to write *TIE* on my hand.

"Please do not write on your hands."

We got up from our pancakes, and when Axel discarded his tray and the beat-up banana peel, I realized with a twinge of sadness that I'd grown somewhat fond of it. As we headed toward the operating room, he put his right hand on my left shoulder and stopped me. He was tall but wiry, not imposing.

"Going to give you some words of wisdom," he said, "that were passed down to me when I became a surgeon. Consider them a surgeon's survival guide." I closed my eyes briefly, indicating I was ready to absorb. "When you can eat, eat. When you can sleep, sleep. When you can fuck, fuck. But do not fuck with the pancreas."

—

With the banana peel successfully sutured, Axel assigned me a mélange of increasingly complex tasks. I was invited into the operating room and allowed to navigate the laparoscope while he removed diseased organs, and before long I was the one excising the appendix or gallbladder (but not the pancreas, of course). Medical school, it seemed, was like baseball or the

arts: neophytes showing aptitude received more attention from instructors and were put in better positions to succeed.

In the Massachusetts General emergency room, I learned to suture human skin. My first patients were a series of unconscious victims of motor vehicle accidents in need of a few arm or leg stitches, and I thrilled at watching open wounds close neatly at the pull of a thread. From there I moved to conscious patients, and soon I was stitching faces. As the terror in my patients' eyes gave way, so did mine. The first facial laceration I dealt with was on a woman who'd been bitten in the lip by her pet toucan. Axel emphasized the importance of lining up her lip properly before throwing the first stitch.

"If the vermilion border is misaligned," he said, manipulating her lips, "she'll be permanently disfigured. Now, go to it."

Sewing people up soon revealed itself as a sophisticated craft, or perhaps art, to which I could devote myself. It presented a focused canvas full of microdecisions, but there was always an optimal solution to any surgical question—the correct way to align the sides of a wound, the best place to throw the first stitch. One could see how surgeons with aptitude gained mastery through repetition, how they could joke about performing certain surgeries in their sleep.

I found the process of putting someone back together deeply affecting. Day after day, I scoured the waiting room looking for lacerations, and any chance to further hone my skills. I sensed that my role as promising student affected Axel, too. He seemed less hollowed-out, less vehement, and he dispensed nuggets of wisdom with increasing frequency:

> "Don't wear a bow tie to work before you're forty. Makes you look like a douche bag."
>
> "Trauma surgeons don't worry about follow-up appointments."
>
> "Don't shit where you eat."
>
> "Don't buy a motorcycle."

At the end of the three-month rotation, Charlie McCabe called me into his office. As I removed the suture kit from my back pocket so I could sit down, we both looked at the spot on his desk where he'd first shown me

how to use a needle and thread. McCabe took off his glasses and clumsily cleaned them with a handkerchief.

“I’m going to cut to the chase,” he said. “You’ve got talent. I’ve talked to Axel, I’ve spoken to my colleagues. I’ve seen it with my own eyes.” I fought back a smile. “Personally, I think you’d be crazy to do anything other than spend the rest of your life in the operating room.” I had been raised Catholic, and though I had stopped going to church sometime in college, McCabe’s words sprinkled down on me like holy water from an aspergillum. “But I’m not gonna bullshit you,” he went on. “It’s hard. At this stage you need to ask yourself a very basic and deceptively simple question: Can I imagine myself being happy as anything other than a surgeon?”

By this point I had a great deal invested in making Charlie McCabe happy. But sitting across from him at age twenty-six, I knew the answer to his question was probably yes. I’d never considered life as a surgeon until a few weeks ago, and while I enjoyed the work—it was new, it was thrilling—I wasn’t convinced that surgery was my calling. I could handle waking up at 4:15 A.M. now, but what about when I was forty? Or (gasp) fifty? None of the surgeons I knew actually seemed happy. But who does?

Axel was someone I admired, but not someone I envied. The few times I overheard him on his phone, he was breaking plans, not making them. The brusque manner and bags under his eyes gave me a small window into his difficult, stressful life, and I wasn’t sure it was for me.

