

Journal of the  
**SURGICAL HUMANITIES**



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# ■ MESSAGE

## from the Chairman

**Ivar Mendez, MD, PhD, FRCSC, FACS**  
Fred H. Wigmore Professor and Unified Head  
Department of Surgery  
University of Saskatchewan

The Surgical Humanities Program was conceived as a platform to sustain and encourage our faculty, residents and students to intergrate the humanities to their daily surgical practice. We firmly believe that the humanities as expressed by activities such as the visual arts, music, literature, poetry and philosophy are not only complimentary to surgery but have a synergistic effect in enhancing our clinical work encouraging creativity and innovation and promoting education.

The Surgical Humanities Journal is an important component of the Surgical Humanities Program at the University of Saskatchewan. It is our hope that this Journal will be a conduit for members of the Department of Surgery to communicate their humanistic accomplishments and contribute to enrich our activities both within and outside the operating room. We expect that, as the Journal develops and matures, the contributions and readership will extend beyond the confines of our institution. I am convinced that the Journal will have a long life and that it will inspire us for years to come.

Sincere thanks to Dr. Francis Christian, Editor of the journal and director of the Surgical Humanities Program as well as the contributors to this first issue. Enjoy this inaugural issue and provide us with your feedback and contributions.



*Dr. Mendez sculpting the bust of Dr. Charles Drake, a world-renowned Canadian neurosurgeon. The bronze sculpture has been installed in front of the University Hospital in London, Ontario.*

# ■ EDITORIAL



It is through the enriching of one's own life and through this, the enriching of the career and work of healing entrusted to us, that an education and engagement in the humanities makes its case for a prominent position in our lives as house staff, surgeons and physicians. Although the goals of such an engagement may well be to enhance our particular specialty's understanding or dealings with patients, there is the inescapable, accompanying and sometimes imperceptible influence of a beautiful poem or fine novel or exquisite work of art or music upon our own souls and sensibilities that is the first benefit from this encounter. From this, must flow a better understanding of ourselves, our patients, the human story, life, suffering and mortality.

In seeking to fulfill this mandate, "Surgical Humanities" is only too aware of its inability - and the inability of any similar journal - to capture completely the ideal and mountain-top of human experience in all its severe and miraculous forms. But in the striving after the summit, in its relentless pursuit of the ideal, we will leave no stone unturned and will always work from issue to issue, to bring you the best written

and visual work that we can. Every era believes itself different and the twenty first century had its own vociferous champions who put forth their own hopeful vision of a utopian future based on the march of scientific progress. Remarkably, very similar forecasts were made, in a different context, a century ago at the dawn of the twentieth century.

More sober reflection of course, told us that whilst science may solve some of the old problems, there will always be new problems and challenges to take their place. And that these problems, both old and new, are rooted in the basic assumptions of our humanity - our capability for great good and great harm, our inherent frailties and the specter of our mortality.

The importance therefore, of a discipline that has a measure of continuity from generation to generation and is not subject to the knowledge base of science at a particular time in history, should be obvious. The humanities provide this continuity, for the music of the Aeolian harp of ancient Greece is still valid as a testament to beauty; so is Shelley's "Ode to a Skylark," written two hundred years ago. The two-faced, evil depravity of Mr. Hyde set side

by side with the rather decent Dr. Jekyll have become so timeless in their relevance to everyday life, that the title of Robert Stevenson's novel has passed into our every day speech ("Jekyll and Hyde"). And Tolstoy's "The Death of Ivan Illich" will continue to speak to future generations about our common humanity and inescapable mortality.

This journal's measure of success will be reckoned not so much in the number of times it is read or re-read but in the hours and days of quiet reflection it produces. Its "impact factor" will not be in the number of citations that result, but in whether it succeeds, however imperfectly, in its goals both to inform and to enrich.

A handwritten signature in black ink, which reads "F. Christian". The signature is written in a cursive, flowing style.

Francis Christian  
Editor-in-Chief





# ■ ETHER DAY

**Murray Dease**  
Anesthesiologist  
Department of Anesthesia  
University of Saskatchewan and  
Saskatoon Health Region

One of the most significant events in the history of medicine very nearly didn't happen.

On Friday October 16, 1846, at ten o'clock in the morning, the most prominent surgeon in United States,<sup>1</sup> Dr. John Collins Warren, was waiting to start his day.

The only operation scheduled was the removal of a tumor from the neck of an otherwise healthy 20-year-old man named Gilbert Abbott. Their would-be-anesthesiologist, 27-year-old dentist and borderline con-man William T.G. Morton, was late.

An event was about to occur that would cause revolutions felt well beyond the field of medicine. It would truly change the world. Elsewhere around the globe, at roughly the same time, give or take 10 years, other world changing events were taking place:

- In the United States war had been declared on Mexico. Abner Doubleday had recently invented baseball. Slavery was a part of American life, and the seeds of the Civil War were being sown.<sup>2</sup>
- North of the American border, Upper and Lower Canada had just united into the Province of Canada.<sup>3</sup> The popularity of the beaver hat was diminishing in Europe and, because of this, by 1850 the fur trade had begun to decline.<sup>4</sup>
- In Europe, England was in the heyday of the Victorian Age. The Irish were running out of potatoes.<sup>2</sup>
- Dickens, Dumas, Bronte, Poe, and Marx were writing their best sellers. Charles Darwin was getting into his act.<sup>5</sup>



- In the musical world, the 1840's saw the births of Dvorak, Tchaikovsky, and Grieg as well as the death of Chopin.<sup>6</sup>
- The first telegraph sent a message from Baltimore to Washington (the message read "What hath God Wrought?"). The Colt revolver, refrigerator, and internal combustion engine were invented.<sup>7</sup>

Back in the medical world, Joseph Lister had just begun his ground-breaking work on antiseptis.<sup>8</sup>

Surgery at this time was a very difficult affair, involving various straps and hooks to hold the patient down as he or she screamed and writhed under the knife. Operations were the last resort of surgeons and patients. Walking to the operating room was like going to a hanging. Surgeons were known to weep or vomit after particularly terrible operations. The following is an actual description of such an operation:

"Of the agony it occasioned, I will say nothing. Suffering so great as I underwent cannot be expressed in words, and fortunately cannot be recalled...the sense of desertion by God and man. During the operation, in spite of the pain it occasioned, my senses were preternaturally acute. I watched what the surgeons did with a fascinated intensity. I still recall with unwelcome vividness the spreading out of the instruments, the twisting of the tourniquet, the first incision, the fingering of the sawed bone, the tying of the blood vessels, and the bloody dismembered limb lying on the floor. Those are not pleasant remembrances. For a long time they haunted me. They can occasion a suffering

of their own, and be the cause of a disquiet which favors neither mental nor bodily health".<sup>9</sup>

Surgery was an awful thing before the mid 1840's because there were few options for surgical anesthesia, and no satisfactory ones. The methods used were either too weak to be effective, or so strong that they caused death (perhaps not so bad if one was facing the prospect of anesthesia-free surgery).<sup>10</sup> Alcohol was readily available and some patients tried getting drunk before their operation. Alcohol can be effective in numbing the existential pain of everyday life, but is not so effective with surgical pain.<sup>11</sup> Alcohol had some merit as an anesthetic, as one nineteenth century physician observed a case of an Irishman who had part of his face eaten by a pig while he was lying dead drunk on the ground,<sup>12</sup> but getting drunk was far from a perfect solution.

