Linda Ruth Thompson Oral History Interview

November 15, 2021

QUESTION: What can you tell us about your background, and why did you decide to attend the University of Virginia School of Medicine?

LINDA RUTH THOMPSON: I'm going to come out straight with the fact that I have probably been a little different from most of the women who went into medicine as early as I did. My great grandfather went to medical school and graduated in the late 1800s.

Never practiced. Lived in Jonesboro, Tennessee, which is a tiny town. And his wife wouldn't move, and so he farmed. However, they had five kids. My grandmother was the eldest. The second three were also female, and the last one was a male-- the boy. He was the only boy.

When my grandmother graduated high school, my great grandfather moved the family down to Greenville, Tennessee, where Tusculum College was. And all of the kids were college educated, including the women. Two of the women that were my great aunts were teachers.

My grandmother was a teacher for a while, then a minister's wife. And when she became widowed, she came back home and ended up as the post mistress for the town of Jonesboro. And that's where she was when I was a kid. She also took care of her mother. She was a big influence in my life.

I was used to women working. It just seemed normal. So I never really thought about it as anything out of the ordinary. My mother was a nurse. She took a break to have kids. And since it was six kids, it was a long break.

But she did go back to work when my youngest sister went in to school. And she did minor repairs when we were kids-- falling down, abrasions, that kind of stuff. And decided when or where we went to the doc.

So when I started college, I ended up, and I went to King College, which was a very small school. I graduated in a class of 40. And that was it. My high school class was 150. I was an avid reader from the time I learned to read and didn't worry about getting into college. Didn't even worry about getting into med school.

In terms of grades, I was a National Merit Scholar. I didn't get the scholarship, but I was. And I always enjoyed learning. But my dad was a sports editor. My mother was not working. He was on the local newspaper.

And so we didn't have a lot of money. So I went to King because it was close. And I got a workship and some assistance with tuition, and managed to do that without living on campus. And that was what enabled me to go to that school.

Now, two of my classmates during school were also pre-med. I went pre-med, because that was the most flexible major available, and I could transfer into any other major, if I wanted to, including things like history or psychology, which I was interested in.

And we had small classes as we got into the higher classes. But the initial classes were also small because of the size of the school. And I work much better in small groups. Always have.

So there were two people in the-- not in my group, but ahead of me, that went to UVA. Eric Orzeck in the class of '64 and Charlotte Coates in the class of '65. So I had some contact, particularly with Charlotte. And that was one of the things that drew me to going to UVA.

I also interviewed at MCV. Did not like the feel of the city. And I liked Charlottesville. I lived in Tennessee. I lived in Bristol. There was a state line right down the middle of the Main Street. And so I was a Tennessee resident.

So my father knew the representative-- he knew a lot of people. He knew the representative for Virginia. And he worked out a deal, because he worked in Virginia and had paid Virginia income taxes, that I could be a Virginia student. Which made it possible for me to go to school as a Virginia student.

It would not have been possible otherwise. There was no money for this. I had a $500 scholarship from my stay at King that I got at graduation. Once I hit the end of second year, I had decided to do medicine. And that was partly because of the influence of the other people that were in the group that were interested in that.

Plus, my biology teacher went on to become an anatomy professor at I think South Carolina University. Shortly after I left, I went into medicine with a little bit of hesitation, because I was not a good patient as a child.

I hated going to the doctor. I hated shots. I was a little squeamish about the sight of blood. So I did not know that that was going to be a good fit. And I am probably one of the few people I know that had the rabies vaccine because of a dog bite when I was three, which I still vividly remember.

And none of those memories were memories that would have made me want to go to medical school. So I went sort of tentatively initially. And by the second year, I knew that's what I wanted to do. So that's kind of how it started. I interviewed in I guess the fall of '61 and scored well on the MCAT and was accepted pretty quickly. So I was really pleased about that.

QUESTION: Tell us about your experience as a student at the UVA School of Medicine, and how was your relationship with your two fellow women classmates, Barbara Starks Favazza and Dorothy Guild Tompkins?

