(Editor’s note: This opening chapter was adapted from Dr.

Richard Caleel’s dramatic and entertaining book *Surgeon*,

published in 1986 and still available with a search. It follows

Dr. Caleel’s first few years as a general surgeon at Chicago

Osteopathic Hospital. The fascinating prelude to this and the

balance of Dr. Caleel’s life and career follow in the ensuing

chapters. –David Wilk)

CHAPTER ONE

Into the Fire

It was my first day as a general surgeon and here I was in the operating room, standing over a gravely ill patient. This was the very sort of challenge that I had dreamed of; I’d progressed through medical school, my internship and four years as a resident to get to this very day, this very place. And now whether this man lived or died would depend on my surgical skill.

I was confident and nervous at the same time, poised for the challenge…but still, it was my first day.

Chicago Osteopathic Hospital stood roughly on the border of two distinctly different areas of the city. On one side was a middle class, integrated neighborhood with single frame homes and well-maintained apartments. It was clean. It was Americana.

On the other side was a tough, all-black ghetto with garbage-strewn streets, run down tenements, abandoned buildings and an air of general hopelessness. Jobs were scarce for people who lived here. Services were sub-standard. It was systemic. Living in this neighborhood was all about survival.

The people here don’t suffer from the same diseases as more affluent people. They are victims of bad nutrition, inadequate hygiene and a general lack of knowledge about their bodies. Poor people in the ghetto don’t feel comfortable visiting physicians for the most part. They don’t have insurance, can’t afford proper medical care, forego buying prescribed medications because day-to-day survival relies on other more immediate priorities. They let disease fester to the point of advanced consequences. They are afraid of finding out what might really be wrong.

The patient on the table in front of me, John M., was sadly typical of this malaise. He had had multiple problems and had let them get so serious that he was in extreme danger of dying.

“First knife,” I instructed my resident, Bill de Leo, and he slapped it into my hand.

I pressed the 10 cm scalpel lightly into my patient’s skin just above his pubic bone and drew it across the prominent bulge in his groin. As the blood boiled up along the line of incision, my intern dabbed it away.

I cut along and exposed John M’s protruding bowel. It was black and dead, not pink and glistening as it should have been. It was gangrenous, dead already and infecting the surrounding tissue, as serious as it gets. I would have to do a resection and that would involve at least another hour on the operating table. There was no certainty that my sick, weakened patient could survive the ordeal.

John M. was a 74 year-old black man whose wife had brought him into the emergency room a few hours earlier gravely concerned. He was feverish and in great agony from extreme abdominal pain. His groin was swollen and tender, his abdomen distended grotesquely. He had a blockage of some kind, had had this for a while, and the possible causes were endless. It was obviously serious and I had needed to determine at once if there was any course to pursue other than immediate surgery.

The patient was a thin, frail old man, weak and under-nourished, with a condition that was far more advanced than it ever should have been. It was a problem all too typical of patients on the poor side of Chicago. Many died who could have been treated had they seen a doctor regularly…or at least at the early signs of a problem.

“He had a heart attack two months ago,” John’s wife volunteered.

“That’s even worse,” I thought to myself.

We filled him with antibiotics, took some blood samples and rushed John into an acute abdominal X-ray series. His blood test showed that his white blood count was extremely high and that he was producing immature white cells at an alarming rate. The X-rays revealed the mechanical obstruction.

I would need to operate, and fast, as John’s body fought a losing battle against the severe infection. Waiting any longer would prove fatal.

I had earned my medical degree from the Chicago College of Osteopathic Medicine, which was attached to Chicago Osteopathic Hospital. I had also served the first year of my residency here before I returned home to Detroit to finish three more years of residency to earn my certification as a general surgeon.

They knew me here and had offered me the best package to start my career as a general surgeon, with a decent starting salary and the opportunity to teach surgery to students, interns and residents. This was a teaching hospital and I had always wanted to teach. I went on to serve on this faculty for some 40 years.

But I also wanted to help these downtrodden people of the ghetto. I had seen their plight in my time at the college and my residency in the hospital. I also knew that it would be a real challenge for me, operating on the sickest and most needy patients, developing my skills on the most serious of cases.