Opioids had been around for centuries and they were effective pain relievers, but their pros came with some very undesirable cons. Delivery of a consistent and effective dose was difficult as the medical syringe had not yet been invented. All patients could do was drink an opioid mixture an hour or so before surgery and hope for the best. The results ranged from mere nausea with no pain relief, to death (once again, maybe not so bad).<sup>13</sup> Dosing became more precise in 1853 when the medical syringe was invented by Alexander Wood,<sup>14</sup> who used the sting of the bee as his inspiration. A rumour did the rounds for a while that Wood and his wife themselves became addicted to precise doses of morphine – but this was later disproved.<sup>15,16</sup>

Hypnotism, or mesmerism, was surprisingly, somewhat effective. James Esdaile was a Scottish surgeon who did a number of operations, including breast and penis (!) amputations, under hypnosis in the early nineteenth century, with apparent success.<sup>17</sup> Mesmerism was quite popular for a while and there is a report from 1845 with a supposedly true first hand account of a woman having nasal polyps removed relatively painlessly with only hypnotism as her anesthetic.<sup>18</sup> These accounts are impressive and it is possible that hypnotism may offer some benefit even today.

A variety of other methods were used in efforts to relieve surgical pain, including distracting the patient being operated on by rubbing their skin with stinging nettles, rendering them unconscious by knocking them out with a blow to the jaw<sup>19</sup> having them breathe carbon dioxide, or by bleeding them into a state of unconsciousness. Crude anesthesia to one of the limbs could be obtained by cutting off the circulation to the limb being operated on or by numbing it with ice.<sup>20</sup> All of these methods were better than nothing (maybe) but obviously none of them were the answer.

The British chemist Humphrey Davies was the first to suggest that nitrous oxide might be used as a surgical anesthetic, but nobody at the time pursued the matter any further.<sup>21,22</sup> Ironically, unbelievably, and surely tragically, nitrous oxide found widespread use at this time in circus type shows where volunteers would breathe the gas and then stagger around onstage and injure themselves, to the amusement of the audience. Unfortunately nobody gave it to a patient having surgery.<sup>22</sup> Another anesthetic gas, ether, was also commonly used in the early nineteenth century as a recreational drug. Nitrous oxide parties and “ether frolics” were all the rage. People would gather in their drawing rooms, take turns inhaling the gas, and then laugh at each other (Despite reports to the contrary, this is not what happens at Anesthesia Grand Rounds).<sup>23</sup>

Some felt that a patient’s ability to endure suffering, just as Jesus had, was a measure of the patient’s worth as a Christian:

“Patients ought to suffer pain while their surgeon is operating; they are all the better for it and recover better!” a nineteenth century physician shouted at a public meeting, “anesthesia will rob God of the deep earnest cries which arise in time of trouble, for help.”<sup>24</sup>

This anti-anesthesia zeitgeist played a big part in delaying the discovery of adequate surgical anesthesia until a man named Crawford Long came along.

Crawford Long was an American surgeon and pharmacist (and cousin of legendary gambler, gunfighter and dentist Doc Holliday). Long used ether to successfully anesthetize a man named James Venable while he removed a tumor from the man’s neck in 1842, making Long the first person in history to use anesthesia.<sup>37</sup> But Crawford waited too long to tell the world about what he had done. He didn’t come forward until after William Morton became famous for the discovery and he therefore never really got the credit he probably deserved.<sup>38</sup>

Long got the idea to use ether as an anesthetic after he heard about a bizarre incident. In 1839, a group of teenagers in Athens, Georgia, were using ether recreationally (oh, those crazy kids!) and they invited a “slave boy” to try some. The boy refused and the teenagers cruelly held him down and forcibly covered his nose and mouth with an ether soaked rag. When they released him, the boy was unconscious and unresponsive. Worried that he was dead, someone ran to get a doctor. When the doctor arrived an hour later the boy was still unconscious. The doctor was able to revive him, and upon awakening he seemed none the worse for wear. “Hmmm....,” thought Crawford Long.

Crawford Long continued to use anesthesia in subsequent years (even though some local residents thought he was engaging in witchcraft) and expanded its use to his obstetrics practice. Long made some efforts to get recognition for his accomplishment, but he didn’t seem to be as interested in fame and personal glory as those who would come after him, and he returned to caring for his patients.<sup>37</sup> A hospital in Atlanta, Georgia was named after him in 1931 and in 1940 his face was on a United States postage stamp.

Two years later another man would accomplish a similar feat with a different gas. The history of anesthesia is filled with strange events and colorful characters, but none as interesting as the case of poor Horace Wells. Wells, like Crawford Long, was a very compassionate and honest man. He was a successful dentist but he often struggled with the pain he had to inflict in order to treat his patients and would sometimes stop work for several weeks after an especially agonizing operation. He considered giving up dentistry altogether.<sup>26</sup>





*Outdoor mural located in Jefferson, Georgia, depicting Crawford Long using ether while operating.*

In 1844, Horace Wells read a promotion for a performance that promised “more laughter than he had experienced in the previous six months!” The performance was one of the nitrous oxide shows so popular at the time.<sup>25</sup> Wells decided to go and set in motion a series of events that would lead to his almost Shakespearean tragic downfall. At the show, Wells witnessed a young man breathe nitrous oxide and then injure his legs so badly that they began to bleed. Sitting among the laughing crowd, Wells came to the same conclusion that Humphry Davies had reached forty five years earlier – that he might use nitrous oxide on his patients. Horace Wells arranged to have nitrous oxide administered to him while another dentist pulled out one of his teeth. Wells experienced little or no pain. With that heroic act, Horace Wells became the second person in history to use general anesthesia.<sup>27</sup>

Horace Wells then incorporated the use of nitrous oxide into his dental practice and found success. He had little interest in personal glory or money, so he made no

attempt to patent his technique, and he didn’t write any papers on the subject either. Wells might have continued to use his anesthesia in relative obscurity, much like Crawford Long had, if he hadn’t shared his findings with two men. One was his former dentistry student and sometime partner, William T.G. Morton, who was a charismatic and shady character who would practically steal the anesthesia show in a couple years. The other was Dr. Charles T. Jackson, an interesting jack-of-all-trades who, in addition to being a physician, had worked as a geologist and also claimed to have invented a number of things, including the telegraph. When Horace Wells met Jackson, Jackson was involved in a legal battle with Samuel Morse over ownership of the telegraph.<sup>65</sup>

In 1845 Morton and Jackson used their contacts to introduce Wells to Dr. John C. Warren, the head of surgery at Massachusetts General Hospital. Warren was arguably the most esteemed surgeon in the country and definitely one of the most influential men in medicine.<sup>1</sup>