LINDA RUTH THOMPSON: When I first arrived at UVA, of course I lived in the dorm. I would have had to have lived in the dorm anyway. But I was shocked to find out that there were no undergraduate female students, because I didn't know that was going on. And Barbara Starks and Dorothy Tompkins and I were on the end of one of the short halls so that we were all together.

We went to class together. Had to walk, usually. Always, actually. And you know, we got to be pretty close that first year. The rest of the class-- we were considered one of the good classes.

I guess it was one of the professors said something to one of the others-- this has got to be a story I heard third or fourth hand-- that every four to five years, there was a class that was really good, where everybody kind of worked together and there wasn't a lot of conflict.

And that was certainly true from the beginning with the guys that I worked with. Actually, it was Bill Tompkins, when we were first doing the initial-- we were in line for one of the initial meetings with people to get registered and stuff like that.

Bill asked me, did I feel bad that I had replaced a guy who could have practiced the full time, because women generally were off for a few years to have kids? And I was totally surprised by the thought. I hadn't even thought about it.

And I sort of mumbled something like, well, I'm not sure. I didn't think anymore about it. And somebody else asked me the same question, the same day. And I don't really even remember who it was. And about a week later, I think it was Bill Wallace asked me the same question.

And by then, I thought about it. And I said, look, I've got longevity in my family. We live into our 80s and 90s. And if I have to take a few years off to have kids, I'll just make it up on the other end. I don't plan to retire.

And I never heard another word about it. So word must have gotten around. And after that, it was not an issue. One of the things I liked-- you know, we did big lectures in kind of the amphitheater at the beginning.

So I hung out basically with Dorothy, Dotty, and Barbara, and some of the ones that I got to know closer over that first and second year. But in second year, we were doing smaller groups at times with some of the classes.

I got to be one of the guinea pigs that got stuck when we were doing a urology test on if you drink a lot of water, what's the bloodwork going to look like? What's the urine going to look like?

I was so terrified of a shot, I could not produce urine at the end of the time. And then I was running for a while after that to the bathroom every so often. Bill Tompkins was the one who drew the blood. And he was very good about it. I almost passed out.

But you know, everybody was supportive, for the most part. And I worked, like I said, very well in small groups. And we had a lot of small groups. And usually by day one or two, I was just one of the guys.

There were occasional remarks about my being female. But god knows, they were calling each other all kinds of names too. So I did not feel singled out. And there was a lot of kidding going on.

People were doing stuff that had nothing to do with medicine. Like, Toby Cosgrove was on the America's sailing race at one point. And there were I think it was-- I can't-- it was John. Maybe it was Starling. I didn't know him as well. Was also doing a lot of bridge.

The first two years, he ended up coming along with the class behind us because of his attention to bridge. But there was a lot of flexibility and there was a lot of different stuff going on. There was a group out at the farm that were living out there close to Monticello. And I was out there for a couple of parties, and that was fun. I didn't do any extracurricular activities that were real organized. I did get into AOA my fourth year. Not the third year.

QUESTION: How did the medical school faculty feel about co-education? Are there specific memories of your classes or professors that you would like to share? Or other medical school experiences?

LINDA RUTH THOMPSON: I've never felt singled out by the faculty. There were a couple guys that I didn't like. The guy who was head of physiology was kind of contemptuous, I guess I would say, of all of us. And Jim Pope used to do cartoon sketches of faculty members.

And I know he's the one that put up the image of this professor as a frog-- a huge frog. And it was behind the screen that covered the blackboard that was down at that point. And the guy pulled it up, and there it was.

We all tried not to laugh, because it was hilarious. But we didn't dare laugh. And he was totally offended, I'm sure. But he still taught the class. And the guy who was-- and I don't remember his name. And I don't remember the name of the guy who is the head of urology.

But he had this kind of sadistic approach to students, where he kind of liked to humiliate them. And he would call on a student. And if a student didn't know, he would really pressure the student to come up with something. And it was really pretty ugly.

But again, it wasn't like he was picking out any particular one. You just hoped when you went to the class-- and this was a big amphitheater class. You just hoped he didn't see you. You know. That was my approach to it.

