Chapter 14: The Émigrés

It is immigrants who brought to this land the skills of their hands and brains to make it a beacon of opportunity and hope for all men.
Herbert H. Lehman

In August 1978 I accepted a position at the City of Hope National Medical Center, a hospital specializing in cancer in the Los Angeles area. In June of that year voters in California approved Proposition 13, which capped property taxes at 1% of a house's purchase value. Consequently, my wife and I were able to buy a home in Flintridge-La Canada, a residential area north east of Los Angeles.

We were a family with two young children and a dog, having just arrived to California from Boston, and the moving van had barely left when Zan came over to meet us. He padded across the street to our ranch-style house, barefoot and shirtless in knee-length shorts, hiding what my trained eye noted as the tell-tale bulge of a seemingly large groin hernia. At 65, he looked healthy in his California tan. He was a tall, stocky man with a full crop of wavy white hair, a disarming smile, a farmer's rugged complexion and an effusively charming character.

As a city dweller, I picked his brains about the orchard that was within our newly acquired property. Past a long stretch of lawn, the orchard was enclosed by a wrought iron fence with clinging rose-bushes, which glittered in the Californian sun. Our little orchard contained a lemon tree, Navel and Valencia orange trees, a fig tree which I recognized from my boyhood days in Egypt, and an Australian variety of persimmon tree, a fruit previously unknown to our family, whose bountiful crop, Zan assured me, would delight us. He was right. I noted his pruning suggestions and was relieved to see the automatic sprinkler system extended into the orchard.

From where we stood, on our front lawn, next to our driveway I saw a white Mercedes swing into Zan's driveway, and with a smile he waved to his wife. Justine was a nurse a few years younger than Zan. She was very pretty, albeit a little reserved, but just as welcoming as her husband. After that first day, Zan frequently padded across to us in the moments after I would come home. Sometimes he would bring his dog Red. Red was half coyote, abandoned as a puppy on his farm. Zan was always barefoot, shirtless, in his knee-length shorts, and always with a beer in hand. I enjoyed our chats as a way to unwind after a long and frequently challenging day in the operating room. Our discussions ranged from the maintenance of our fruit trees to the Iranian revolution that had dethroned the Shah in January 1979. In his baritone voice he would ask if I knew that the largest Iranian expatriate community, of about one million, lived in Los Angeles? Or did I know that since the weather was similar to Iran that Californian's pistachio nuts were rapidly displacing Iran's biggest export after oil, since we had imposed sanctions?

Zan seldom mentioned his grown family—I gleaned from occasional comments that he was estranged from his son—but he frequently raised the topic of his hernia. I got the impression, as he quizzed me hypothetically, that he was verifying what Justine had already told him. He referred to it as his "benign sliding inguinal hernia." Did he need reminding that this was a potentially fatal condition? I sensed he either understood this or maybe because of our chats, he was coming to this realization. Either way it was a constant conversation piece which I sensed he might miss, were his hernia ever fixed. I seldom treated friends and neighbors, valuing our relationship more than the strain of unexpected operative outcomes, but with Zan it was different. As he gained my confidence and our relationship evolved, he sensed that he came to view me as a son. He frequently suggested that my six-year-old son call him Grandpa, although he had his

own grandchildren. Yet he never spoke of his estrangement with his son. Behind his bon vivant exterior, I could see that the true Zan was a lonely man who yearned for human companionship.

In fragmented pieces of his life, offered casually and interspersed with commentary on the daily political news, Zan gradually allowed his persona to come into focus. And with that increased openness our conversation often drifted towards his implicit expectation that I might operate on him, averting an inevitable surgical disaster if his hernia got stuck and did not fall back into his abdominal cavity. I didn't try to change his silent assumption particularly since he never verbalized it and I felt it may just have been my supposition. Nevertheless, I felt this tacit prospect was an unwarranted burden to our friendship.

Zan was my neighbor's given name, but where the unique name of Zan originated remained a mystery to him. I discovered in my own investigations that it is a variant form of the Slavic and Greek name Zander, a derivative of Alexander—my son's middle name. Zan was named after his father, who was a barber in the Austro-Hungarian army and emigrated from Bohemia to the New World in the years preceding World War I to avoid military duty. Zan could not remember how his father reached these shores, or when, or whether he landed in Canada or the United States of America. He did know that his father's destination was Australia, and North America was only a transit-stop. Reaching California, Zan senior was seduced by Hollywood's allure. His experience as a hair dresser, a coiffeur, a maker of toupees and hairpieces was much needed. The influenza pandemic of 1918 had killed an estimated 100 million; luckily for Zan senior, the sudden onset of a high fever that affected an estimated 500 million survivors destroyed their hair follicles, leaving them bald or with unseemly thinning hair. Business was thriving in the shop at the corner of H and Grand when one day in 1919 a striking Irish beauty

walked in. Florence had survived the flu but was distressed about her alopecia. Did Zan senior, looking into her emerald eyes, glimpse the soul beyond her patchy crown? In November of the following year a son was born to the happy couple.

Zan Jr. attended public primary schools and entered the University of Southern California (USC) in 1938. He joined the Sigma Phi Epsilon fraternity and majored in business, with the expectation he would take over from his dad. Pearl Harbor changed his plans. Zan joined the Civilian Pilot Training Program and, after basic training, was posted to Minnesota in 1942 where his lack of visual depth perception kept him on the sidelines. He witnessed young recruits constantly practicing taking off and landing from hastily prepared airfields. He was haunted by the frequent crashes, burning planes, and pilots trapped in their cockpits. The images of fiery deaths and silent screams were seared into his brain.