Dr. Warren was intrigued by the idea of painless surgery and he arranged for Wells to demonstrate his technique to Boston's surgical elites at Mass General.<sup>28</sup> The demonstration didn't go well, however. Initially, Wells was to provide anesthesia for a patient scheduled for a leg amputation, but at the last minute the patient got cold feet (pun intended).<sup>29</sup> Undaunted, the influential Dr. Warren then somehow convinced one of the medical students to volunteer to have Wells pull out his tooth under anesthesia. Wells tried to do this, with the help of William Morton, but the anesthetic didn't work and the patient cried out in pain. The demonstration ended in failure.<sup>30</sup> Wells would later reflect that the nitrous oxide he had obtained in Boston may have not been as potent as the stuff he was used to in Hartford, and that he may have removed the gas from the patient's face too soon because he was nervous about performing in front of the group of important doctors. In any case, the crowd jeered "Humbug!", laughed Wells out of the building and, effectively, out of his Boston dental practice.<sup>31</sup>

For the next two years, Wells made a living in various pursuits, including as a traveling canary salesman.<sup>32</sup> Finding this unfulfilling, he eventually came back to dentistry. He decided to make a new start as a dentist in New York. He also decided not to give up on anesthesia. He was disillusioned with nitrous oxide, so he looked for alternatives and found another gas, chloroform. Like many men of science of that era, he experimented on himself and began using chloroform to see how it worked. The results were not good. Horace Wells liked chloroform too much and got hooked on it. The addiction caused him to become increasingly deranged, and turned the sensitive idealist into a sadistic monster. One day, under the influence of chloroform, he "hurled vitriol" (threw a vial of sulphuric acid) in the face of a prostitute and was subsequently arrested. This was big news at the time, and some believe that the sensational headlines about Horace Wells' medical experimentation gone wrong inspired Robert Louis Stevenson's famous novel "Dr. Jekyll and Mr. Hyde".<sup>36</sup> Wells eventually sobered up, went to trial, and was found guilty. He was horribly ashamed of himself and realized that there was no hope of renewing his dental practice. He was sent to jail, Manhattan's infamous Tombs prison.<sup>33</sup> Horace Wells didn't spend much time in prison, though. The next morning he was found dead in his cell. A handkerchief doused in chloroform was wedged in his mouth and secured by another handkerchief tied around his head. There was a deep gash in his leg where he had

used his razor to cut an artery. It appeared that Wells had administered his last anesthetic on himself to ease the pain of his suicide.<sup>34</sup>

The next saga of this remarkable, true story now moves to a key, but unlikely player. William T.G. Morton spent every waking minute of his life trying to make good things happen for himself. Morton was born in 1819 in Massachusetts into a farming family. He spent most of his youth wandering around and earning a bad reputation through various activities such as passing bad cheques in New York, cooking the books at a dry goods store, committing mail fraud, and getting excommunicated from his Christian church. Morton would go to almost any lengths in his efforts to get rich and famous. As a young man, he managed to become engaged to the daughter of one of the richest men in Cincinnati by posing as a wealthy gentleman with an impeccable pedigree.

When this relationship fell apart, Morton needed another way to make money, so he decided to become a dentist. He studied dentistry in Baltimore but he left college without graduating. At the age of twenty-three, Morton met Horace Wells and Horace taught him how to be a dentist and help him set up a practice. Wells had invented a new type of dental plating and Morton maneuvered himself into a partnership with Wells to promote the new invention.<sup>40</sup> The two men travelled to Boston and met with Dr. Charles Jackson, a prominent physician who would also play a major role in the anesthesia saga.

Morton stayed in Boston and opened a dental practice. He then began to pursue another pretty young woman from a rich family (Morton was married and divorced multiple times). Morton was, apparently, a strikingly attractive young man (like most anesthesia providers) and was said to possess "an excess of charm" (again, no surprise).<sup>42</sup>

Morton had been present at the demonstration of nitrous oxide that his former partner, Horace Wells, gave to the Boston medical elite in 1845. In the year after Morton saw his friend Horace Wells' hopes and dreams come crashing down, Morton was very busy. At this time, dental technology was able to produce good sets of false teeth, but in order to use them patients would have to have all of their existing rotten teeth pulled out. Understandably, because of the pain involved, many people simply lived with their bad teeth (I would). Morton reasoned that if he could make the process less painful, he could increase the





*Close up photograph provided by Dr. Murray Dease, of the painting depicting the first administration of an inhaled anesthetic.*

market for his false teeth and become a rich man.<sup>43</sup> Morton gave up on nitrous oxide as an anesthetic after witnessing the Wells debacle. He needed an agent that would work better. Morton decided to try ether, which was being used recreationally. He had a small barrier to overcome, however. He didn't know anything about ether, or chemistry in general, for that matter. Fortunately for him he was now boarding at Dr. Charles Jackson's house. Jackson, in addition to being a respected physician, was known to be a gifted chemist. Morton needed to get Dr. Jackson to teach him about ether without revealing why he wanted the information. Morton was worried that Jackson would steal his idea to use ether as an anesthetic and "take the prize from my grasp."<sup>44</sup> Morton probably didn't have to worry about this, though. Jackson had been one of Horace Wells' harshest critics and was inclined to ridicule Wells for his attempts to provide anesthesia, which he didn't see as a worthwhile pursuit.<sup>45</sup> Dr. Jackson didn't have any interest in anesthesia (at this time). He was too busy trying to wrestle the telegraph patent from Samuel Morse.

Morton raced back to his office and tried to get one of his patients to agree to be the test subject, but none would, even after he tried bribing them with five dollars. In frustration, Morton finally tested it on himself and passed out for eight minutes (he considered this a complete success). Later that evening a man appeared at his office with a toothache and Morton convinced him to inhale ether through a handkerchief. The patient did and he passed out. He awoke to see the beaming face of Morton, who, like the true showman he was, asked the patient if he was ready to have the tooth out. When the patient said he was, Morton stepped to the side and pointed to the bicuspid on the floor.

"Well, it is out now!' Morton declared.<sup>46</sup> Ta-dah!

The next 2 weeks were a whirlwind for Morton. He pulled over forty teeth more or less painlessly and without major incident using his technique, ether poured on a handkerchief over the patient's mouth and nose. The newspaper ran a story on him. He was a minor celebrity.<sup>47</sup>



At this point, Dr. Warren got involved again. It's interesting that Morton and Warren would become forever linked because it would be difficult to find two men who were more unlike each other. Where Morton came from humble beginnings, Dr. Warren came from an important medical family (Warren's father Jack had presided over the founding of Harvard's medical school and his uncle, also a physician, was a war hero of the American revolution). Morton had never really accomplished much so far in his life. Dr. Warren was the founder of the New England Journal of Medicine, the third president of the American Medical Association, the first dean of the Harvard Medical School, and a founding member of Massachusetts General Hospital. Where Morton was known to be a con-man, unreliable and untrustworthy, Warren was a bastion of the community. Where Morton was young and handsome, Warren was sixty-eight with a thin, stooping form and scanty grey hair. Where Morton was extremely charming and personable, Dr. Warren was brusque and severe and not to be trifled with.<sup>49</sup> The two men differed even in their attitudes toward anesthetics, which Morton saw as a vehicle to personal riches and Warren saw as a tool to alleviate human suffering. But despite all these differences, fate brought the two men together. Dr. Warren wanted to see what William Morton could do. A demonstration was arranged to take place on October 16, 1846 at Massachusetts General Hospital.