I took the fourth year that was the standard fourth year. I'll come back to the issue with doing electives during the fourth year shortly, because after my second year of med school I knew I didn't know-- well, no, after my third year, I knew I didn't know enough medicine.

And I knew I was going into psychiatry at that point. So I didn't deviate from the program. So I was in a small group with this guy teaching us. And [Ben] Shappley, who had this horrible, horrible stutter if he got stressed, he was in the group.

And he was the first one this guy went after. I don't know why he picked Ben. And Ben could not even get the words out articulately. And he had spittle coming out of his mouth, he was trying so hard to come up with something. And it was just horrifying.

And the professor was so horrified, he stopped it. And he never did it again with us. And he taught us something. And he was really a good teacher. So I don't know what he did the rest of the time, but there was this other side to him that I would never have seen if I hadn't had any contact with him, other than the amphitheater stuff.

So I gave him a pass after that. I don't know why he enjoyed that. I really don't. Because he was a good teacher. But some people are that way. Most of the teachers were not. I don't know if that went on with some of the other classes by more people, but most of us got along really well with the professors.

I certainly did. And you know, we all have our foibles. I was already at that point past the point where I got offended by it, unless it was a personal attack that was really intended to give me harm in one way or another. That's a different story. And I'll tell that later.

There were two people who were really instrumental in helping me both stay in medical school and define what I was going to do. And I don't remember his name, but the guy who was the head of the biochemistry was an excellent teacher. I happened to be in his small group of students.

And I was pretty shy when I first went to medical school. I didn't talk a lot. And I didn't speak out in any of the amphitheaters to ask questions or anything until well into the end of my second year. And this was the first year of class.

And he asked a question about the Krebs cycle. And I don't know how I came to it, but I liked drawing the molecules on whatever it was. I started doing it in chemistry in college. And I could draw the Krebs cycle with no trouble at all.

And the answer to the question was the end point of the Krebs cycle. Nobody else said anything, and I finally said ADTP. And he looked at me like, where is this coming from? And after that, I started talking more in the class, in the small group.

And you know, I really did very well in that. And he was a good teacher. And so I needed-- I had to borrow money. I borrowed $1,500 to start medical school to go with my $500 scholarship. I did that from my sister and brother-in-law.

So I approached him about what he might know about getting me some additional financial help so that I could stay in medical school. And he connected me with what's now the Norfolk Foundation. It had a different name back then.

And he wrote a letter supporting my getting the scholarship. And I got the scholarship. I got $1,400 for the last three years of my medical stay there. And he was critically important in that, for which I've always been very, very grateful.

Because I could live on $1,900 a year. I'm not very much of a spendthrift, except when it comes to books and records. And now DVDs and Blu-rays. But he was very, very helpful with that.

And that was critical, because I don't know where the money would have come from. I worked my first summer between semesters as a nurse's aide in Bristol. And that generated some money that I saved. The wages were $70 an hour-- or $0.70 an hour at that time.

But I was able to manage to have a few hundred dollars to take with me back to school in addition to the scholarship and everything. The issue that came up-- I think I've covered most of-- the issue that came up when-- there was a question about what my relationship was to Barbara and Dorothy.

We were very close that first year. The second year, we wanted an apartment. And we wanted an apartment together. And they would not let Barbara go with us out to an apartment. We were not supposed to all live in the same place, which I found horribly racist.

And I was not happy with that and Dotty was not happy with that. We did get an apartment that was separate from that. And so I didn't have as much time with Barbara after that. But Barbara had been my lab partner in anatomy. And I had Al Jacobson and Steve-- gosh.

I know his name. Let me look him up on here. Caplan. Steve Caplan. He was only 19. We called him Little Stevie. Well, he wasn't Little Stevie. He was Big Stevie, because he's tall.

But he got some ribbing for that. But he was really good to work with. We all worked really well together. We had a close relationship. Armando was over there on the next table. I don't know if that's when he and Barbara got together or not.

But she eventually married him. But this has nothing to do with the questions you asked. But we had this-- we started out-- the first week you're in anatomy lab, you know, you're kind of repelled by the smell, and none of it looks very good.

