The hazards of lying about sharks

ANDREW KNIGHT
DipECAWBM (AWSEL), PhD, MRCVS, FOCAE

prefers to meet wild sharks than angry gods, but hasn't yet mastered the skill required to placate the god of truth – and paid the price

MOTHER always warned me about sharks. Even today, she's on the phone anytime one is spotted off an Australian beach, ensuring I'll be careful next time I surf.

Regrettably, the Thames seems to offer neither waves nor the opportunity to meet any of these wonderful, profoundly misunderstood creatures.

However, there seems little point in arguing that, statistically, I have a greater chance of drowning in a bathtub than dying in the jaws of a shark. So I reassure her that I'll steer well clear of any sharks I meet during my locum adventures. Or at least, ensure they're appropriately muzzled.

Perils of dishonesty

This tale relates to when I had made just such a promise. After "neglecting" to mention my future shark-diving plans to mum the previous day, I was innocently cycling home from the gym.

Unfortunately, Veritas, the Roman god of truth – who clearly still watches over the streets of London – apparently chose that moment to smite me for my dishonesty. As I crossed a line of parked cars, a fellow cyclist came up the inside at speed, and hit me with a strangled cry that sounded oddly like "shaaaaaaaaaark".

Horrified, we scraped ourselves off the road and checked her bike, which looked extremely expensive. She was a triathlete in training, and I was highly concerned about my potential liability if it had been damaged. Thankfully, both she and her bike were fine.

I couldn't bend my arm, but an active boyhood had conferred considerable expertise regarding the telltale agony indicative of fractures, which was clearly lacking – unless I tried to bend my elbow. A passing police car inquired whether we were okay. "Fine", I replied, waving them on. My doctor's surgery was 50 metres down the street, but the thought of a check-up never surfaced.

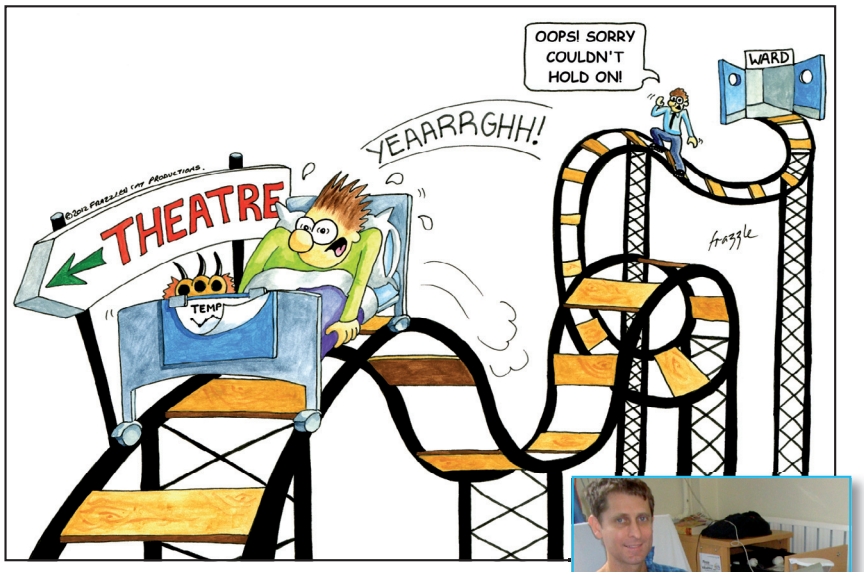
I was, therefore, surprised when an accident and emergency department radiograph the next day revealed a fracture. Suddenly, the soft tissue swelling, pain and loss of function all made sense. How many years of medical education I would need to self-diagnose a fracture remained unclear, but five years was clearly inadequate.

At least this afforded me a fascinating opportunity to examine human orthopaedic care first-hand, and to compare its standards with those of the veterinary world. So it was with considerable interest that I presented myself to hospital for my fracture repair. This had become necessary because while I could work, my limited supination was impeding far more important activities, such as climbing.

Slippers and trench coats

The first clinical difference had caused me weeks of worry. I'd been advised to arrive with slippers, and a dressing gown long enough to cover my behind when I walked to theatre wearing little other than a rear-fastening gown.

After being appalled by the prices of new dressing gowns, which I was determined not to pay, as I never expected to use one again, I spent weeks scouring secondhand shops. The closest I could find was a trench coat. At least this created a very interesting effect when combined with my only slippers, which were enormous, hairy and ended in long black claws (see right). The horrified shrieks of my girlfriend only increased my resolve to try it out on the ward.



Soon enough the big day dawned, or rather, would do about two hours after my alarm woke me at the ungodly hour of 5am, to facilitate my on-time arrival. Thoughts of breakfast – normally generous, due to a healthy metabolism – haunted my rumbling stomach with increasing urgency as I fasted my way across London.

I was directed to a bay containing six other blokes at the end of a ward. To my disbelief I was requested to don white stockings, which were apparently the latest thing in preventing thrombophlebitis in the bed-ridden. I mumbled something affirmative, and put these effeminate items aside for much, much later.

One by one, my companions were wheeled away on their beds, to be generously fed, I noted, on their eventual return and recovery. I was, it seemed, at the end of the surgical list. To distract my protesting stomach, I struck up a conversation with the fortuitously immobilised chap next to me, shortly after he regained consciousness.

Interestingly, it transpired

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he was a cardiologist. Like most of us he was present following vehicular injury, which, in his case, had also involved a bicycle.

As we compared our clinical worlds I listened with horrified fascination to his descriptions of residency training, which appeared to last for at least six years, and used to regularly involve shifts of 72 hours to 96 hours. Sometimes, residents were able to snatch an hour of sleep here or there, but often not.