Dr. Warren was taking something of a risk himself by giving Morton this opportunity and it is a testament to his dedication to his patients and to the advancement of science that he did so.<sup>50</sup> Also, many surgeons simply believed that effective anesthesia was not possible, ("a chimera that we can no longer pursue in our times").<sup>50</sup> Remember also that Dr. Warren had been present for the Horace Wells incident and no one would have blamed him if he was discouraged after that and didn't want to try again.<sup>51</sup> But Dr. Warren was determined and undaunted.

When Warren invited Morton to give a demonstration of his anesthesia technique, Morton immediately agreed and accepted the date Warren offered him, which was only a day or two away. Morton had a problem and not much time to solve it. Assuming the demonstration was a success, Morton wanted to be able to patent the anesthesia process and make some money any time ether was used anywhere. In order to do that, he felt he needed to turn his discovery into an invention.<sup>51</sup> This was a problem, though, because he hadn't invented

either the anesthetic (ether) or his method of delivering it (handkerchiefs). He decided to modify the agent by adding oil of orange to it. This gave the ether a more pleasant smell, but did nothing to modify its effects. He dubbed this concoction "Letheon", after the Greek word for oblivion or forgetfulness.<sup>52</sup> Then he set about to invent a device to administer this miracle drug. He came up with a glass globe with a long stem for the patient to breathe through. A sponge soaked in "Letheon" was to be placed inside.<sup>51</sup>

At ten twenty five, almost half an hour after Morton was supposed to have begun his demonstration, he still wasn't there. The esteemed crowd of physicians, not to mention the nervous patient, a young man named Gilbert Abbott, were getting restless. Dr. Warren had finally had enough and he rose and observed wryly that it appeared that Morton "was otherwise engaged".<sup>52</sup> Warren then made preparations to operate on poor Gilbert Abbott without anesthetic. This never happened though. As if the timing had been scripted, this is apparently the exact moment Morton rushed into the room.

My personal trip to this famous room was much less exciting than William Morton's, but it was not entirely uneventful. In April of 2012 my wife Sara and I flew from Saskatoon to Boston. In addition to eating and drinking and seeing some of Boston's great historical attractions, we had planned to visit the Ether Dome.

The next day my wife and my friends and I made our way to the prestigious Massachusetts General Hospital. Walking through the hospital was an interesting experience for me. Having done all of my training in Saskatchewan, I found myself alternately being in awe of the place and the physicians we ran across, and then thinking "Hey! I'm a doctor! The medicine is the same. I could do anesthetics here!"

We weren't really sure what to expect when we got to Mass General. I knew the Ether Dome was somewhere on the hospital grounds, but the place was enormous. My wife suggested we find an information desk ("why don't we ask for directions?") so we did and waited behind an elderly couple. The woman behind the counter was a big African American lady who reminded me of "Roz" from the old TV comedy "Night Court". Once she was done with the older couple she helped us, actually taking us to the Ether Dome which was several hallways and elevator rides

away in the Bulfinch Building, the oldest public hospital building in the United States. She asked us questions about Canada and gave us some sightseeing advice. We walked up some ancient stairs to a doorway and we were on the threshold of walking into the Ether Dome, perhaps standing on the very spot where William Morton made the final adjustments on his ether inhaler one hundred and sixty six years ago. It was pretty cool.



*The author and his wife, Ether Dome, Boston*

In 1846, when William Morton finally had his ether device assembled to his satisfaction, he strolled into the auditorium with at least the appearance of confidence, like a leading man on stage. “Your patient is ready,” Dr. Warren said to Morton, barely able to contain the sarcasm in his voice.<sup>53</sup>

Morton stepped to center stage of the operating theater. When he placed his inhaler to Gilbert Abbot’s lips, he really didn’t know what he was doing, but he did it anyway. And he made history. Less than five minutes later, Gilbert Abbot was asleep. Morton removed the mouthpiece.

“Your patient is ready,” he said to Dr. Warren, triumphantly.<sup>53</sup> Dr. Warren removed a vascular tumor from Abbot’s neck without incident. When Gilbert Abbott awoke, he confirmed that he had felt no pain.

Dr. Warren, remembering the taunts that had been hurled at Horace Wells, exclaimed “Gentlemen, this is no humbug”. And with that, in the room that would become known as the Ether Dome, the world was changed and the age of anesthesia had begun!

My group spent about twenty minutes in the ether dome. I was surprised that the room is still used for lectures, since it was declared a national historic site in 1965. You can visit it any day from 9 am to 8 pm unless it is in use.<sup>54</sup> The Ether dome was smaller than I expected. We would see Morton’s actually glass globe inhaler and ether sponge in the nearby excellent museum of surgical and anesthesia history.

When the Ether Dome was an operating room, in the days before aseptic surgery, physicians and medical students would sit here in their street clothes and watch operations. On the wall at the front of the room is a painting depicting what the room and the people in it looked like on Ether Day. The painting was completed in 2000 when the medical staff commissioned a portrait artist and then got a drama department to make them look like the stars of Ether Day with make up and period costumes.<sup>56</sup> Some photos of the ether dome can be found here.<sup>58</sup>

So what happened after Ether Day? After the success of Ether Day, William Morton continued to operate as a hustler, trying to get as much for himself as possible. News of Morton’s success quickly spread. This was a huge boon to anyone who needed surgery, and to all of mankind, but it didn’t work out as planned for two greedy men, Charles Jackson and William Morton. When Jackson saw all the attention William Morton was getting for Ether Day, he abruptly changed his tune and instead of distancing himself from Morton’s “Letheon”, he tried to claim credit for it.<sup>59</sup> Both men would battle each other and the medical profession over ownership of Ether Day. Apparently, this was a recurring theme in Jackson’s life. A discovery would be announced by someone, Jackson would then claim prior discovery, and a controversy would ensue.<sup>65</sup>

William Morton didn’t really get any satisfaction either. Morton attempted to get what was probably the first patent for a drug and eventually did receive a patent for his “Letheon”,<sup>60</sup> but the patent was largely ignored. Morton never made the fortune he had dreamed of.



*The first use of ether as an anaesthetic in 1846 by the dental surgeon W.T.G. Morton (detail from an oil painting by Ernest Board)*

And perhaps this is what should have all turned out. Morton hadn't really discovered or invented anything useful. His glass ether inhaler device and his orange smelling "Letheon" were basically just a sham he had invented to make it look like he had invented something. And others, such as Crawford Long and the unfortunate Horace Wells and even Charles Jackson had arguably contributed more to Gilbert Abbot's painless surgery than Morton had. Dr. Warren the surgeon also certainly deserves a big share of the credit. It is probably difficult to overestimate Dr. Warren's influence in the medical community in 1846. Without his courage, open mind and noble dedication to the relief of human suffering, the widespread use of ether would not have occurred so quickly.