But the second day, we started to bring in drinks. By the end of the week, we were eating sandwiches. You know, that's just how it went. And you know, sometimes we'd stay late, if we needed to. I found that fascinating, the whole thing.

And one of the professors of anatomy is-- we have a scholarship in his name as part of our class contribution. We're working on getting four scholarships for students at this point. We've got three that are pretty well-funded, and the anatomy professor is one of those.

The story is that we left-- you know, went home for Thanksgiving. And we come back and in our lab-- there were six tables. There were several other labs for the other guys. And Dorothy was not in our group, not in our room.

Somebody-- we have no idea who-- had pulled the skeleton out of the closet so that it's hanging there, and covered the chest cavity with Christmas tree lights, which were lit. And then there was a red light down in the crotch and two little tiny silver balls.

And we all had a great laugh over that. Well, I want you to know that for the next three weeks until it was time for Christmas vacation, people came from all over the hospital that probably never would have been in an anatomy lab otherwise. And they'd stick their head in the door, and they'd look at it, and they'd start to laugh, and they'd walk away.

This went on that whole three weeks. Came back from the break for Christmas, it was all gone. Still have no idea who did that. But that was the kind of thing that kind of says something about our class.

But it was accepted. It was funny. Nobody made a big deal out of it. And it was hilarious. So anyway, Dotty and I had an apartment together the second year. And this was more Dotty's idea than mine. I was not a cook at that point.

We'd have groups of eight over for dinner. We had the same dinner. It was always a spaghetti and salad, that sort of dinner. And that way, we got to know everybody. And it was really fun. And I think they really enjoyed it.

So it's another piece of doing the-- I mean, just being with the guys and being with the other people in the class and getting to know them. Because we didn't get as much time with that the further we went in the time we were there.

Somewhere along there, Dotty started getting involved with Bill Tompkins. And they were very close. And by the end of the year, they had decided to get married. So they were going to have their own place.

I was part of the bridesmaids for the wedding. And you know, I haven't had as much contact with them since we left school. But that's been a good marriage, I think. And I ended up having somebody-- I can't remember. I think somebody Dotty knew, that moved in, was not a med student. Had all kinds of other interests, but was also very, very high maintenance.

And I did not do well with that. A piece of this that probably warrants talking about a bit. And it wasn't part of my becoming a physician. But I had a significant amount of depression as an adolescent, starting around 17 years of age.

Also, we have a family history of bipolar disorder. I had a hypomanic episode when I was probably in my early 20s, following a depressive episode. And by then, I was trying to think about how to fix it.

But I also had my plan for checking out if it got too bad. And we had our classes in pharmacology. And I can remember leaving that class, because the first time I knew that if I didn't inject myself with a lethal dose of morphine, that there was a way of stopping that.

And I'm thinking, I've got to come up with a better plan. That was my response to it. I left the class feeling shaken a bit, because I had planned on getting my hands on-- I never actually got the materials to do it. But I knew that I would be able to probably as soon as I graduated.

Because you could order this stuff off of a catalog-- out of a medical supply house. You didn't have to do anything else, except have an M.D. And I had no wish to die a painful death. I mean, I really did not want to do that.

And when I found out that if they found me too fast and gave me Narcan, I would wake up-- I did not want to wake up in a hospital. I absolutely did not want to do that. So I never told anybody about any of this until well after it was gone.

And it left me in a position to be very sensitive to who was really seriously suicidal, because I knew what that was like, and I knew how serious it was. And I could spot it pretty quickly.

So it was a godsend, in a way. But that's where I was at that point. And the year that I was living with this other young woman who was high maintenance, there was conflict between her and a neighbor downstairs that roomed with somebody that I knew from the Bristol area.

And it was just very awkward. And I don't know, she just demanded a lot of attention and that kind of thing. And I finally said, you know, I'm moving out. And I got me an apartment close by.

But by then, that was when I figured out that if you're that depressed, you'd better leave early, because it only gets worse. I was to the point when I made that move, I thought it would clear quickly. It didn't clear quickly.

I carried it for another six months. And during that initial three to four weeks, I couldn't read for the first time in my life. And that was my escape. However, I was an extern that year for-- it was between my third and fourth years in medical school.