Each military unit mandated two statisticians. His superiors recognized his mathematical training from his business background, so he was sent to Harvard for two years to become proficient in the field, after which he returned to spend time at the Santa Ana Army Air Base. There cadets learned about the mechanics and physics of flight and were required to pass courses in mathematics, the hard sciences and aeronautics.

Zan met Justine at USC where she was a student nurse, and in 1946 they married. Loving the outdoors, they purchased a sixty-acre farm in Chino, California, where he raised dairy cattle and rotated crops. This became his vocation and his passion; the strenuous lifestyle he led before may have been the nidus of his hernia.

Once Homo sapiens adopted an erect posture, external hernias appeared. A lower abdominal inguinal or groin hernia occurs when the contents of the abdominal cavity bulge out through a weakness in the lower musculature of the abdominal wall.

Hernias are 25 times more common in men than women because their etiology starts during fetal development at about 12 weeks in utero, when both testicles develop from a ridge of tissue near the right and left kidneys at the back of the abdominal cavity. As these structures descend the three to four millimeters into the right and left half of the scrotum with their blood supply and the spermatic cord, they draw down a sleeve of peritoneum, the lining of the inner abdominal cavity, over the pubic bone into the dangling scrotal sac.

The peritoneum forms the inguinal canal in the groin. On their downward migration, the testicles pass through an inguinal ring, which is the convergence at the pubic bone of the three different anterior abdominal muscles that make up the abdominal wall. Soon after birth, both inguinal canals obliterate. The bilateral descent separates the warm abdominal contents from the cooler scrotal environment, conducive for the testicles to produce sperm.

However, there are cases where the inguinal canal does not obliterate completely, forming instead an inguinal sack which can be detected in newborns or young children. More commonly, the inguinal ring weakens with progressive age from strenuous activity that causes increased intra-abdominal pressure. This occurs more often on the left than the right side. When a weakness occurs, the intra-abdominal content descends into the hernia sack, which can extend as far down as the testicle, particularly when the patient strains or stands erect. On lying down, the contents usually recede into the abdominal cavity.

The peril arises when the hernia's content consists of a loop of bowel that slides in and out of the sack, which could dangerously become cinched at the neck of the inguinal ring and get stuck in the sack. The low-pressure venous blood vessels become constricted at the neck by the tight inguinal ring, while the high-pressure arterial blood continues its flow into the bowel trapping it in the sack, causing it to become engorged with blood. Before long the incarcerated

hernia becomes choked off at the tight neck, killing off all of the tissue beyond the choke point. The patient presents as an emergency with a painful swelling in the groin, bowel obstruction and physiological shock from the dead bowel. This translates into a hazardous emergency operation.

Zan faced this danger daily, and cavalierly decided to ignore it for reasons I eventually figured out. His denial-based ambivalence was not a macho feeling of invincibility, but simply fear. He was afraid of losing control of his faculties, of being helpless, when anesthetized, and his lingering fear of death was reinforced by recurring images of the trapped pilots who burned to death in front of him.

In the summer of 1979, we had our first of many July 4th neighborhood poolside parties. Inevitably, Zan and I would discuss the political situation developing in Iran. Since the Shah's exile from the new Islamic Republic of Iran, the Shah had become a diplomatic pariah, unwelcomed internationally for fear of alienating Ayatollah Khomeini's Islamic fundamentalists. He would shuttle between Egypt, Morocco, Mexico and the Bahamas, seeking a home and surgical treatment for his debilitating pancreatic cancer. President Carter's unwillingness to offer him sanctuary for fear of precipitating an Iranian oil embargo dominated the news that spring. Predictably the subject cropped up in murmurs as many of our neighbors were retired oil executives. Their demeanor lightened in the late-afternoon heat, eased by the flow of alcohol. Opinions varied and disagreements arose so that conversations were changed to avoid offense.

Out of this discussion and fully unprompted, Zan said in a moment of characteristically rash bravado, "Gosh, I've had it for so many years and it hasn't bothered me, it'll probably be all right, Doc." After a swig of his beer and a long pause, he added, "If you're willing to fix it I'll let you do it someday, when you are not busy and you have the time. I just don't trust doctors, but you're different."

How I was different, he did not say, nor did I seek clarification. It just felt like a kumbaya moment as I put my arms about his shoulders, sensing an affinity between us. Standing poolside among our neighbors, in his white Lacoste tee-shirt, pink shorts, and loafers with a beer in hand, he caught me stealing, yet again, a glance at his groin. He eyed me silently, wondering if I believed him. Justine stood beside him. Her resigned look confirmed what I thought about his continued inaction. Her gaze was that of a concerned wife, and as I correctly guessed it meant that she had long ago given up prodding him to seek medical help. She and I knew the seriousness of this type of hernia.

Eventually Zan came to his senses. He finally made an appointment to see me a few months after that poolside party, on Tuesday, October 22, 1979, the day the Shah was admitted to the United States on humanitarian grounds. TV coverage showed a frail and debilitated man, older looking than his 59 years, driven to New York-Presbyterian Hospital, Cornell Medical Center.

I believed that Zan valued my professional opinion and that he trusted me. He was apprehensive, using joviality to mask his anxiety. He kidded around with receptionists and nurses, repeating that I was his adopted son as he entered the examining room. His hernia was impressive. It dangled to his mid-thigh and almost reached his left knee. Neither my nurse nor Elsa, my third-year surgical resident, had seen anything like it before. As a matter of fact, I had once seen a similar case, although not as extreme, while working in a surgical clinic in India.

"You know, Zan, this is what I'd call a third world hernia!"