But the selfish scoundrel William Morton still deserves some credit, I think. Without him, Ether Day would not have been possible. Crawford Long didn't have the vision to tell the world about his findings. Charles Jackson didn't have the courage or foresight to put his knowledge into practice. And poor Horace Wells lacked the confidence and nerve to show the world what was possible. Where the drama of the situation terrified Wells, Morton's showmanship won through.<sup>62</sup> In the end, William Morton's desire to help himself helped everybody.

Boston is famous for the American Revolution, but another revolution also began there. The anesthesia revolution might be even more important. The introduction of anesthesia was one of the most important events in all of human history. It was voted the third most important advance in medicine, after only proper sanitation and antibiotics.<sup>64</sup> In addition to giving me a job, it made great advances in surgery possible, and profoundly reduced human suffering. Many of the articles and books I read commented that by showing that it was possible to conquer pain and suffering, anesthesia made people more sensitive to the pain of others and made people more compassionate. Personally, I had never really thought about what it would be like to have surgery without anesthesia, or even worse, have the same thing happen to your children or other loved ones, but it must have been a pretty awful experience. We have it pretty good and we take a lot for granted. We owe a lot to Dr. Warren and the shady, interesting characters of Ether Day.



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# ■ MY CONVERSATION

*An attempt to explain my philosophy of art and the manner in which I create a painting...*

**Marlessa Wesolowski**  
Artist in Residence  
St. Paul's Hospital Healing Arts Program

Painting allows me to explore and express in ways I could not otherwise. Words and prose come second to the pursuit of a visual journal of my understandings. Art is therapeutic for me - an authentic expression that has healing power. My art is a world where I can bring forward my unconscious and merge it with awareness. It is an opportunity to learn about myself. What I feel and connect with physiologically and emotionally become markings of the inner mind. It is the realization of those patterns that drive my need to extract them into physical images that become works of art. Painting has always been intimately connected to my spiritual and philosophical appreciations and becomes an intimate dialogue with this medium of art. It is by these means that the painting becomes the history of a conversation. Fundamental changes can occur in the process and are captured and illuminated on canvas.

My work is influenced by abstract expressionism. This abstract influence has resulted in larger pieces that are without recognizable images as seen in nature, such as landscapes or figures. Rather, they are non-objective compositions of strict and sometimes chaotic order. This geometric dialect is not so much a numerical presentation as it is an arrangement of dynamic lines, improvisation of shapes and symbols, and vibrant blocks of layered colour, free of any representations toward an obvious reality.



*Marlessa Wesolowski (2007)*

From a technical perspective, my geometric work begins with a flat surface upon which I begin a methodical layering technique. I systematically apply tape to the canvas that becomes sharply angled shapes. It is within these taped parameters that I apply paint. So it goes, over and over the process repeats itself until a three-dimensional image emerges that has principally been of preconception. Specific sources of reality inspire me such as; clouds with sharp edges, nature, and time spent with people. It is a sense of curiosity and openness that allows me to explore my unique inner landscape of emotions, ideas, and daydreams. Each painting often lays the foundation or direction for the next. The canvas is a place where I can unravel complex questions about lived experience while continuing to cultivate my creative growth and endeavours.

As an artist in residence my work is immersed in a hospital setting where the intention is to have a continuous presence and reflection; it is a position best served in mindfulness. The focus of course, is on people in a state of crisis of the body, mind, and/or soul, and the reflection of a human in need of a deeper and perhaps, spiritual connection or understanding. Reflection and mindfulness for me are most productive when centered in a creative mode, however, vulnerably.



An abstract painting composed of numerous overlapping, three-dimensional rectangular blocks in various colors including red, orange, yellow, green, blue, and brown. The blocks are arranged in a way that creates a sense of depth and movement, with some appearing to recede into the background while others project forward.

# Healing Arts Program

*Primal (inset image; acrylic on canvas, 2007) by Marlessa Wesolowski*

## ■ ART+HOSPITAL=HEALING

**Marlessa Wesolowski**

Artist in Residence, St. Paul's Hospital Healing Arts Program

The discipline of art seeks to connect people and develop a deeper knowledge of the human condition. It does so by eliciting our innate search for meaning by welcoming us to be curious of our potential. The creativity, playfulness, and connection that art can provide helps to gain knowledge of self and others through stimulating our imaginations and may provide a platform for dialogue that typically does not have cultural boundaries. Through supported creativity using visual arts I help people in their own creative process to transform their thoughts, feelings, and relationships into visual statements, while deepening their experience and celebrating their uniqueness. The ability to create enriches our lives in substantial and meaningful ways.

More and more universities and healthcare organisations are now acknowledging the importance of the arts to health and healthcare and when integrated into this culture, the arts can promote compassion, healing, and support.

I have been the principal person of the arts-based, patient-oriented Healing Arts Program of St. Paul's Hospital in Saskatoon since it began in 2005. In addition to the patient population, I work independently and collaboratively with people of the hospital and community groups to develop and deliver all-inclusive arts-based services that enhance and support holistic care. In this environment as the artist in residence I contribute to the direction and provide support for the integration and development of a

creative culture. I strive to cultivate a progressive direction through positive engagement for those who become involved, where my focus is on creative potential and the expressions thereof. A volunteer of the program says:

"I always knew creative expression had some therapeutic effects but this concept truly came to life during my experience at the hospital... I have learned that a hospital environment isolates patients from the real world and that art can sometimes set them free by helping them retrieve their creativity. In class, there is constant talk of patient-centered care; the Healing Arts Program really emphasizes this type of care... During my time [there], I also learned how to be more patient and empathetic, which are important qualities for a health care practitioner". (Healing

Arts Program Volunteer, U of S Pharmacy Student, Service Learning Reflection). In the hospital context, art seeks to help people develop a deeper knowledge through their creative distinctiveness. My position in healthcare works on a principle understanding that people in hospital may have an unidentified need to express deep concerns regarding their experience that surrounds difficult contextual factors. Creating opportunity for an arts-based means to explore and express these feelings makes this position a complex role that extends beyond creative expression. As such, artists in residence in healthcare settings are not therapists, but accomplished artists who are skilful at facilitating the use of art as a means for people to go beyond their current understanding in the course of assessing personal experience. "Painting occupies most of my spare time. Instead of boredom of feeling sad about myself I have other ways of motivating myself. I feel cheerful when I paint because I am able to

hum or sing ... and my memories are focused on my work instead of my pain. I don't have time to feel sorry for myself because I've lost most of my limbs. Instead of feeling that way, I feel more strength when it comes to painting....I can build up my self-esteem or the way I feel about life. I can express myself with this. I feel good that I am doing something." - Patient Supported creativity encourages people in their personal journey of self-exploration and creativity. Imagination is forming new images that help make knowledge applicable in solving problems and is fundamental to integrating experience and the learning process. My artist practice is a method that cultivates the individual and concentrates more on processes associated with concepts of self in a healing environment than it does the aesthetic quality of the art created. Presence for those in this process is a fundamental principle in my approach and is considered by many humanistic theorists to be central to effecting meaningful change.