And I was an extern on psychiatry. And I practically lived at the hospital. You know? And I learned a lot that was very helpful in-- I had been on psychiatry for two months as part of my usual rotation, and I liked it.

But I got to know Ian Stevenson very well, because he had some interesting ideas about reincarnation. I had been reared a Southern Baptist, and that I should accept the literal reading of the Bible.

Well, I read the Bible as a teenager, and there were a lot of things in the Bible that they never taught in Sunday school or talked about in the preaching they did. And some of the stories in the history part of the Bible are pretty horrific.

There were massacres and that sort of thing. And I'm thinking, there's something wrong here. I didn't quite have an idea of what it was. But it was of concern. And then I came across an article by Isaac Asimov-- because I read a lot of science fiction then-- about DNA.

And I don't know, it was a five-page article in Analog Science Fiction, which I took. And it was like, huh, well, that is easy, and it makes sense. And you know, it was like the death of "the Bible is literal". And that's all it took.

So you know, it was something I began to question. I didn't explore it in any detail. But then what I was learning in medical school was very supportive of questioning some of these things.

QUESTION: What was it like to work with Dr. Ian Stevenson (Professor and Chair of the UVA Dept. of Psychiatry)? How did he influence your own career in psychiatry?

LINDA RUTH THOMPSON: I spent a lot of time in the library there, sometimes in the evening. And sometimes we would talk about issues with what it was like before we had drugs, before we had ECT. And there were books there that gave vivid descriptions of people who had full-blown manic episodes and died as a result of the exhaustion that was involved in that.

And we didn't have any real private time together, particularly. But occasionally, we would talk just kind of in passing about some of the stuff, because well, they weren't teaching-- they were teaching more about really how to use the medication.

But we also were doing some therapy with people. And people had longer lengths of stay in the hospital, which was critically important for most of them. And so by the time I finished the summer, I was very interested in going into psychiatry.

And I talked to him several times about it after that and told him that I was going to be doing regular-- I didn't volunteer for a time on psychiatry for my senior year. And I wanted him to be clear that I still wanted to do psychiatry, but I wanted to see the rest of medicine before I specialized in psychiatry, because I felt it was important.

And he was supportive of that. So essentially, I had my residency lined up even before I left. And then I came back. I'm jumping ahead a little bit. And in the meantime, he had either resigned from the position of chairman or been forced out. And I don't know which it was.

But he ended up in a different part of the campus doing the paranormal department, which I think was funded partly by other people than just whoever was paying his salary when he was the chairman. And I had a lot of respect for that. I did not have time to track him down and find out about it, because I was too busy with what we were doing and learning how to cover call, all of that kind of stuff.

QUESTION: Can you tell us about your fourth and final year of medical school, and any additional thoughts about your time at the UVA School of Medicine?

LINDA RUTH THOMPSON: My fourth year of medical school, there were a couple of experiences that made me really glad I had made the decision. I had some time on cardiovascular surgery, for instance.

And we had a young man-- he was 28 years old-- who had a bicuspid aortic valve that got-- he had gotten some kind of septic thing that generalized, and it took out his aortic valve. And he came in over the weekend. And that was at that time when I spent most of my time at the hospital because I was still depressed.

But he was bluish purple. And he was so desperate to get enough oxygen, covered with sweat. He had his feet propped up on the bed so rail so that he could get his knees as close to his chest as he could, because that was the most effective way to breathe.

He could not talk. We had to do yes/no questions. That's the only way we could communicate with him. And I wasn't actively involved in the evaluation, but I was there to see it. And the senior resident almost immediately got in contact with the chairman of the department, who was not on call that weekend, and told him about this guy.

And he had no insurance at all. He was indigent. But we treated a lot of indigent people. And the chairman of the department came in that day and replaced his aortic valve. And I was really impressed.

Again, I cannot remember his name, because I'm not that good with names that I haven't even thought about for many, many years. But he came in. And by then-- I could see him. I continued to see him in the recovery in-- he was in the ICU.