I widened the initial incision to make sure I got all the dead tissue. His gangrenous bowel looked like it could rupture at any second. I would need to remove the diseased portion of John’s bowel and connect it to healthy living tissue. Every minute John was on the table reduced his chance of survival. As I proceeded, the buzzer went off.

“No heart beat,” the anesthesiologist announced. “Pressure dropping.”

I needed to get his heart beating right away.

“Hang in there John,” I said softly, but I knew he couldn’t hear me. “We need to get your old heart ticking again.”

The anesthesiologist administered medication to stimulate John’s heart while I proceeded to begin closed heart massage. I brought my fist down over his heart and his brittle ribs cracked under the blow.

“No heartbeat,” the anesthesiologist reported again, urgency in his voice.

I tried again, wincing at the popping sound of more bones breaking. But still no heartbeat. I ordered an intra cardiac epinephrine shot and plunged the seven-inch needle through John’s skin directly into his heart. Sweat was pouring down my face and a nurse leaned in to wipe it away from my eyes.

“Come on John,” I said to myself.

“No heartbeat.”

“Get a cardiologist,” I ordered. “Get one here Stat!”

For me it was a nightmare come true. My first operation on my first day and I was in danger of losing my first patient. I’d get another chance, but that was not the point. This patient was down to his last few minutes of life if I couldn’t get his heart started again right now. It was on me.

Performing an operation is like performing in a Broadway play. The patient and surgeon are the stars, the resident, nurses and technicians are all the supporting cast. The patient’s family is the ultimate audience. In this theatrical atmosphere, the stakes are high and the critics are waiting in the wings to devastate you with bad reviews.

Yet, like one outstanding performance in an ongoing play, a successful operation is a triumph in itself – but it is rarely the cause for heaping praise upon the surgeon. A successful operation is expected.

This puts great pressure on the surgeon to be brilliant every time he walks into an operating room…even though that may be several times in the same day. There is little allowance for the uniqueness of the operation or the stress factors of a tough schedule or the fatigue of the surgeon.

I had worked hard to earn an education my parents could not afford because I always believed that hard work would pay off. My parents were immigrants from Lebanon and our neighborhood in Detroit was middle class by the time I came along. That was after years of struggle. Becoming a doctor seemed like the best way out. But that necessitated hard work and sacrifices. I learned that hard work brings a certain personal strength and independence that you can’t find anywhere else.

But as I advanced through my training and medical career, it became increasingly clear that the most important dimension to the medical profession was helping people who needed help. It was this sense of responsibility that drew me to this particular hospital and guided me through my medical career.

“Get the defibrillator,” I instructed the scrub nurse, hoping I could get John’s heart started that way. She wheeled it over to me, my intern greased the points, and I placed them over the patient’s heart.

“Contact,” I announced to be sure everyone was clear.

John M’s body arched up off the table and the oscilloscope showed a second or two of frantic movement…but then the smooth, dead line resumed.

I hit him again with 400 watts, then again, but still only momentary activity followed by no heartbeat.

“Well, that’s it,” Bill de Leo, my resident, said softly, starting to take off his gloves. “Myocardial infraction. The poor guy never had a chance.”

“Stay where you are,” I said sternly. “We are NOT done! I’m going to open up his chest.”

It was a long shot, but what other shot did my patient have? Besides, he was already under anesthesia, chest partially open, receiving oxygen. Officially he was dead…but one more incision couldn’t hurt him. Maybe there was a chance I could bring him back to life.

I made the cut so that now I was looking directly into John’s chest cavity. His heart was scarred and enlarged from his heart disease. Gently I gripped John’s heart with both hands and began to massage it, trying to get it to respond. It was hot and slippery to the touch.

“No heart beat,” the anesthesiologist said, his tone reflecting that this was a matter of life and death.

“Dead as a mackerel,” de Leo said conclusively. I shot him a frozen glance intended to shut him up.

Just then Dr. Tremain, my superior at the hospital, walked in.

“Any problem?” he asked.

“Jesus!” I thought, “He’s just in time to see me kill my first patient.”