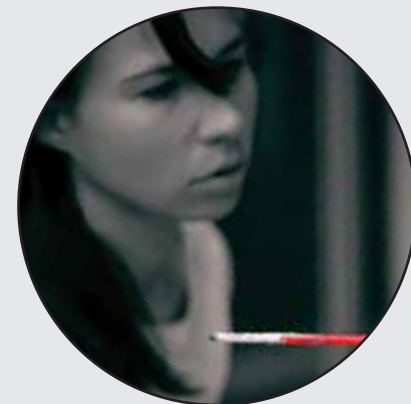
"I painted for a patient who was also paralyzed. The patient gave the orders and I was their hand. When I was finished, they told me to write the words Live, Laugh and Love on the bottom of the page and this painting is now on their hospital room wall. The amount of hope this person had to get better was very moving." (Healing Arts Program Volunteer, U of S Pharmacy Student, Service Learning Reflection).

Connecting on an individual level with people I interact and create with, is the essence of my work. This position requires being sensitive to recognize that each person is not completely as his or her physical illness states, but as they are in mind and spirit, in moments of suffering and acceptance of illness, or hope and joy in recovery. Caring with an unconditional acceptance of a person's creative expression, allows one to be available to respond to their vulnerability with an empathy and compassion that is genuine and humane.

**Marlessa Wesolowski** is a multidisciplinary artist, arts-based practitioner, and supporter for the integration of the arts into health care and community health. Marlessa's work has been exhibited nationally and she regularly discourses and facilitates workshops in the potential of art, health, and creative spontaneity.

Her work as an artist focuses on connecting with patients and the community through arts based projects founded in a philosophy that is inclusive, collaborative, interdisciplinary, and creative.

Since its beginning, Wesolowski has been the principal person of the arts-based, patient and community oriented program of St. Paul's Hospital in Saskatoon. In this environment as artist in residence she engages in a whole-person approach to arts in health care. Since 2005, she has worked in the studio areas at St. Paul's Hospital, where creativity is encouraged and rediscovered in a healing context.



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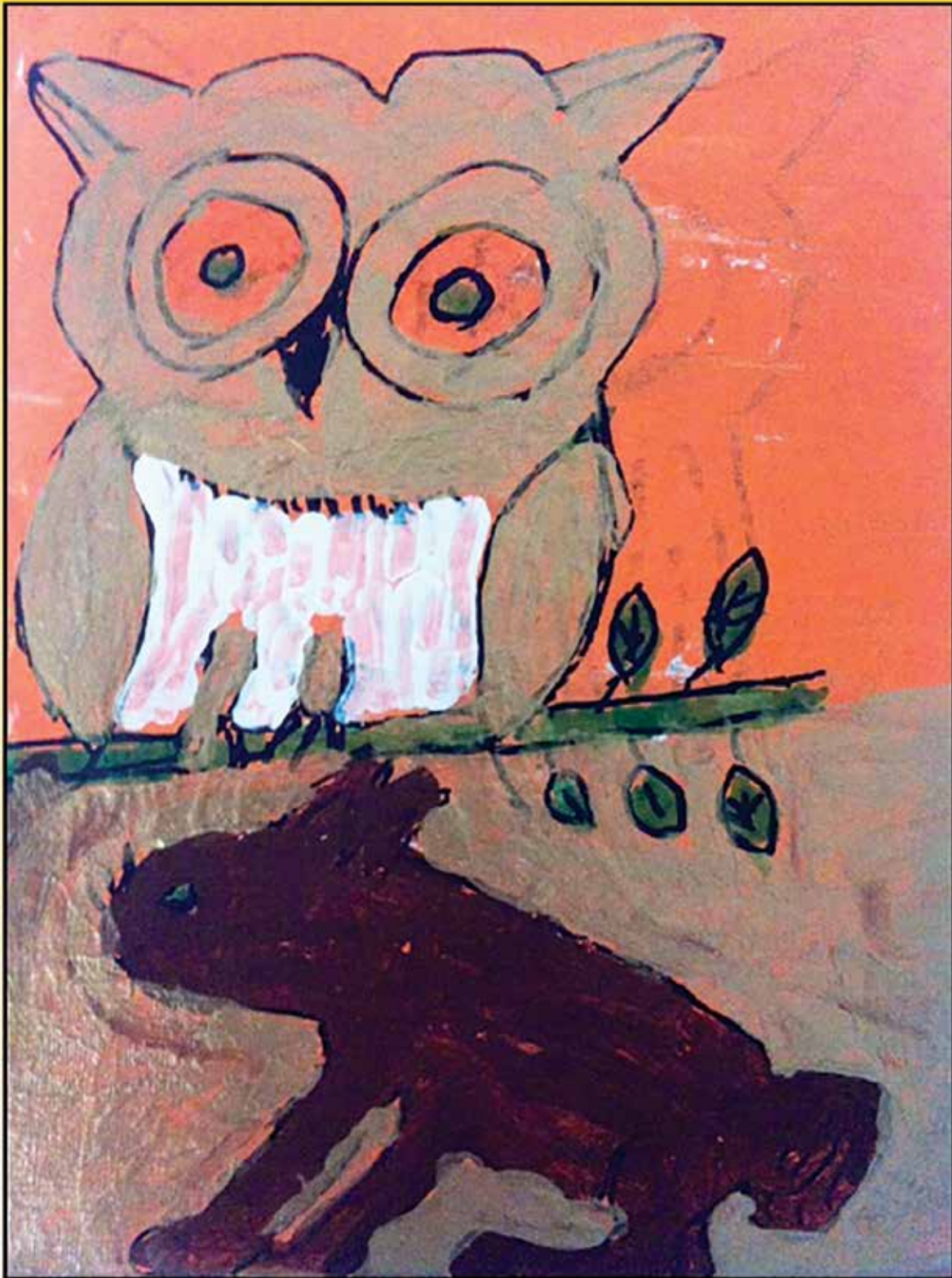
*Mr. Bird paints with a paintbrush specially adapted to his hand, which has been bandaged for a number of years. Picture shows Mr. Bird painting whilst on dialysis.*

*By permission of Thompson Bird, St. Paul's Healing Arts Program*

# OLGA The Golden Owl

Olga the golden owl lived at Churchill River. One day while strolling along the banks of the Churchill river she met a baby white rabbit. All of sudden her stomach started to rumble and all she could dream about was rabbit stew. She was about to hunt the helpless, fragile baby rabbit when something over came her emotions. Although she was very hungry, she pitied the poor rabbit. She realized that the baby rabbit was injured and starving herself. Olga forgot about her own hunger. She decided to try and help the poor rabbit. The baby rabbit was trying hard to get away from Olga, when Olga realized that the little rabbit could not even stand on her feet. She was so scared and helpless that Olga decided to sooth and feed her. It took Olga awhile to find certain food that she could nurture Rene the rabbit back to a healthy state with. The longer they stayed together it became known to them their connection was unique. There was a close attachment so strong that nothing would separate them. After a few weeks Rene was healthy again. She eventually became full grown and it was time for them to move on with their lives. They promised to each other that they would keep in touch, and they went their own separate paths.