By then, they knew I wanted to be a psychiatrist. They didn't know why I was in with them. But I wanted to be a psychiatrist. So he got the psychotic kind of stuff that you get in the ICU a lot of times like that.

And so they sent me in. And they said, tell us if it's anything that we need to do a consult on. So I went in, and I sat down, and I started talking to him, and I asked him-- he couldn't get out of bed at that point.

And I asked him if he was seeing things, and he was. And if he was hearing anything, and if they were saying bad things to him, or that kind of thing. Trying to look for paranoia. And he started giving me this look. And he said, I know you all think I'm crazy.

He says, but I can't get up. I can't move. All I can do is lay here. But I can breathe. I can look at them. It's like watching movies on the ceiling. But I can breathe, and that's all I care about.

And I went back and told them, I said, he's fine. Don't worry about it. He'll be fine as soon as he's up and walking around. And you know, he was. So they began to value what I could bring to situations like that.

And that was one of the major issues with that. We did start getting told toward the end of the year that we could have-- and I think it was a horrible mistake-- we could have electives in whatever specialty we wanted to. We didn't have to stay at UVA. We could go to other hospitals.

And a lot of the guys were really excited about that. Now, in my time, we had-- and everybody talked about it. We had case learners and we had book learners. A lot of the guys spent a lot of time in the library reading about different things.

And all of us did well, so it was not like any of us were penalized for choosing one or the other way. I was always a case learner. And we had basic textbooks, usually in every chart room.

And if we needed to read about something, you could do that. And I got my hands on a work manual. And I would read up on it at night, if I didn't have time to do it during the day. And it was a great way to learn medicine.

And the other thing we did, those of us who were case learners typically hung out more together. And if we had findings that were pretty uncommon, like a particular lung amount of congestion, a particular change in heart murmurs, that sort of thing, other stuff-- if the patient was in a position where it was not going to be hurtful to them, we would go in as a small group, and everybody got a chance to listen or look at it.

And that was very helpful. We learned a lot by just being able to see it and have an idea of what it was. So we did that. And it was very effective. And the idea of missing a lot of the subspecialties did not appeal to me at all.

So I decided not to do it. A fair number of my classmates did. And like I say, we've all turned out pretty well. So you know, I don't think it was a problem for them. But I do think having the broad exposure to medicine was critically important for me.

Then I had to go to the dean, because he talked to everybody, and he was helping us get internships. The matching program wasn't really there in the same way. And I told him I wanted a rotating internship.

And I had already been inducted into AOA at that point. Well, he did not want to waste an AOA on what was considered a second-class internship, because it was supposedly what you did if you were going to be a regular doc out in the community, that you could go and hang out your shingle after that internship. And you would use a specialist when you need to.

And we really argued for probably 45 minutes. And he wanted me to do Peds. He wanted me to do some kind of internal medicine, that kind of thing. And I finally said to him, look, I have an appointment for an interview at McGill University in Canada if I am not able to get a rotating internship.

Because I think it's important that I have that much more exposure to regular medicine before I go into psychiatry. And he was shocked. He was just mortified. And he finally caved. And he gave me a referral to the University of Iowa Hospital.

And that's where I ended up. And it was one of the best decisions I made. So going into that internship-- and Eric Orzeck was already out there. He had also gotten into it as an intern. I drove out there and I interviewed and I didn't have any trouble getting in.

I ended up borrowing money to be able to interview there, for the trip to Montreal. Which would have been sort of a rerun of my third year, which made that less appealing. But they got me what I wanted. So I was not unhappy with it.

I got to deliver-- I had been on GYN in obstetrics as a fourth-year student. I got to deliver a couple of babies there that were not-- you know, women who had already had several babies, that went easily. And that was a fascinating experience.

And I got out. That was the first thing I did as an intern, was OBGYN. And I got to deliver probably 30 babies at least, which I enjoyed. I got to-- I didn't assist, because the chairman was there. But I got to watch the birth of triplets to this woman.

And I had seen her initially in the clinic. And I'm probing around on her belly, and it was like she had a bunch of tennis balls in there. And I said to the resident, I think there's more than one baby here. And he came over and said, it's probably elbows and knees and stuff.