He chuckled and repeated aloud, "a third world hernia," obviously amused. I named it that because only in the third world do patients neglect it such that it grows to this size. I laid him back and proceeded to reduce the hernia. It felt like massaging a thick putty sausage. It reduced

relatively easily, the gurgling sound confirming its bowel content. Then I stood him up again, keeping my fingers tightly pressed over the inguinal ring on his pubic bone, covered with sparse, graying pubic hair.

"You see, Zan, when I shut the ring your hernia doesn't reappear. That's a good sign. It means an operation will fix your problem."

He looked perplexed and concerned. "But it isn't a problem and it doesn't show," he argued. "So, why fix it?"

I looked at him with incredulity. "It's not normal to have a hernia. Wearing knee length shorts, of course, conceals it. And of course, when you lie down the hernia disappears."

"Well, not always," he interrupted, "Sometimes I have to massage it back, but it's really not a problem."

"Not yet. But if you aren't willing to have it fixed under controlled conditions, are you then willing to have an operation when it's incarcerated and a life-threatening emergency?"

He scanned the surrounding faces looking for a different opinion. Elsa only nodded and produced a consent form. I quietly worried about what I suspected was his long-time drinking habit; no matter what time of day I saw him socially he almost always seemed to have a beer in hand. It might affect his liver function, so that he was more sensitive to the anesthetic agents and other medications we planned to use. It could also prolong his bleeding times and extend his clotting time, leading to bleeding into his wound. At worst he may experience withdrawal symptoms and the biochemical effects on his brain manifesting post-operative delirium tremens (DT), which would endanger his recovery.

I scheduled the operation for Monday, 5th November 1979, starting at 7:30 a.m. as my first case of the day. Zan was to report to the pre-operative holding unit by 7 a.m. That morning, as I backed my VW Rabbit out of our driveway, I failed to note signs of inactivity across the street. I spent the early morning drive to the hospital riveted by news that the previous day the Iranian Revolutionary Guards had stormed our Embassy in Tehran and taken 52 hostages in reprisal for the US admitting the Shah for humanitarian reasons. The operation room was ready, so too was the rest of my surgical team. We hung around in our blues waiting. Mark, the anesthetist, had previously examined Zan. Now, as we waited, he expressed his concern about Zan's suspected chronic alcohol consumption. Although his liver function blood tests had been normal, he too believed Zan drank more than the couple of nightly high-balls, some wine with dinner and his daily beers. In surgical parlance, an alcoholic is one who drinks more than the doctor; Mark and I drank next to nothing. Worrying about post-operative DT, expecting Zan to be wheeled in on a gurney at any moment, we planned to give him the commercially available intravenous 3% alcohol in 5% glucose solution at the faintest signs of impending DTs.

We continued to wait.

Mark rechecked his anesthetic machine. He was a tall man with a fair complexion and big, powerful hands. He was quiet and thoughtful. Mary, the scrub nurse with whom I had worked frequently, checked the array of surgical instruments on her table, running through the sequence of instruments I would use. Together with Sandy, the operation room circulator, they traded information about the Shah and the hostage crisis in low voices. The other operation room technicians stood around waiting silently.

And we continued to wait.

By 8 a.m. it was clear that Zan was a no-show. I felt acutely embarrassed since the entire team by now knew that he was a friend and neighbor. Zan led me to believe that I had his confidence. He had lured me into his consenting mindset, and then destroyed our trust. Because he was special, I had asked the most competent anesthetist to assist me. For all I knew, this could have been Mark's scheduled day off. Where had I failed? How could I have missed Zan's signs of doubt?

"To hell with this, let's do the next patient," I said. Mark nodded. Sandy passed the word down the line to the ward. "Get Mr. Nazari ready." Mary my scrub nurse removed her sterile gown and gloves and gathered up the instruments. Instead of going for coffee and waiting for the next case, she was instructed to work in another room. A small TV blared in the nursing lounge, covering the unfolding hostage crisis.

By 9:30 a.m. when Mr. Nazari was wheeled in, I still felt irritated because the best part of my morning had been wasted. I was angry at myself for having believed Zan would turn up and I was incensed at being let down. A different young scrub nurse, unknown to me and much younger than Mary, was now standing at the instrument table. She introduced herself, but in my livid state I did not remember her name.

The presence of a new scrub further irritated me. I made a mental note to remind Mrs. Devlin, the operation room supervisor that I wanted to work with the same group of nurses all the time. Uncertain of my routine, the new scrub asked numerous questions about what instruments and sutures I was going to use and in what sequence. This too irritated me. Over the years I'd made no bones about it: I liked working repeatedly with the same people. This continuity led to familiarity and trust, minimized extraneous conversation, and heighted concentration on the surgical problem. Success of an operation depends not only on the

surgeon's skill but on a team of experienced health care colleagues working in unison, from admission to discharge, focused on the patient's emotional and physical welfare. Each patient is unique and each operation a new physiological experiment, in which the patient may respond differently to anesthesia and to the stress of surgery. My insistence, I felt, was in the patient's best interest. Such teamwork forged a cohesive group, which helped move the operation along, shortened operating time, minimizing potential for errors, and led to rapid, uneventful operation and ultimately to the patient's recovery.

Mr. Nazari did not speak English. I spoke no Farsi. In fact, unlike Zan, Mr. Nazari spoke very little. When I initially saw him in my office, the second patient after having seen Zan, Mr. Nazari was accompanied by his son-in-law who translated our sparse need-to-know interchange. According to him, Mr. Nazari's former job was as the Shah's appointed mayor of Tehran. He had fled Iran in the wake of the Islamic Revolution that swept out all those associated with the Shah. At 73, he was tall, frail and underweight. He had a small ulcer on his tongue's right border which appeared while he was living with his daughter in Los Angeles. I suspected it was an early cancer from years of smoking. A biopsy that bled copiously confirmed the diagnosis, and with no evidence of enlarged lymph nodes in his neck I recommended its excision.

