A FIRST DENTAL INTERN IN A VA HOSPITAL

by

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On July 1, 1957, I arrived in East Orange, N.J., to join the Staff of the Veterans Administration Hospital. My position as Dental Intern opened a new teaching area at this facility and its continued funding depended upon how well the program went. The Hospital in other departments, had well-established residency programs, but I was to be the only one of Intern Rank on the Staff. Novelty, as always, led to a good deal of scrutiny from all sides and levels, but I was least prepared for my first (and, as I recall, my last) meeting with the Chief Hospital Administrator.

Herbert Feinberg, M.D., as head of a 1,000-bed, relatively new facility, directed the institution and its personnel forcefully, and was uncommonly proud of having accumulated 1,000 days of sick leave. In fact, at every large group meeting that he attended, he seemed to relish it again—I suppose to inspire us to emulate him.

The Chief of the Dental Service, John W. Morrissey, D.D.S., on the other hand, ran a small group of four dentists (I now became the fifth), one hygienist and one x-ray technician. Several assistants and secretaries completed the Staff which ran smoothly except for the required weekly Staff Meetings. Dr. Morrissey was reputed to have tried to take a European jaunt as recuperative leave following a hernia operation, but had been denied this use of sick days. (He later tried again after being married, with the same result.)

On this first day, I was given my uniform—white trousers and coat starched like boards and hitched with buttons only. It always took me longer to dress on Mondays and Thursdays just getting those trouser legs open and the buttonholes opened. Dr. Morrissey, wanting to get his new program started properly, began at the top of the hierarchy and introduced me to Dr. Feinberg. Whether he was just under time pressure or didn't want to spend time with the lowest member of the professional staff, I don't know, but his first words to me were: "Your

pants are too long!" My chief and I mumbled a few words about adjustments and stumbled out.

I felt that this was not the best of beginnings but the government usually worked things out. So, with the return of the uniforms from the laundry, everything had shrunk two sizes and fit rather well. However, it was several months before I could pass Dr. Feinberg in the hall without nervously reaching for my waist and hitching my trousers a bit higher.

An internship is not all humerous stories. Nor is it the tense, high drama of TV and novels. Most days it falls somewhere in between with occasional episodes out of the ordinary.

Internships fall into two categories: specialty or rotating. Specialty, as its name implies, means that only one area is concentrated upon to the exclusion of all others—surgical, endodontic, periodontic etc. Rotating, as I did, covers all aspects of dentistry, plus training and exposure in all the departments of a general medical and surgical hospital. As the "new boy" in the scheme of things (all other teaching was by residents, the next rung up the specialty ladder) I received a fair grilling from the heads of some departments. Never having worked with a dentist in a teaching situation, many were at a loss as to where to start with this new creature. For some it became a matter of diplomacy on my part with some delicate egos who could have made the continuance of this program difficult. However, I was well trained in the theory of general medicine at Columbia University and was able to hold my own, as well as being a good ambassador for the Dental Service.

Probably the most difficult part of joining an existant professional staff is in knowing when you are accepted for your abilities. As an intern with each new department contact, you are an untried quantity possessing, probably, questionable abilities not of any worth. Most of the treatment given by the Dental Staff was usually, and best, done in the Dental Wing of the hospital. With all our equipment located there, our access to, and control of, the patients' problems proceeded far more easily.

Some patients could not be brought to us so we went to the bedside. These visits generally covered minor emergencies or routine exams. Before my arrival, the Staff rotated these duties but subsequently I took them over. This left me arriving at a new floor in response to a telephone call to the Dental Service and trying to explain who I was and why I was there to the floor secretary. The reply usually ran, "Gee! it's always been Dr. Thompson, and, well—O.K." I'd talk to the physician in charge (same conversation over again), treat the patient, smile at everyone on the way out, and they'd still forget my name. This changed with time—at least it did for me at two in the morning.

The usual routine when any hospital patient required oral surgery, extractions in particular, necessitates a clearance from the physician in charge. This is to prevent treatment which may be contra-indicated by the individual's disease or medication therapy. All worked well until late afternoon emergencies. Then the patient would arrive without the chart because a medical conference was in session and his physician was unreachable for the same reason. But the patient is in pain, the hour is late, and something must be done. If an extraction is required, it often is done, everything is now comfortable, and the patient is returned to the ward.

Most times it proceeds smoothly. However, when I had been at East Orange for several months, one didn't go smoothly—the extraction area continued to ooze slowly on return to the patient's floor. Apparently he said nothing until early evening when he was seen by various members of the Medical Staff from Residents to Chief of Staff and, later, the Surgical Staff, all of whom could stop the hemorrhage, the man was assured, but, ultimately, could not. It was now 2 a.m. and someone remembered the Dental Intern who roomed on the third floor of the hospital.

I told them I'd meet the patient at the Dental Suite with his chart and take care of the problem. On reading the chart, it was clear what the problem was. On examining the patient, the treatment was clear. He was hypertensive—about 180/90—which meant that the heart pounded out the blood into the vessels like a trip-hammer. With two

extractions late in the afternoon (not by me, fortunately) it was little wonder there was trouble.

What was required was to clean him up, crush the small, boney bleeder, and suture up tightly. Then I just talked to him for awhile because with that kind of an evening's history, I was sure his blood pressure was well above its normal high level. He relaxed, the pressure went down, the sutures held, and after that the calls came down to the Dental Service for Dr. Sanborn to look at the problem, please. I had made it, and I no longer had to explain who I was or what I could do.