“Everything is fine,” I croaked, my mouth and throat dry from the tension. But that’s when I felt it. A tiny pulse. Then a stronger beat, just for a moment, then it stopped. But then it started again, stronger and more regular than before. Old John M. had come through! I could have kissed him.

“Pulse 60, pressure coming up,” the anesthesiologist reported, almost in disbelief. I gently let go of John’s heart.

“Nothing to it,” I said standing up, trying to sound as if I did this all the time.

That evening I told my wife, Annette, what had transpired on my first day. She pulled me close in a warm, loving embrace. When she let go, her lovely face was glowing. “I have never doubted you would be great,” she said softly.

I knew how lucky I was to have Annette as my wife. She had been a fast-rising model in Chicago when I met her, and I was just a medical student. Annette could have had any man she wanted, but somehow she chose me. I don’t know what she saw, but thank heaven I was the one she gave her love to. Then she persevered through all those bare years of my schooling and apprenticeship, standing by me through the seemingly endless struggles of no money.

Now we could see the light at the end of the tunnel. My salary as a surgeon and associate professor of surgery would be a sizeable boost from all those lean years. Plus, as a private practitioner, I could make extra money from any cases where patients had insurance. It was just in time, too, since we were now parents of a beautiful daughter, Maria.

One day a family came into the hospital, I was called down, and I escorted them into a conference room. The patient was Doris P., a 48 year-old black woman, and she was accompanied by her husband Renaldo and seven children. The entire family was dressed as if they were going to church. They told me that they were Jehovah’s Witnesses.

“We make decisions together as a family,” Renaldo P. informed me, clarifying why the entire clan was present. “My wife has cancer and we are hoping that you can operate successfully. But if you cannot accept the requirements of our religion we will understand…and try to find someone who can.”

“In other words, you won’t accept blood or blood products, like plasma or gamma globulin,” I replied, having some knowledge of their religion.

He answered affirmatively and I said that I would need to examine her first and run some diagnostic tests. I had never performed a “bloodless surgery,” but I had read how exacting it was and about the dangers to the patient that it entailed.

They showed me Doris’ charts and I could see that she had cancer of the esophagus and her doctor would not operate without infusing her. It was a prudent choice. They had attempted radiation therapy, and it did shrink the tumor mass for a while, but it made her very sick and weak and the tumor began to grow again. More radiation was not recommended.

Doris did not seem to be in very good shape. She was thin to the point of emaciation, understandable in light of the problems with her esophagus. Her cheeks were hollow and her voice was high and breathy.

“You must agree to one thing if you operate,” Doris reminded me. “I will not receive another person’s blood. I would rather join the Lord than break his commandments.”

“Yes, understood,” I replied, my unhappiness no doubt evident in my tone. “I will accept your wishes.”

But I had no intention of risking her life if a transfusion in conjunction with surgery was necessary to save it. I felt that in a choice between life and death, she would make the necessary compromise.

On the way out of the conference room each of her seven children shook my hand solemnly and said good bye. They were a solid family facing a crisis with courage and understanding, depending on one another for support.

A few days after I met Doris, I received a phone call from a friend and colleague of mine, Dr. John Fetzer. He was a heart specialist who had been a mentor and who I had recommended to be head of our new cardiac unit at Chicago Osteopathic Hospital. I could tell from his tone on the phone that he was depressed and preoccupied with something.

“John, you don’t sound good. What’s going on?” I asked.

He sighed. “It’s my daughter Judy, Richard,” he began to tell me. “She was in pain and we thought it was a duodenal ulcer. But after several months of treatment, she’s not getting any better. In fact, she’s much worse.”

Judy, a 19 year-old student at the University of Michigan, had consulted three other physicians there, but they were not seeing beyond the ulcer diagnosis for some reason. I agreed to see her as a favor to my friend.

She and Dr. Fetzer both looked terrible. I had seen Judy a couple of years earlier and she had been a tall, lovely, vibrant, self-assured young teenager. Now she was thin, drawn and in obvious pain. She looked like an old woman. Judy had been away at college a few months earlier when the sickness came on and her condition had steadily worsened since then.