His chest x-ray showed chronic obstructive pulmonary disease from years of smoking. His pulmonary function tests were borderline normal, while his electrocardiogram showed cardiac enlargement from his lung disease. Mark agreed he was a high risk operative candidate. He had prepared some bronchodilators to assist with breathing during anesthesia, and had arranged for an ICU bed to monitor his heart after the operation. Unlike Zan's case, which was

more complex because it was a long-standing problem and for which I had allowed three hours operating time, Mr. Nazari's case was a straightforward one-hour case.

The profuse bleeding, I encountered after the biopsy on Mr. Nazari was a major concern, one that I shared with Elsa and Mark. He planned to place an orotracheal tube through his mouth into the windpipe to the lungs. I would pack gauze ribbon around the tube at the back of the throat to prevent blood from my excision trickling into his lungs.

To minimize bleeding when cutting out the cancerous ulcer, I asked the operation room to get some local anesthetic to inject around the ulcer, 0.5% Lidocaine with 5 micrograms of Epinephrine solution. The premixed manufactured combination of a local anesthetic with epinephrine was of the right strength to constrict blood vessels, which would help minimize operative site blood loss. However, epinephrine has an undesirable side effect: if it is mixed in too strong a solution or if too much is used, it stimulates the heart to beat faster.

Mr. Nazari was moved to the operating table and various monitors were attached to him. Elsa and I scrubbed. Elsa started to ask questions about how I wanted her to approach this case, but stopped seeing that I was still pre-occupied and angry by Zan's no-show. We gowned and gloved in silence. Sandy washed Mr. Nazari face, dried the area and painted it with antiseptic solution, leaving Elsa and I to cover him with sterile drapes. Only his mouth showed. We were ready to proceed.

I broke the silence. "Stitch."

"Which one?"

Looking at her in dismay, I said, "The zero Proline on a three-quarter non-cutting needle."

She hesitated and blushed, seeing me glance at the clock. Sandy hustled about the operation room to gather the suture, opening the package and handing it to her. The scrub loaded the 30-inch-long suture on a needle holder and passed it to Elsa.

"Cut all sutures ¾ lengths." Stretching out my hand, I added, "Forceps."

Elsa stuck the suture through the tongue's non-vascular mid-line raphe, cut the needle off and clamped the two ends together. This allowed for Mr. Nazari's tongue to be moved in all directions. Next, the scrub had the gauze tape and long forceps ready for me to pack around the anesthetic tube. There was a pause as she looked at me, trying to read what I wanted next. Keeping my focus on the operative field, I held out my hand expecting to be handed the local anesthetic. My hand remained empty and I had to look up from the depth of my patient's mouth, losing my visual focus. This hesitation was intolerable and was incrementally delaying the procedure. It was obvious the new scrub nurse had never assisted on a similar case, but I felt that this was neither the time nor place to break in a new scrub nurse. My irritation was directed at Mrs. Devlin for giving me a rookie. The result was a lack of fluidity, which usually made an operation a sensual delight: to me, operating was the ultimate pleasurable experience. This sensory pleasure was the primary reason I became a surgeon, and became almost addicted to operating long hours. Mr. Nazari's operation, however, was turning into surgery interuptus. The tension in the room was rising like a thickening fog. Elsa and Mark were exchanging glances as they noticed my mood darkening.

"Local."

"Which?"

I felt exasperated. The scrub nurse repeated the question, a tone of frustration now also creeping into her voice.

"Local anesthetic: 0.5% Lido with 5 mic Epi."

"Epinephrine?"

"Yes, Epinephrine!"

A flutter of activity followed. The scrub brought in the glass vials and drew up a solution. We stood around, avoiding eye contact. Mark had his back to the scrub table. Elsa kept herself busy, using the sucker to clear out the saliva from Mr. Nazari's mouth. I felt horrible for being in such a foul mood, and embarrassed at my attitude and its impact on my reputation as a surgeon.

We waited.

Finally, the scrub handed me a syringe, which I fleetingly noted was not labeled. Nevertheless, I grabbed it from her. Elsa tugged on the tongue-suture, exposing the ulcer.

"Injecting!"

Mark noted my action on the anesthesia record and flicked his glances between the cardiac monitor and me.

Mark asked, "How much?"

"About 5 milliliters," I replied.

The next thing I heard was Mark's quivering voice. "Hold it! He's going into V-tach."

We froze.

It is the one word that all dreaded. In surgical lingo it meant Mr. Nazari's heart had gone into ventricular tachycardia, a potential harbinger of worse things to come. Ventricular tachycardia is the abnormally rapid regular heart rhythm that originates from the lower chambers of the heart or the ventricles. Mark's monitor showed the rapidly ineffective cardiac contractions of over 100 beats per minute, instead of the steady slow 60 cardiac contractions expected during anesthesia. Beads of sweat collected under my mask.

"Oh no, dear God, not this," I murmured.

I feared the life-threatening ventricular fibrillation, when the ventricles contract rapidly in a chaotic, purposeless fashion. This rhythm does not pump blood effectively to the body, leading to cardiac arrest and death. We gazed at the monitor and saw the steady waves change to erratic squiggles. I immediately lowered the head of the table to get more blood to Mr. Nazari's brain. Mark injected a series of antidotes to fibrillation into Mr. Nazari's IV. Sandy stood frozen, flicking her glances between us, waiting to spring into action if his heart stopped.

Mark shouted, "Cardiac arrest, code blue, code blue!"