“I enjoy being in the operating room,” I said haltingly. McCabe was a man who had trained some of the country’s best surgeons. I didn’t want to blow a life-changing opportunity, but I also didn’t want to be dishonest with him or myself. I was going to blow it. “Can I get back to you?” I asked.

McCabe looked down at his desk and smiled the way one might in mixed company at an off-color joke. “Sure,” he said softly. “Of course.”

Those skills I learned in surgery—suturing, navigating a laparoscope, clipping a wayward artery—were my fondest memories of medical school. I possessed an intricate, highly specialized skill set, but it was of no use to me, two weeks removed from my Harvard Medical School graduation in June 2008, as I prepared to face my first night on call in Columbia University Medical Center’s cardiac care unit.

PART I

1

Carl Gladstone woke on the west side of Manhattan in the small hours of June 18, 2008. The professor, as was his custom, put on a pot of coffee and loped into the shower. After trimming his mustache and inspecting his thinning brown mane, he may have revisited a question that had been nagging him. Did he, in fact, look like Theodore Roosevelt, as one of his students had recently suggested?

Gladstone grabbed his briefcase and Yankees baseball cap and headed out of the Hell's Kitchen apartment to his office. A northbound train ride deposited him at a college in Westchester County, where he'd spent the entirety of his academic career, teaching accounting. After catching up on email, scanning the Yankees box score, and perhaps agonizing over the one thing that could possibly drive him to an early retirement—deriving new questions for his exams—he stood up, tucked in his shirt, and walked down the hall to an empty classroom.

As the students filed in for the 11:00 A.M. class, Gladstone methodically began to write on a chalkboard. Satisfied with his work, he pivoted to survey the room. He cleared his throat to call the chattering students to order. Then he felt a twinge in his right arm.

A moment later, he was on the floor.

Quick-thinking students dropped their backpacks and phones and lunged into action; an ambulance was called, and despite momentary doubts ("Do we really give our teacher mouth-to-mouth?"), a young man initiated CPR. After several awkward attempts at chest compressions, Gladstone regained consciousness as quickly as he had lost it. He stood up, backed away from the students, and asked everyone to return to their seats.

Within minutes, an ambulance arrived. After some haggling with the emergency medical technicians, Gladstone acknowledged that he was still

having chest pain and agreed to be transported to the Columbia University Medical Center. As the ambulance took off, emergency room physicians and nurses received notification of Gladstone's impending arrival. By the time his stretcher burst through the swinging doors of the ER, a cardiologist was waiting for him.

Nurses instantly slapped twelve EKG leads on his chest as the team transferred him from the ambulance stretcher to an emergency cot. Gladstone was surely unaware of the unusual EKG report the leads were generating just a few feet from his head. The report, which resembled a red-and-white checkered seismograph, was retrieved by the bedside cardiologist. It revealed broad, irregular waves that plateaued rather than forming sharp points, a finding known as tombstoning because of its grave prognostic implications. A large segment of his heart had suddenly and unexpectedly lost blood flow.

Seeing the tombstones, the cardiologist informed the emergency room staff that there was no time for X-rays or blood tests. Gladstone was rushed upstairs and into a dark room—the cardiac catheterization lab—where a team of interventional cardiologists went to work on his convulsing, failing heart. Gasping for air, Gladstone was quickly sedated and a large tube called a cardiac catheter was plunged into his groin, then snaked into his aorta. A doctor shot dye through the catheter and into his heart's blood vessels, and the image was projected onto a flat-screen monitor for the team to see. There were a few silent nods as the image became clear. His left main coronary artery was blocked—an abnormality known as the widow maker's lesion—and the cardiologists quickly went about opening it up by inflating and deflating a small balloon that rested on a guide wire at the end of the catheter.

Time to treatment is critical; restoration of blood flow in the obstructed artery is the key determinant of both short- and long-term outcomes for patients suffering heart attacks. Hospitals are now evaluated by the time that elapses from a patient's arrival in the emergency room until the balloon has been inflated inside the clogged artery. This door-to-balloon time should be no more than ninety minutes according to the American Heart Association. For Carl Gladstone, it had been less than fifty.