I admitted Judy and immediately ran a series of tests. This was before the invention of CAT Scans and MRIs, so we relied heavily on X-rays. When I examined her, I found her abdomen a little swollen, but it was her pelvis that was not right. She exhibited a “frozen pelvis,” which meant her entire pelvic region was a solid mass. I couldn’t move any of her organs around, which was not normal. The possibility of an ulcer or an infection causing these symptoms seemed pretty minimal.

I told Judy and John that I wanted to run a few more tests. I did not tell her that a frozen pelvis was closely associated with ovarian cancer. I did, however confide my concerns to her father when we were alone. His reaction was predictable. I needed to perform an exploratory surgery to try to figure out the actual problem.

I called Doris P. in again to convey test results and to reveal my plan of action. She arrived with her family, but I asked that the children remain outside for this discussion. I presented three options, however the first two were only temporary fixes. The tumor would kill her in time.

The third option was surgery to remove the tumorous section of Doris’ esophagus. But I could not recommend it without using a transfusion. Her hemoglobin was already dangerously low. Conducting this major surgery without transfusing fresh blood would almost certainly kill her.

They agreed to discuss the options and let me know.

The family returned in a few days and told me they had elected to have me perform the surgery, but without the use of another person’s blood.

“The surgery will likely kill you then,” I told them sternly. “As a surgeon I would want to use every means possible to keep you alive.” But I knew they would not budge. Doris and her family refused to discuss transfusions any further.

“It’s in God’s hands,” Doris told me.

As this was the end of the week, we scheduled the surgery for the next week. I did not want her blood count to go any lower with the tumor constantly oozing blood inside her.

“Suppose we give her blood while she’s still asleep?” my resident suggested. “She would never know it and it would very likely save her life.”

“She wouldn’t know it, but I would,” I replied. “We made an arrangement and I’m going to stick to it. She will not die – because we are going to do the best damn job you’ve ever seen!”

I studied Judy Fetzer’s case all night. I was looking for the pattern to her test results. I had pieces of the puzzle, however the whole picture was incomplete. But when I performed the surgery the next morning, the answer was clear.

Judy had a chronic ruptured appendix. The infection had been growing and festering inside her for many months until the abscess had engulfed her reproductive organs.

Usually a patient with a ruptured appendix is so sick that the condition is obvious and surgery is required at once. It was just Judy’s bad luck that she had lived with the disease without the classic extreme pain and other symptoms. I was very relieved to find this; the solution was quite obvious.

I removed her appendix and drained the abscess.

Judy’s mother and father were overjoyed at the news, but I cautioned them that her post-operative course of recovery might not be quick or uneventful. She had been sick for so long that a few systemic problems were to be expected.

Still, a great weight had been lifted off all of us.

I cut into Doris’ rib chest at the seventh interspace of her ribs. I was very careful to control all the bleeding with electro cautery and I tried to be as gentle as I could with the tissue. The idea was to be as unobtrusive as possible, a rule I always tried to follow and emphasized to my students. Surgery is precision. It is not a race.

After moving Doris’ lung to the side, I finally had her esophagus in view. The cancerous lesion was just below the arch of her aorta, an extremely difficult area to work in. The danger of Doris bleeding to death was very real. I wondered what I would do if she were bleeding to death in front of me. Would I give her blood?

I checked for bleeding arteries and began the resection. I had done this many times before, but of course, never without transfusing new blood. I tabulated Doris’ stomach and brought it up into her chest to attach it to the healthy remains of her esophagus. I completed the surgery and knew I had done the best I could.

“A beautiful piece of work,” my anesthesiologist said admiringly. “If you had given her blood, she might have a decent chance of making it.”

I turned my back on him, furious, yet knowing he was almost certainly right.

I was on a flight to Atlanta for a surgeons’ conference when I got the emergency phone call in the airport. Judy Fetzer’s condition had suddenly worsened considerably. John Fetzer feared that she was dying. I immediately boarded a flight for home.

When I got to Judy’s bedside, I could see that she was sweaty and restless, half-comatose. I was informed that she had become dramatically worse in only a few hours. Oddly, her white blood count was not abnormally high, nor was her temperature.