Mr. Nazari's heart had stopped beating. We had four minutes to save his life.

Sandy dashed to the phone and an emergency "Code blue. O.R. three," went over the hospital PA system.

"What the hell did you give me to inject?"

"0.5% Epinephrine, like you asked."

"Epinephrine? Neat Epinephrine?"

"Yes."

"Are you fucking crazy? I wanted 0.5% Lidocaine **WITH** 5 micrograms of Epinephrine."

"You said Epinephrine," she said, distraught.

Whipping off the sterile drapes, Elsa started external cardiac massage. The operation room doors swung open. Mrs. Devlin and the cardiac resuscitation team descended en mass in their street clothes and shoes into our sterile environment. One of them relieved Elsa in cardiac compression.

Since the patient was mine, I ran the code. Mrs. Devlin recorded and timed all drugs administered and related resuscitation fluids and activities as I called them out. Accuracy was mandatory: these records could be subpoenaed or pored over by the hospital's credentialing committee. The monitor showed the cardiac compression as an EKG blip, but no spontaneous heart beat. Two minutes had elapsed. A key element of resuscitation is to intubate the patient and provide a continuous flow of oxygen. Mr. Nazari was already intubated, anesthesia was reversed and oxygen enriched air bathed Mr. Nazari's lungs.

"Stop pumping," Mark declared. Mr. Nazari's EKG monitor showed a few spontaneous heart beats but too few to sustain him.

I stepped in to continue cardiac massage with a newfound vigor, determined that he would live. I forcefully compressed his chest, seeing a rewarding EKG blip with each compression when I suddenly felt cracking under my hands. Mr. Nazari's frail ribs were fracturing. I continued less vigorously, worrying that the jagged rib edges would puncture his overinflated lungs, which could cause air to leak out and become trapped uselessly between chest wall and lungs. This is called pneumothorax, and would decrease the oxygenation of his blood.

"X-ray! I want a chest x-ray, stat."

The x-ray machine and its technician appeared in response to the code, and "stat" is surgical lingo for "instantly, immediately"—right now. The machine was rushed into the field; an x-ray plate was placed behind Mr. Nazari's chest and with a cry of "x-ray!" The OR cleared instantly of all women, to avoid the cumulative effects of radiation to their ovaries, while the surgeons scurried behind an operation room protective lead shield. An image was obtained of Mr. Nazari's chest and lung.

At that moment, I had a flashback to a cardiac resuscitation I'd witnessed. I was in my fourth year of surgical training and acting Chief-Resident of a surgical team at Rhode Island VA Hospital. We were on Sunday morning rounds and we cut through the medical ward to their ICU. Randas, my testosterone riddled Brazilian Intern assured us that it was, what he called a "short cut." But we knew it was just for him to see and flirt with the head nurse. He regaled us with his tantalizing description of "Miss Cutie," emphasizing that her white uniform hemline was at least 5 inches above her knee-typical surgical banter that diminished the tension and stress, and which would abate with the years as more of our colleagues became women.

"She has such beautiful legs," he said in his strong Brazilian accent, "And such a cute ass," he sculptured her bottom with both hands.

"She would be perfect on a float in Rio's Carnival or on the beach in Ipanema, not stuck here in Providence," adding, "She looks sooo beautiful."

What Randas omitted was that she was slim and barely 5-foot-tall; he was a towering 6-foot plus. We passed the door to a patient's room and saw his heartthrob up on tippy-toes, reaching up to thump the heart of a barrel-chested man lying on a high bed, who had stopped breathing. Seeing us she yelled, "Code blue!"

"Miss Cutie" and "code blue" were like a red flag to Randas, who rushed to help her. My other residents went into top emergency mode starting a central I.V and drawing blood, as Randas ran the code, yelling out meds he wanted given.

Randas pumped the patient's chest, while the nurse squeezed behind the headboard, lifted it off, and jumped onto the bed, both knees landing firmly on either side of the patient's head, and reaching out to assist Randas pumping the chest. Her skirt hitched up revealing lacy red panties. Randas grinned from ear to ear. He just grinned, pumping automatically, hands

intertwining hers. When the patient regained consciousness, his head was cradled in her Victoria's Secret crotch. Randas repeatedly related this story in his accented Brazilian English on numerous occasions with increasing embellishment, "the patient must have thought he'd woken up in heaven."

The memory of this flashback occurred spontaneously at my greatest moment of stress when my patient arrested. Test results were returned for Mr. Nazari's blood gasses, which showed effective aeration. The CXR confirmed several broken ribs and small pneumothoracies in both lungs. Mark continued to ventilate Mr. Nazari manually, squeezing a bag. By eight minutes, redundant members of the Code team began to drift out of the operation room, sensing the futility of their efforts.

How long to continue trying to resuscitate Mr. Nazari's heart was my call. I was not willing to lose him. I was not willing to give up. I avoided direct eye contact with members of the resuscitation team as we continued our efforts, but judging by their expressions not everyone agreed with this prolonged effort. I had a strong sense of obligation to Mr. Nazari because he had entrusted me with his life and his cardiac arrest was avoidable. I was indifferent to the notion that he was old and had cancer, as someone on my team brought to my attention. I was also indifferent to the idea that a death on the OR table automatically became a coroner's case, which would lead to extensive internal and external investigations, or that my behavior could be censured by my peers. I was determined to save Mr. Nazari. More members of the code team quietly left the room as we entered the fifteenth minute. They knew that with each passing second I was dealing with an increasingly lost cause. They probably suspected that I was in denial. Remaining in the operation room with me were Mark and his assistant, Mrs. Devlin with some of her nurses, and Elsa, together with a live but unconscious Mr. Nazari and his cancer.