And he probed around a little bit and he said, I think you may be right. And so we sent her for an x-ray. They had three kids at home. They were working on a farm. They didn't have any insurance. And it wasn't twins, it was triplets.

And she went to shock, practically. So we put her in the-- it used to be house staff quarters, but most of the house staff lived out in town at that point. But that's where we put the high-risk pregnancies.

And she was supposedly about seven months on. And she hadn't had any prenatal care. And she was really upset. And her husband had to go back and take care of the other kids and get other people to take care of the other kids.

Well, we tried to stop the-- she went into labor, and we tried to stop it with IV alcohol, which sometimes we'll do it. But it didn't this time. And she was drunk, but she was also angry. She cussed us up one side and down the other while this was being done.

And they couldn't put her under anesthesia for fear that they were going to harm the babies. Turned out, they were bigger than we expected, and she was probably eight months along. Because the biggest was 4 pounds, 2 ounces, and the smallest was 3 pounds, 3 ounces. And they were all fine. And they survived. And they were able to take them home.

She got home before they did. But it was a very interesting experience. And we had three pediatricians and three attending pediatrician residents and staff that were there doing that. Very interesting experience.

And I did it assist and scrub in on a woman who was brought in from the area where she was staying. She had placenta previa. And she had gone into labor and got a premature loosening of the placenta, which was across the cervix. And she was going to bleed out.

So our 10 minute scrub down was about two minutes. And the resident got in there, and we called in the attending, but he didn't make it in time. And it was an emergency c-section. But the baby survived and she survived.

I'm pretty sure she's not going to be able to have any other children, or had any other children. Because it was pretty extensive. So it was a range of stuff like that. And a lot of it was-- one of the babies I delivered, I delivered on the gurney as we were trying to get her to the delivery room.

And she's trying to explain to her husband how to feed the other six kids that were home. And some of it was comical at times. And we just would have fun unwinding as we talked about those experiences.

But that was the beginning of it. But probably the most critical thing that happened in that internship that was most helpful to me, we had-- I got a little girl in that was mine, because I was the next up. She was 10 years old, and she had started to bleed rather badly around her gums and stuff.

And she was feeling weaker and that sort of thing. And this had started just about three weeks before. And we pulled her blood for ordinary check, and she had a huge amount-- she had 600,000 white cells. She had a very aggressive leukemia.

And she was worked up. And we had started-- they had started, I should say-- trying to do chemo with this. And she was feeling very sick with that. And then one evening, I was on call. And she had not been doing that well when we saw her on rounds in the morning.

But she was beginning to fade. And she wasn't totally conscious. And so it was about 11:00 o'clock at night. So I called the oncology guy who happened to be-- he was on call that month for anything that needed attention.

And I think his name was Andre Lascari, is what I remember. And he always looked-- and we had a lot of kids with cancer on that unit. So he spent a lot of time there. Very nice guy. Always looked a little sad.

And he said, I'll be there in 30 minutes. And I was afraid that I had done something wrong. I'd given him the report and what I had done. And I didn't expect him to come in. But he came in at night. And you went back with me and he went through the exam.

And she was unconscious by then. And he said, she's probably going to die tonight. But maybe it'll be tomorrow or maybe it'll be a couple of days. Then he had me go out with him to talk to the mother, who was out there. And several of the kids were there.

They weren't allowed to stay with the children there at night, because they would have been too exhausted. But they had a very tight group among the people-- the women who were there, with children who were mostly not going to survive.

And I watched the way he talked to her. And he told her that I would be monitoring the situation. And did it as well as you can do, something like that. I think she was crying and very upset. And you know, he was holding her hand and touching her and giving her what he could in the way of comfort.

And then he took me back to the chart room so we could talk about it. And he said, I want you to have the nurses wake you up every two hours. Go in and examine her and go out and give this woman a report.

And that's what I did. And she passed away about 6:00 o'clock in the morning. He had also gone over with me the importance of getting permission to do an autopsy, which we knew was not going to be easy.