*Olga the Golden Owl by Thompson Bird*

# This JUST-IN

Mark was a 37-year old husband and father. He was out with his kids one Sunday enjoying a beautiful Saskatchewan winter day. The skidoo lost control over a divot though, and Mark flipped over the handlebars and landed on his head. The helmet shattered. His wife saw the event and called 911. Everything else was a blur.

Mark had a serious head injury along with multiple long bone fractures. His lungs and spleen were contused. Neurosurgery was paged and as the resident on call I walked into the resuscitation bay with a mission: do whatever I could to save this man's life. The trauma team was there working in full force; the orthopedic resident was diligently assessing the extent of his injuries. General surgery was swiftly putting in a chest tube. Anesthesia was carefully monitoring the airway. Blood was being drawn and the Xray technologist was waiting patiently. I looked at the patient and checked the pupils. Non-reactive. Corneals absent too. I made my way to the computer to look at the scan. The scan was not reassuring, and the injuries to Mark's brain were not compatible with life. Mark was going to die. The same Mark who was playing with his kids a few hours prior. I thought to myself, "How am I going to tell his family?"

A typical day starts as I walk through the Emergency Room to get to the OR locker room. Sometimes the ER is bustling, other days there is an almost unsettling calm. Remnants of an early morning trauma litter the halls. Family members pace, worried.

The morning progresses as I walk down the hall towards the ICU where rounds begin. On the way, there are rooms that are never empty. You can smell the remnants of last night's supper and old Tim Horton's coffee. Just inside are the families of some of the most critically ill patients in the hospital. Some are wide-awake, some are finally getting some sleep, but all are confused. Herein lies one of our greatest duties as surgeons in training: our commitment to the family.

How can it be that one minute a loved one is skiing, driving, sleeping, and the next they are en route to a hospital? How is it that things can change so quickly? I wonder about the answers to these questions almost daily. Perhaps these are some of the very questions that plague the grieving sibling, daughter or parent. One thing is certain: they desperately want answers, meaning, and a sense of justice.

## FAMILY MEETING



**Justine Pearl**  
Senior Neurosurgery Resident  
Department of Surgery  
University of Saskatchewan and  
Saskatoon Health Region

I have often wondered about a family's expectations of their loved one's surgeon. Standard of care. Meticulous surgical technique. Complication avoidance. But above all, I have come to learn that family members want to know that the surgeon cares for their ill family member as if he or she were their own. That even if the outcome were bad, the surgeon still cared about that patient enough to realize that there is a family left behind. One way we can demonstrate this dedication is with the family meeting.

The family meeting is a sacred event for both the treating physician and the family. It often takes place at odd hours and even odd places. Sometimes it is outside the resuscitation bay, families in their pajamas, unkempt, having been woken from an otherwise peaceful slumber by a veritable nightmare. Other times, it is orchestrated down to the last detail: the time (usually at a more civilized hour), the place, the attendees, the friends and family travelling frantically to Saskatoon to make it in time, the relatives on Skype or on the phone, struggling to hear every detail. A hallway, a quiet room, the resuscitation bay. Day, night, dawn. But they all have one similarity: time stops. People trying to reach these family members have their calls ignored. The pager rings and is silenced. Nurses and doctors bustle around us. But the family pays no attention. The doctor is talking, and answers may follow.

How does a physician learn to conduct a family meeting? In medical school, we had simulations on "breaking bad news," and these can be somewhat helpful. However, nothing prepares a resident for the emotional charge that comes with giving bad news. Often a resident has to prepare him/herself for the bad news as well, as it represents a failure of what we set out to do: save lives. Every case is different but one thing remains the same: that resident is about to change the lives of strangers. A bond has to be formed nearly immediately and the tone of the room gauged. The needs of other patients must be gently deferred. Residents are often the only doctors available to break bad news in the middle of the night and are often ill prepared for the wave of feelings that ensues.

Neurosurgery, like other surgical specialties, can be burdened with poor outcomes. Sometimes the conclusion takes months to occur, other times a patient's life is lost before we even had a chance. Giving bad news often occurs more frequently than good news in the halls of the ICU. For this reason, every resident must be comfortable holding a family meeting and breaking devastating news.

It is never easy, but it is one of the most important things we can do to show that we are committed to our patients, even if they have passed away.

The time came to meet with Mark's wife and extended family. An eerie silence came over the room as I walked in, and in retrospect I think the family knew that I did not have positive news. I explained the nature of Mark's injuries and how we were unable to save him, despite our best efforts. Some members were sobbing, others stoic and quiet. I sat with the family for what seemed like hours but was probably only a few minutes. I asked them if there was anything I could do. Mark's wife spoke first, a strength in her voice that was undeniable. "He wouldn't want to live incapacitated. Make him comfortable and we will say goodbye." I reminded her I did not need a decision now. She said, "Thank you."

The thank you shocked me. Who says thank you after receiving bad news? Is that an indication that the meeting went "well"? Is the family at peace? Is there an element of denial?