The scrub was nowhere to be seen, and I never saw her again in the five years I worked there. Sandy was busy setting up side tables with the ancillary equipment I had ordered, while I was beginning to feel progressively more despondent.

Before long we entered the sixteenth minute. The epinephrine was wearing off, and the onset of Mr. Nazari's cardiac activity became spontaneous. The natural "beep-beep" of his cardiac monitor was audible; he had a pulse. An EKG showed he had suffered some damage to his heart, but he was alive. He lay on the operation room table without anesthesia, his eyes closed, conscious and awake. His pupils responded sluggishly to light. Had he also suffered brain damage? Only time would tell.

We took a collective deep breath. He was surrounded by discarded drapes, catheters, dried blood and general trash. It was a disaster area, which Sandy and the others set to clearing.

To survive, Mr. Nazari would need large-bore intravenous catheters for fluids, an arterial catheter to monitor BP and oxygen saturation in his blood while he remained on a respirator. Sandy inserted a Foley catheter into his bladder to measure urine output, reflecting his circulatory volume and hydration fluids status. Bilateral chest tubes were inserted for his tension pneumothorax by Elsa. In my mind, the ulcer was the reason he was in the operation room in the first place, and I was determined to excise it right now.

I made my intentions clear to Mark, who agreed that the patient was as stable as he'd ever be. Mrs. Devlin scrubbed, which she seldom did. Was this an act of atonement? Had she remembered our past discussions? While she was getting a fresh operating table ready with new instruments, the team took turns to rotate out of the operation room to freshen up. I went and saw Mr. Nazari's family and told them that when I injected the local about his ulcer its strength was too great and it made his heart stop. I explained that we had persisted to get it beating once more

and that I was now going to cut out the cancer. I maintained my professional external demeanor, but inside I was profoundly sorry and ashamed.

"Thank Allah he is alive," his daughter said in a distinct Iranian-English accent. Her husband pumped my hand and thanked me for all I had done. In my state of profound remorse, their gratitude was confusing. I had draped the crepe, so the saying goes, suggesting there might yet be a death.

I excised the ulcer using electrocoagulation. No words were exchanged between Mrs. Devlin and me. The mood was solemn, but we finished the operation. It was nearly 3:30pm when we wheeled Mr. Nazari into the ICU. His family was glad to see him.

That evening as cars rushed past me I found myself driving home at a crawling speed. I felt utterly exhausted and dejected. Cars continued to whizz by, but I could barely think. I felt numb. How could I have behaved so badly to the scrub and created such a disaster, just because my sense of pride was injured by Zan's no show? I recognize now, years later, that I behaved like a pompous ass toward everyone. I took Zan's failure to appear personally, but it never occurred to me at the time that he probably intended to appear, but that he was just too scared. My injured vanity led to an error: I had rushed the case, I had not made my request for local with epinephrine clear enough, and I had blindly trusted the scrub with whom I'd never worked before, and accepted an unlabelled syringe loaded with an unknown solution, against all I had been taught. In my judgment, my professional conduct had violated the working understandings on which surgical actions rest. Professionalism meant the personal verification of data, almost to the point of compulsion, never trusting others where it pertained to patients. And I never apologized to the scrub, whom I never saw again, or to Mark or to Elsa as I should have. Somehow it had

been easier to apologize to Mr. Nazari's family than to face my colleagues and apologize to them, which I now recognize was false sense of professional pride. But worse still, when I came home I did not have the fortitude to face my wife or my two children. I could not tell them that I felt like I had failed them, that I was not a big shot surgeon but only a human with all the foibles and weaknesses of one. I was too ashamed to face them. I could not bear the thought that they would think less of me.

No sooner had I arrived home than Zan moseyed over. "Doc, did you hear what happened? They invaded our Embassy in Tehran and took our boys hostage," he started off. Seeing me exhausted, disheveled and in an unreceptive mood, he tried to disarm me.

"You're not mad that I didn't come, are you? How could I when our boys were taken captive? They needed my support. Those Iranians mean business. Look..." He pointed across to his house, where I saw Old Glory, a huge 5' x 8' flag hung along the length of the front of his house's façade. It flapped lightly in the fading evening light.

"That flew over the Capitol in 1948. See, its got only 48 stars. It was given to my Poppa by some big-wig in D.C. I'm going to fly it until our boys are freed and home." He said this as if it was a justification for his no-show. Sensing my dark mood in my lack of my response and my solemn face, he ambled back with his beer in hand, shaking his head.

6

Like many immigrants, Zan's father had been an enterprising man. He was initiated into Scottish Rite Freemasonry as an Apprentice Freemason at the North Hollywood Masonic Temple. His connection to his home town of Trunov, now in post-WWII Czech Republic and a traditional center for gemstone polishing, had spurred him into buying an interest in a turquoise mine in the Black Mountains of Mohave County, Arizona.

Driving in their 1928 Buick over gravel roads, it took the family 12 hours to get to the Kingman road, near their mine. Over the years as a boy, Zan amassed a collection of the semi-precious stones that he found at the mine, adding to the ones his father had given him. The colors ranged from sky blue to shades of green to yellowish gray. These turquoise stones are rare and valuable, and prized as gems and ornamental stones because of their unique hues. At the time we got to know each other Zan kept the stones in burlap sacks in his garage. He called it his retirement nest-egg. He related that some time later he had given them to his son for safe keeping and that the stones subsequently disappeared, for when he asked for them they were not forthcoming. I hypothesized that this may have been the cause of Zan's estrangement from his son.