By contrast, sleep deprivation exceeding 48 hours can produce hallucinations, and longer periods have been defined as torture. Perhaps this explained the pale, sweating and spaced-out look of the resident who'd nevertheless keenly attended the surgical discussion led by my specialist, shortly after 7am.

Such training apparently has some fascinating effects on bodily physiology and cognitive capacities, including vomiting and the loss of basic mathematical skills. The implications for drug dosage calculations and patient care appeared most interesting.

In contrast, my companion strongly believed that the 1998 transposition of the European Working Time Directive into UK regulations had resulted in a marked reduction in clinical standards. Even under the opt-out clauses available, trainee doctors are no longer allowed to work more than 56 hours weekly, and should receive a full 11 rest hours out of every 24.

"People are falling off the end of the [six-year] conveyor belt untrained", bemoaned my companion, after describing this sacrilegious drop in standards. Apparently, in the good old days residents would have done 1,800 angioplasties under supervision, but now might do only 300. I briefly considered revealing just how few spays veterinary students normally perform before being let loose on to their own patients, but was distracted by a resident who appeared to take my blood.

Being oddly squeamish about my own blood in comparison to that of my patients, I struggled unsuccessfully not to go too white and clammy, as the 10ml syringe became horrifyingly full.

Thankfully, the cardiologist informed me that this "vagal response" was normal in young men. Apparently, women cope much better with these things, which is somehow linked to their capacity for childbirth. This was a revelation. I may not, after all, be as much of a wimp as I'd secretly feared. I'm just not as tough as a woman.

Soon, it was my turn to be wheeled off. My deep disappointment at not being asked to walk to theatre in my trench coat and slippers was quickly dispelled by the breathtaking view down the main hospital corridor. For reasons that presumably made good sense to the original architects, but few others lacking skateboards, it ran straight down the side of a hill, towards the operating theatres far below. I held my breath as the orderly struggled to keep my heavy iron bed from escaping. Should his grip falter the sturdiness of its frame would ensure my own survival, although, I feared, at the cost of any others I might meet.

Adventures in anaesthesia

He was, however, broad-shouldered from years of such labours, and delivered me safely to the prep area at the bottom, where I met a wise and kindly anaesthetist, and two of his stressed-looking residents. They catheterised the back of my hand and told me I would wake up with another line attached to my leg. Interestingly, the only premed was some kind of human benzodiazepine, given intravenously into my hand before induction.

The latter would occur with propofol, however my enquiries as to the human dose were met with a friendly, but determined, silence. Did they fear I would try to anaesthetise myself someday at work, I wondered? What had they surmised about the psychological health of vets, or about me?

Next they hooked me up to an ECG, which was interesting, but the real treat came when they nerve-blocked my arm to eliminate the pain for the first 12 to 24 hours, thereby reducing my anaesthetic and analgesic requirements.

The chap kindly set up the ultrasound screen right in front of me, and I was soon enjoying an amazing view of the innards of my own neck. Fortunately, the pumping carotid artery didn't seem quite real enough to trigger another vagal attack, despite its flashes of colour. Spellbound, I tried not to move a millimetre as he inserted an incredibly long needle deep within my neck, before handing over to one of his nervous residents for a bupivacaine injection into a large dark area we all hoped contained the target nerve. I was keen to see the doubtless space-age insides of their orthopaedic theatre next, but just as I was about to ask, some cunning blighter added propofol to my line. The next thing I knew was when I woke up in recovery.

Demonic possession?

Fortunately, however, my fun was far from over. The first thing I discovered was that my arm seemed dead. It was exactly as if someone had turned it to rubber. It hung limply from my shoulder and I had to keep checking in case it fell off the bed.

I'd been warned the side of my face might also droop alarmingly, but no one appeared to be staring, so I guessed I'd been spared such facial nerve involvement.

Around midnight, I decided to take a stroll. The big moment had finally arrived for my slippers. Unfortunately, the catheter in one leg meant I could wear only one slipper, on the same side as my rubber arm. But, it did offer the opportunity to ask some important questions of the ward sister.

Pointing out that my fingertips had started twitching of their own accord (albeit possibly due to the nerve block wearing off – a theory I kept to myself), and that one foot appeared to have sprouted long nails and hair, I enquired whether demonic possession was a common problem on the ward. The response, I suppose, was predictable. Human nurses appear no less robust than their veterinary counterparts.

By morning, however, the twitching had stopped and my arm had fully returned to the world of the living. I was discharged, with firm instructions to avoid the hazards of public transport, with all the potential contact with the unwashed masses and wound jostling that could entail. A taxi would be far safer. Regrettably, my locuming income dictated otherwise, and so we compromised – I obeyed hospital instructions as far as the front door, then caught the shuttle bus, tubes and trains.

A taxing regime

I nearly passed out when I saw the wound at my first dressing change, five days postsurgery. Admittedly, it was very neat, but so terribly long. I clearly needed to redouble my wound healing efforts, which primarily centred around a high calorie diet of nutritious vegan cheesecakes, combined with extreme physical laziness.

This relentless regime allowed time for a little reflection, however. It was fascinating to see the inside of the human orthopaedic world, and deeply humbling to see how long and hard the doctors and residents work. The sacrifices their careers demand of them are at least as severe as those demanded of veterinary specialists, and they do it all to help people like me.

I hope I never draw the attention of the god Veritas again, but I also remain keen to see some sharks in the wild before they all go extinct, and mother, bless her, remains just as determined I should not. Hence, it's probably only a matter of time. I will, however, be sure to request a proper tour of the operating theatre in future.

ANDREW KNIGHT is a fellow of the Oxford Centre for Animal Ethics, which aims to advance the ethical status of animals; director of Animal Consultants International, which provides multidisciplinary expertise for animal issues; and a spokesperson for Animals Count – a political party for people and animals. He is interested in a range of bioethical issues.