The ship Ob, with the sixth Soviet Antarctic expedition on board, sailed from Leningrad on 5 November 1960. After 36 days at sea she decanted part of the expedition onto the ice shelf on the Princess Astrid Coast. Their task was to build a new Antarctic polar base inland at Schirmacher Oasis and overwinter there. After nine weeks, on 18 February 1961, the new base, called Novolazarevskaya, was opened.

They finished just in time. The polar winter was already descending, bringing months of darkness, snowstorms, and extreme frosts. The sea had frozen over. The ship had sailed and would not be back for a year. Contact with the outside world was no longer possible. Through the long winter the 12 residents of Novolazarevskaya would have only themselves to rely on.

One of the expedition’s members was the 27 year old Leningrad surgeon Leonid Ivanovich Rogozov. He had interrupted a promising scholarly career and left on the expedition shortly before he was due to defend his dissertation on new methods of operating on cancer of the oesophagus. In the Antarctic he was first and foremost the team’s doctor, although he also served as the meteorologist and the driver of their terrain vehicle.

29 April 1961
After several weeks Rogozov fell ill. He noticed symptoms of weakness, malaise, nausea, and, later, pain in the upper part of his abdomen, which shifted to the right lower quadrant. His body temperature rose to 37.5°C. Rogozov wrote in his diary:

“It seems that I have appendicitis. I am keeping quiet about it, even smiling. Why frighten my friends? Who could be of help? A polar explorer’s only encounter with medicine is likely to have been in a dentist’s chair.”

As a surgeon Rogozov had no difficulty diagnosing acute appendicitis. In this situation, however, it was a cruel trick of fate. He knew that if he was to survive he had to undergo an operation. But he was in the frontier conditions of a newly founded Antarctic colony on the brink of the polar night. Transportation was impossible. Flying was out of the question, because of the snowstorms. And there was one further problem: he was the only physician on the base.

30 April
All the available conservative treatment was applied (antibiotics, local cooling), but the patient’s general condition was getting worse: his body temperature rose, vomiting became more frequent.

“I did not sleep at all last night. It hurts like the devil! A snowstorm whipping through my soul, wailing like a hundred jackals. Still no obvious symptoms that perforation is imminent, but an oppressive feeling of foreboding hangs over me . . . This is it . . . I have to think through the only possible way out: to operate on myself . . . It’s almost impossible . . . but I can’t just fold my arms and give up.

Preparation for the operation
Following Rogozov’s instructions, the team members assembled an improvised operating theatre. They moved everything out of Rogozov’s room, leaving only his bed, two tables, and a table lamp. The aerologists Fedor Kabot and Robert Pyzhov flooded the room thoroughly with ultraviolet lighting and sterilised the bed linen and instruments.

As well as Rogozov, the meteorologist Alexandr Artemev, the mechanic Zinovy Teplinsky, and the station director, Vladislav Gerbovich, were selected to undergo a sterile wash. Rogozov explained how the operation would proceed...
The operation

The operation began at 2 am local time. Rogozov first infiltrated the layers of abdominal wall with 20 ml of 0.5% procaine, using several injections. After 15 minutes he made a 10-12 cm incision. The visibility in the depth of the wound was not ideal; sometimes he had to raise his head to obtain a better view or to use the mirror, but for the most part he worked by feel. After 30-40 minutes Rogozov started to take short breaks because of general weakness and vertigo. Finally he removed the severely affected appendix. He applied antibiotics in the peritoneal cavity and closed the wound. The operation itself lasted an hour and 45 minutes.1 2 Partway through, Gerbovich called in Yuri Vereshchagin to take photographs of the operation. Gerbovich wrote in his diary that night3:

“When Rogozov had made the incision and was manipulating his own innards as he removed the appendix, his intestine gurgled, which was highly unpleasant for us; it made one want to turn away, flee, not look—but I kept my head and stayed. Artemev and Teplinsky also held their places, although it later turned out they had both gone quite dizzy and were close to fainting . . . Rogozov himself was calm and focused on his work, but sweat was running down his face and he frequently asked Teplinsky to wipe his forehead . . . The operation ended at 4 am local time. By the end, Rogozov was very pale and obviously tired, but he finished everything off.”
Prescriber’s narcophobia syndrome: physicians’ disease and patients’ misfortune

Prescriber’s narcophobia syndrome (PNS) is a professionally disabling neuropsychiatric malady. It strikes physicians who, as medical students, wished to alleviate suffering and improve patients’ wellbeing. Once afflicted, physicians become frustrated by patients in pain and treat them without compassion.

Physicians succumb to PNS early in practice and often for decades. However, brief remissions occur when treating a malpractice attorney, hospital administrator, or someone who reminds the physician of himself or herself. PNS is highly infectious, passed at the bedside from teachers to students.

Usually the victim of a physician with PNS projects obvious verbal and behavioural cues of severe pain. Hence PNS may reveal sadistic sociopathy of a physician wishing for the patient to suffer. This explains forced discharge of patients with persistent pain and prescribing ineffective non-narcotic agents with poor side effect profiles. Alternatively, PNS may uncover a variant of autism in a doctor who is unable to perceive the patient’s emotions or read behavioural cues.

Such doctors avoid eye contact with patients in pain and are hyperfocused on their diseases instead of how they feel. Alternatively, paranoid schizophrenia may explain physicians’ bizarre thinking that every patient requesting effective pain relief is a “drug seeker trying to get high.” Supporting evidence includes physicians’ delusional belief that not treating pain will cure the “addiction” caused by desire for pain relief.

The “modified” CAGE questionnaire

- Do you ask a colleague to Cut down on their narcotic prescribing?
- Do you become Angry when patients claim that narcotics work for their pain?
- Do you feel Guilt after writing a narcotic prescription?
- Do you avoid Eye contact with your patients in pain?

Answering Yes to ≥2 makes PNS more likely

Initiating prompt therapy for PNS stops the vicious cycle of oligoanalgesia and professional frustration. Educational literature shows the inadequacy of non-narcotic agents for treating severe pain and highlights the safety and efficacy of judicious narcotic use. Behavioural counsellors literally “hold your hand” while you write a prescription for oxycodone and point out increased patient satisfaction.

However, the traumatic approach works best. Begin by kicking the narcophbic physician in the shins to create a non-disabling, continuously painful disruption to daily function and enjoyment of life (the doctor’s recent patients will gladly do this part). Then, the physician is given his or her choice of non-narcotic analgesia to show its relative impotence. Finally, narcotics are administered, offering rapid relief. Consequent is a life altering realisation of how much good the physician may do for patients by a change of behaviour. Remember the ethic of reciprocity, or “golden rule.” One day, every physician will find himself or herself in enough pain to seek out another physician. How would you like that physician to approach your pain?

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Competing interest: VR is a son of Leonid Rogozov

5. Gerbovich VI. Fragment from diaries in V proshlom u nega moglo by bol’shoe budushchee. Omsk Humanitarian Institute, 2007;63-185.

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