Zan Sr. was an exemplary member of the fraternity of Freemasons. Involvement in charity and community service activities ensured his rapid rise to Master Mason, the third degree necessary for participation in most aspects of Masonry. With the help of influential brethren, his citizenship was assured. As Zan was growing up, his father was elevated to be a Sublime 33rd Degree Mason, which made him an honorary member of the Supreme Council of the Ancient and Accepted Scottish Rite Southern Jurisdiction Headquarters in Washington D.C. While in Washington to receive his white hat in 1948, a garment worn only by members of this echelon, he met a fellow member of the Supreme Council, President Harry Truman. It was President Truman who gave him the 5' x 8' Stars and Stripes which had once flown over the Capitol. It had 48 stars, reflecting the State of the Union at the time.

Despite Zan's explanation, I was mad as hell with him and his avoidance to come to the hospital, and I was angry at myself for having let Zan's absence lead me into make a near fatal mistake. I was too proud to let him know of the consequences of his no-show, and for a while I

avoided him. In my heart I knew he did not do anything maliciously; I knew that as the son of an immigrant, he loved his county. It was my shared love for this country and its values that made me somewhat sympathetic to the feelings Zak manifested by his flying his flag, so for a while I felt very conflicted. Zan flew the flag day-after-day, as the hostage crisis hijacked the media attention and paralyzed Carter's presidency.

I visited Mr. Nazari in the ICU on our daily rounds and compulsively paid detailed attention to his every care. As the days went by, he became responsive to the nurses' commands and to his visitors, to everyone's joy. His ventilator was removed and a day later his arterial line and chest tubes were also removed, which was a measure of positive progress. His progress seemed related to the frequency of his family's visits. I called them from time to time, not only to give them a progress report but also to encourage them to visit, knowing that strong family support was essential to recovery. The nurses were magnificent, hard working and conscientious, but my daily presence was still necessary to emphasize my expectations for Mr. Nazari's ongoing recovery. I cancelled going to surgical professional meetings throughout November and December of 1979, sensing my responsibility to Mr. Nazari, and not wishing to hand over his care to a colleague in my absence—he was my responsibility. The hostage crisis persisted, and in an effort towards its resolution the Shah was asked to leave the United States in mid-December, having received palliative therapy for his cancer. Despite his return to exile in Egypt, a resolution of the hostage crisis seemed elusive.

In early 1980, I was pleased to see that Mr. Nazari was making sufficient progress to be moved out of the ICU, though he had lost further weight and looked alarmingly skeletal. He would require weeks of intense nutrition and physical therapy to build up his strength sufficiently to be discharged from the hospital.

In the late spring of 1980, when his farming schedule allowed and with Justine's nudging, I rescheduled Zan for his operation. Throughout this time his flag had hung defiantly: he even rigged up a spotlight. The hostage crisis in Tehran became a political stand-off, and my relationship with Zan returned to normal. I was an appreciative neighbor when at home and a doctor when he wished to discuss his hernia.

Not wishing to be surprised a second time, I met Zan in the surgical holding area. He was his usual jovial self and this time was accompanied by Justine. I had scheduled him as my last case of the day starting around noon, just in case he did not appear once more. When I saw him he was not yet undressed, and I wondered what was amiss. The admitting nurse said that he had drunk some coffee and had eaten a healthy breakfast, rather than fasting since of midnight.

"Doc, you know me, I can't start the day without my coffee. Well then...I just had some toast and eggs."

He saw my face fall. Justine merely said, "See, I said nothing to eat, but you don't listen." I sat down next to him and asked him straight, "Do you really want me to operate on you? Do you want to run the risk, which we discussed previously, of having an emergency operation?"

His answers were a simple declarative "Yes and no." And so, we rescheduled his operation for a third time.

With Zan's case cancelled yet again I wandered over to my research lab, which I did on a daily basis, usually between cases and late in the afternoon. I encountered a Middle Eastern looking man in a pale suit hanging around the entrance. He was neither one of my research fellows, nor one of my research Ph.D. or technicians.

"Are you Dr Meguid? My name is Lavi, Dr. Lavi. My rabbi said you could give me a job," he said in broken English. I looked at him perplexed.

"I know of no rabbi. I'm not Jewish and I have no job available, but come in and tell me more about yourself."

Dr. Lavi had been the Shah's orthopedic surgeon and had fled Iran to Germany where he had trained at Heidelberg University in orthopedics. Seeing no prospects of an independent clinical practice, he came to Los Angeles via the Iranian network. He spoke fluent German, so we continued our conversation in that language as I had gone to grade school in Wedel, near Hamburg. When he left Iran, ostensibly on vacation, he had left his home and all of his assets, but had managed to bribe a customs officer so that he could take with him a sizable number of high-quality Persian carpets of all sizes, hues and patterns. Now he was cash-strapped. Could he sell me one? I replied no; Persian carpets were not on my priority list, as I was a salaried surgeon with two children, we expected to support in their upcoming college years. Nor were luxurious fine Persian carpets part of my social aspiration as I liked wooden floors, no matter how great a deal he was offering me.

As a follow immigrant, though, I recognized his needs: the dignity, recognition and self-respect that comes with the ability to work. However, he could not work as a surgeon without first re-taking all the essential medical exams. Then he would have to be re-trained as a surgeon by going through a one-year general surgical training program followed by a three-year training in general orthopedics. Thereafter, he would need a few years more if he wanted to specialize. I estimated he was already in his late forties and his poor command of English suggested an even more protracted training course, not to mention that residents did not earn high salaries. Finally, he revealed that he had a 13-year-old son. How many years could he be in training with a son who would soon be going to college too?