But how important it was, because this was a rare kind of leukemia. And we needed to learn as much as we could from it. And she died about 6:00 o'clock. They called me. I went in and pronounced her dead. And then I went out and talked to the mother.

And the kids were asleep at that point on the furniture that was available. And I talked to her about getting permission. And she said, I need to see her. And I said, I'll arrange that for you. And I talked to her about the importance of having the autopsy done.

And so a nurse came in and took her back so she could be with her for a few minutes. And she came back out and she signed the autopsy permission. And then she left. You know, it was really sad.

And 10:00 o'clock that morning, I was there at the autopsy. And you know, you could see what it was doing to her-- how large the spleen was, all of that stuff. And it was like a three-week course. Four week, I guess, by then.

And being able to watch how he talked to her, I have used that in similar situations ever since. It was one of the most important things in my training. We had another situation, and that was also in the internship, where we had a woman who was an alcoholic, and who is dying of liver disease.

And she had severe esophageal-- you know, the varicose veins that you get that would bleed. And she was bleeding out periodically. And we had brought her back I guess two or three times. And in the chart room, we were talking about it. She wasn't my patient.

And they decided not to resuscitate her again. And I have no idea if anybody talked to her about that, because I didn't know. I was working on the unit. I was the only one there. And she started to bleed again. And she could tell when she was bleeding, because she would start getting weak.

And so the nurses called me over. The nurses were all-- we were on ward medicine, which was wonderful. I'll come back to that in a minute. And the nurse came over, and she was saying she was bleeding. And the nurse wasn't doing anything, because she wasn't going to be resuscitated.

And she started to cry for help. And I knew it was going to be horrible if she died that way. So I staged a coding. I just came over. I said, bring all the stuff. Bring me the needles that I need. And I started working on trying to find a vein in her foot, because that's where we were working from the last time.

And I said, we'll do the best we can. And the nurse stayed with her and was holding her hand and promising her that she would be all right. And she relaxed. And when she went under for the last time, she had a small smile on her face. I'll never forget that. And I worked at it for probably another five minutes or so, and then I stopped. And we checked it, and she had passed.

And I went out, and her boyfriend was out there. He was also alcoholic. And he came in. I said she had passed away, and he spent some time with her. And then she was removed. Most people now have private rooms.

But it was really-- and all the wards were that way. OBGYN, medicine, surgery, for the most part. There were some private rooms in the hall leading into it for people who really needed privacy, like by people who were in sepsis and stuff like that.

But the nurses were always aware of everything that was going on. And that was such a blessing. And that is something that is really missing these days. The last thing that happened that I remember was I worked on the ER a fair amount when I was on surgery.

I did a month in neurology and I did a month of ophthalmology. But the last three months, I was on surgery. And one of the issues we had, which was interesting, was a woman came in who was traditional Indian, maybe even an arranged marriage.

And her systems were-- her complaints were severe pelvic pain, and when you pressed on her lower abdomen, it was in the area of the ovaries and the uterus. And I am thinking, this is not going to be good, because it's probably PID.

And I called in the resident who had the same feeling. And her husband was right outside. And he came in when we weren't there. And they were very traditional. And we're going, how are we going to talk to these people about this?

So we chickened out and we called in the GYN person, who examined her and who had the same feeling. But yeah, it was probably PID. But nobody was willing to go in and talk about it to this couple. So the GYN person admitted her to GYN and said we would figure it out in the morning.

So that's what happened. And he came down the next morning and he said it's a good thing we didn't have that discussion, because her cheeks were out to here and she had mumps. And we had asked him about illness in the family in the past on that. She didn't tell us that, because she didn't think it had anything to do with the childhood disease. But she had mumps from her son.

And we were so grateful that we hadn't had to have conversation with him, because it would have been horribly destructive for a marriage like that. Just horribly destructive. And it was three weeks before I was supposed to leave and come back to Virginia. I had never had classic mumps.

And I'm going, oh, well, this could be interesting. But I never got it. You know, I'd been exposed three other times growing up. Never got it. Never had measles. Most of the time, didn't get flu. So I was quite happy to drive away and not be hospitalized with mumps at that point in my career. So that was the end of that. And I went back to Virginia.