I ran some tests that showed Judy’s adrenal glands had almost completely shut down. I put her on steroids at once, but her heart and respiratory rates were still quite high. I called in a couple of consultants. So many things were going wrong that I needed all the help I could get.

Judy improved slightly at first with the steroids, but then her condition started to worsen again. One system after another was failing. Her lungs were filling with fluid and her overworked heart was exhibiting pericarditis – an inflammation of its surrounding sac. She was sicker than ever and in danger of dying.

A few hours after Doris’ surgery, I visited her in intensive care. Her ever-present family lined the corridor next to the intensive care unit, looking glum and very worried. And it was justified. Doris’ blood count was down to six grams – less than half the normal level. That impairs the body’s ability to withstand trauma and heal itself. And combined with her already weakened condition, it left her with very little chance of surviving. I spoke to her husband.

“Look, I respect your religious beliefs, but I do not expect her to survive unless I transfuse her! She simply does not have enough blood in her body to make it through all this!”

“When she wakes up, I will ask her,” Renaldo promised. “But I do not think she will agree.”

Doris opened her eyes a bit later, weak and disoriented, I was called immediately and we went in to have that talk.

“Doris, the operation went well but we have to get you some fresh blood,” I pleaded, looking her right in the eyes.

Renaldo bent over her and I stepped away to give them some privacy. He stood up and shook his head somberly. “She refuses, I’m afraid.” Doris motioned for me to come close.

“The Lord is my shepherd,” she managed to whisper.

For the rest of the day I toyed with the idea of transfusing her without her knowledge. I honestly don’t know what stopped me. As a physician, it was my duty to do everything in my power to preserve a human life. I respected her wishes but with a tremendous amount of misgiving.

I checked on Doris periodically and although she remained in critical condition, she did not die. Meanwhile her family spent time visiting other patients, trying to bring them a bit of joy. That was typical of Doris and her family: thinking of other people before themselves.

Annette was in the hospital, having just delivered our second child, Thomas. She told me that a little boy named Asa had come into her room and given her a simple yo-yo for the baby. The visitor had been one of Doris’ children and I told Annette how thoughtful the entire family was. We both agreed it was just wonderful to raise your children with those selfless values.

After a few days, Doris was a bit better. We were able to move her to a regular room and her blood count had climbed to eight grams. I felt that if her body could get it up a bit more, she would have a real chance of leaving the hospital under her own power.

“It is the power of God,” she told me with a weak but radiant smile.

Who was I to disagree?

When the time came to release Doris, I could not have been happier for her. Whether it was good luck, our surgical skills or the grace of God, something had worked and she was going home to rejoin her family.

After monitoring Judy Fetzer’s decline, thinking about every possibility, a thought came to me. It was a long shot, but it did make some sense. Her condition was so bizarre that the solution had to be something unconventional. There were no indications that I was on the right track, but from somewhere my instincts told me she might have a pelvic abscess. I was determined to operate again.

I discussed my theory with a few other doctors, but no one expressed much confidence. Her pelvis was pretty distant from the areas of distress.

I made the incision in the back part of Judy’s vagina, between her vagina and rectum, and inserted a tube into an abscess I could not see but was hoping was in there…hoping it would prove to be the actual hidden cause of Judy’s decline.

“Son of a bitch!” my assistant hollered. “You were right! It’s a gusher!”

We evacuated a whole quart of greenish-yellowish pus from deep within Judy’s pelvis, confirming my desperate diagnosis. It was the best looking pus I had ever seen. It meant that Judy had a chance to make it through all this alive.

I told her father the good news and he sat with Judy all night, holding his daughter’s hand. After a long day and night he reported that for the first time in months Judy was actually getting better.

Her recovery was certainly not ideal. There was another scary incident where Judy developed an intestinal blockage and fistula. This put her in danger of sepsis, blood poisoning. I had to perform an emergency resection of her intestine, but it solved the problem. Finally Judy did recover. Her healthy color and cheerfulness returned.

Judy was ready to leave the hospital and return to her life as a college student.