Other people had generously helped me settle in the US, so I wanted to help him. He needed a place to go to work, somewhere he could hang his jacket, sit at a desk and study to prepare for the medical qualifying examination. We discussed his options at length. As he became more comfortable with me, he accepted what I had to offer, he shared his tentative plan. Once he passed his qualifying exam, he could become a family physician to the numerous Iranian expatriates, like Mr. Nazari, who spoke only Farsi and who had made LA their home.

The flag remained highly visible and it gave me great pleasure seeing it ripple gently in the breeze as I looked out of our kitchen window. I shared Zan's patriotism, admiring his determination and the red, white and blue colors, but I was equally determined to not have to operate on him in an emergency.

Mr. Nazari continued to make incremental progress as January became February in 1980. Our goal to build up his strength with intense daily physical therapy was succeeding; I often saw him in therapy and encouraged him. However, his unsteady mental status remained a concern. Finally, by mid May 1980 preparations were made to discharge him.

I went to his room, now situated farthest from the nursing station as his needs had diminished, to bid him farewell. His tongue had healed well and he was able to eat and swallow without difficulty. His heart had recovered and his rib fractures had also healed.

On entering his room, I found him dressed and sitting in a chair ready to be picked up. He had aged visibly. We attempted to chat for a while, and then he asked me, "Who are you? What is your name?"

I looked at him for a long while as the past events replayed at high speed through my mind. I should not have been surprised at his confusion or lapse in memory. The medical profession recognized this condition as "hospitalit-ies," which was the result of being in hospital

for too long with loss of recognized circadian rhythm by the brain from being constantly disturbed during the day and awoken at night because of nursing attention. Without burdening Mr. Nazari further by reminding him of my name, I merely took his hand in mine and slowly said, "I'm just a friend. Who I am does not matter, but I am glad I met you and that you're going home?" I think he understood what I said; at least he recognized the warmth in the tone of my voice. He nodded and with that we said our goodbyes.

In the late fall Justine delivered Zan to the pre-op holding unit where I was waiting for him. This time he was ready—a mere 12 months after his first appointment. A lot had happened since: Mr. Nazari had survived to go home, the Shah had died in July in Egypt of pancreatic cancer, and I had grown wiser. While lying in the pre-OR bed Zan asked, "Doc, I'm not going to die, am I?"

"No, we don't electively operate on patients that we know are going to die. You'll be OK. You'll be just fine and I'll see you when you wake up."

The anesthetist injected a sedative into his I.V. and started to place an anesthetic mask on Zan's face. He pushed it aside and in a drowsy voice asked, "Doc. When can Justine have sex?"

"She can any time, but you'll have to wait six months," I said jokingly. I doubt he heard me, as he was by then fast asleep, but it elicited a chuckle from my team.

I felt a sense of closure as he was prepped, draped and I started my operation assisted by a new surgical resident. Operating on the massive hernia which contained the entire sigmoid colon, I reduced the enlargement, placing the bowel into his abdominal cavity. Then I started to repair the attenuated inguinal ring.

The phone interrupted the serene silence during our operation. Sandy took it. "It's your wife." In eleven years, she had only ever called with a family emergency twice before.

"Yes, I'll talk to her." Sandy held the phone to my ear.

"Lavi is here. Did you buy a rug? He's measured out the dining room, moving the furniture, rolling out a huge 10 x 18 feet Persian rug and vacuuming it. What am I to do?"

"Oh! No, I didn't. I'll talk to him later."

I continued the operation. We fashioned a jock strap from bandages to support Zan's redundant scrotal skin. The operation was a classical repair of a chronic sliding inguinal hernia of a size not commonly seen in the US. It took three hours of cutting, dissecting, sewing and fixing. It was secure and unlikely to recur.

As I placed a dressing over the inguinal incision and a counter abdominal incision through which I had entered his abdomen and pulled back his colon, it dawned on me. Dr. Lavi must have passed his basic exams. He said that he'd intended to purchase a practice from an elderly retiring general practitioner in the prestigious West Los Angeles area, where the affluent Iranian community was concentrated. He was now set up for life, surrounded by over a million Farsi-speaking ex-patriots, like Mr. Nazari.

Zan was discharged on the fourth post-operative day. Fortunately, he did not remember his question about sex or my joking response, although I was slightly concerned, knowing that patients can hear what is said while anesthetized. Just in case, I told it to him when I saw him on rounds and he too chuckled. His parting question, as he looked perplexed at me, was, "Doc, what happened to my nuts?"

"Zan, my friend, your crown jewels are still there." He chuckled and repeated aloud "crown jewels," obviously reassured. He looked down and in a perplexed voice said, "But they used to nearly reach my knee."

"Zan, that was your guts lying on top of your testicle. Your guts are now in your abdomen and your testicles in your scrotum, just as things should be."

In January 1981, we received an invitation to Dr Lavi's son's Bar Mitzvah at a temple in West Los Angeles. We accepted the invitation. We told him that the Persian carpet was magnificent! It had a tight weave and was predominantly red in color with medallion borders and several large medallions within its lush and intricate pattern. It was the height of opulence but still blended well into our décor. The carpet was of the finest quality we had ever seen. It was not a matter of purchase after all, but a thoughtful present which now adorns my study. After that month, after 444 days in captivity, the hostages were released. We were elated at the news. Zan moseyed over, barefoot in a tee-shirt and his knee length shorts, albeit without the telltale bulge, smiling and beaming with pride. In one hand was his beer, and in the other the flag that I so admired, folded neatly in a triangle.

For the past many years, it has decorated my white living room wall; a daily reminder of my neighbor Zan, who has since retired to Hawaii. The flag still fills me with a sense of pride for living in a nation that welcomes immigrants.

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