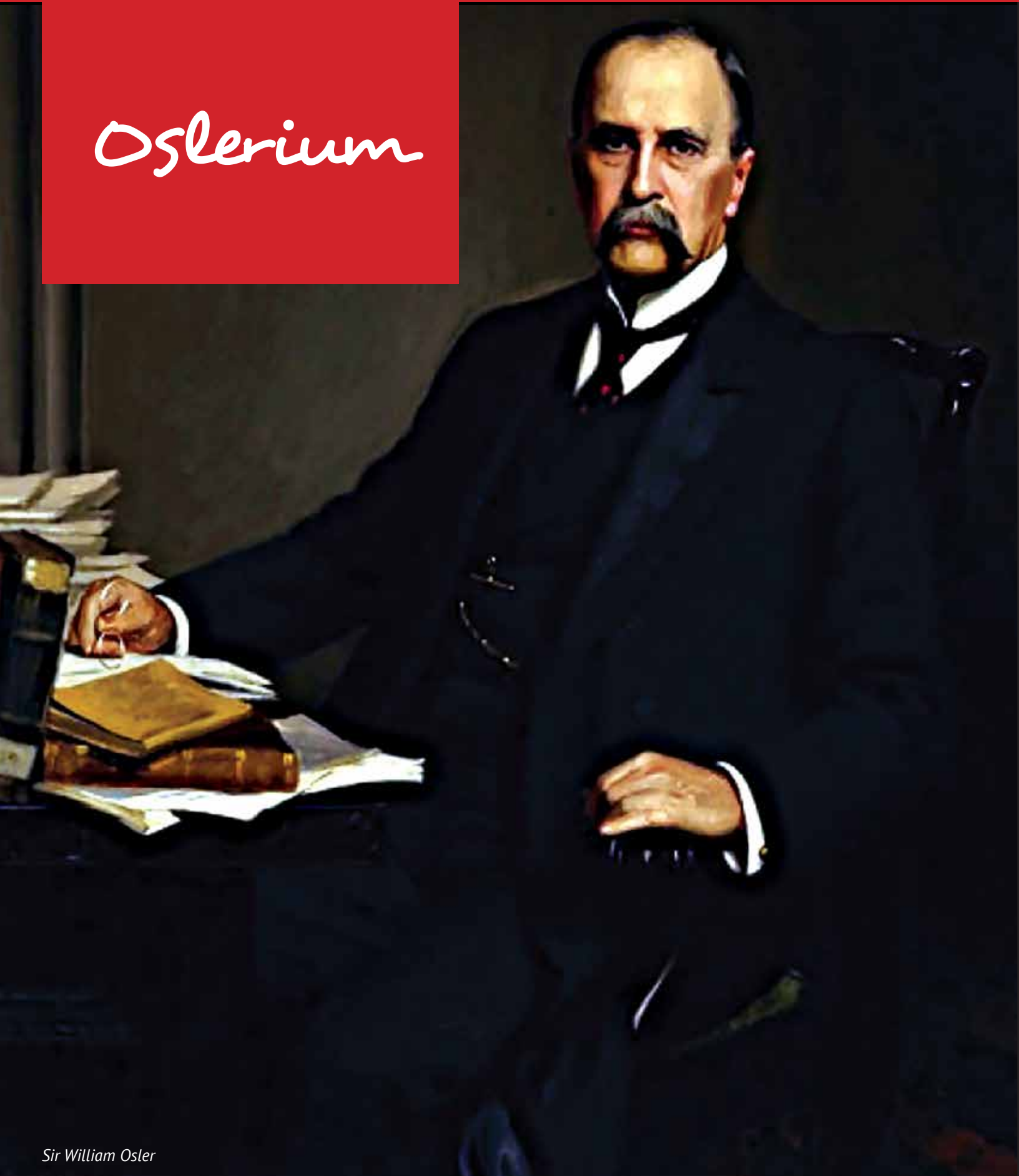
I wonder if the thank you stems from their realization that even though the life is lost, the dedication persists. One would expect that if a doctor's primary mandate is the care and survival of a patient, and that the particular life in question were lost, the doctor's involvement would cease. The family meeting is living proof that this is simply never the case. The doctor's duty does not end with a patient's last breath. Their duty shifts, rather, over to the family left alone.

In the end, I have come to realize that all family members want out of the family meeting is your time. They want the knowledge that even if the future is bleak, their physician cares for their loved one, and cares enough to stop time and meet with them, sit with them, pray with them. They want to know that their loved one hasn't been written off just because they are closer to death than to life, and that they are not alone.

The day ends much as it started, walking through the Emergency Room to the parking lot. At that time, every day, I say a thank you of my own. My thankfulness stems from the gift we physicians have been given. The honour of sitting with a family in despair and trying to make those moments even a little easier for them. It is a gift and a privilege to be let into a stranger's life, and I promise myself as I leave that I will never take that for granted.



# Oslerium



*Sir William Osler*



Every issue of "Surgical Humanities" will carry an excerpt from the works of the pre-eminent Canadian physician Sir William Osler (1849-1919).

The life of William Osler in itself provides a fundamental justification for an education and engagement in the surgical humanities. Osler's medical textbook, "Principles and Practice of Medicine" (first published 1892) widely used as a standard and acclaimed though it was during his lifetime, has largely been forgotten, or remembered only in relation to his other achievements. But in the other great body of his work - his speeches, his essays and his commentaries on the profession, on the business of daily living, on professionalism, on our profession's imperative for humane practice and on the wisdom of our forbears - he has achieved immortality.

Osler's father, Rev. Featherstone Osler, was a missionary sent from Cornwall, England, to the backwoods of Ontario. William Osler was born in Bond Head, Upper Canada (now Ontario) to Featherstone and Ellen Osler on the 12th of July, 1849.

This was a remote town in an already remote country at the time, and Osler was sent for his schooling to Trinity College School, an independent school for boys in Port Hope, Ontario.

In the fall of 1868, Osler enrolled in the Toronto School of Medicine, but soon transferred to McGill, because it had better clinical opportunities. He graduated from the McGill University School of Medicine in 1872 and taking advantage of an older brother's generosity, Osler spent the next two

years studying in Europe and visiting the great clinics and hospitals of Berlin, Vienna and London.

Upon his return to Canada, he was appointed to the faculty of McGill University and spent the next five years teaching physiology and pathology in the winter term and clinical medicine in the summer.

In 1884, Osler was appointed to the staff of the University of Pennsylvania as Professor of clinical medicine and this was the start of a 21 year period of work and achievement in the United States. His appointment to the founding professorship and staff of the new John Hopkins Medical School in Baltimore in 1888 marked the beginning of a very fruitful association with the "Big Four" - the pathologist William Welch, surgeon William Halstead, gynecologist Howard Kelly (and Osler himself).

Together, the "big four" would introduce far reaching changes in medical education that are still felt today - the clinical clerkship for medical students and the residency system of training were both products of this association. About this time, Osler also began a series of brilliant speeches and addresses whose impact would be felt far beyond the audiences for whom they were intended. The "Principles and Practice of Medicine," a monumental treatise, was published in 1892.

William Osler and Grace Revere were married in 1892. Their only child, Revere Osler was killed in action in Belgium during one of the many disastrous and ill-fated campaigns of the first world war.

In 1905, Osler was offered the prestigious Regius professorship of Medicine in Oxford, England, and the Oslers made the last move of their eventful lives, across the Atlantic, once more, to England. Another distinguished period of William's career followed - he was knighted and continued to write and deliver memorable addresses to distinguished audiences and societies.

Sir William Osler died of pneumonia in 1919, a complication of the influenza pandemic of 1918-1920.

Harvey Cushing, the pioneer neurosurgeon and Osler's biographer called him, "one of the most greatly beloved physicians of all time."

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Note: Sir William's brother, Edmund Osler (who was a railway baron) has a living connection with Saskatchewan - the town of Osler (about 20 min North of Saskatoon) is named for him; and there is an "Osler Street" close to the Royal University Hospital.

*The Editor*

*This issue's "Oslerium" contains excerpts from William Osler's address to the graduating class and students of Yale University on April 20, 1913. →*

# A WAY OF LIFE

William Osler's speech to the graduating class  
and students of Yale  
April, 1913

Fellow students,

Every man has a philosophy of life in thought, in word, or in deed, worked out in himself unconsciously. In possession of the very best, he may not know of its existence; with the very worst he may pride himself as a paragon. As it grows with the growth it cannot be taught to the young in formal lectures. What have bright eyes, red blood, quick breath and taut muscles to do with philosophy? Did not the great Stagirite say that young men were unfit students of it? – they will hear as though they heard not, and to no profit. Why then should I trouble you? Because I have a message that may be helpful. It is not philosophical, nor is it strictly moral or religious, one or other of which I was told my address should be, and yet in a way it is all three. It is the oldest and the freshest, the simplest and the most useful, so simple indeed is it that

some of you may turn away disappointed as was Naaman the Syrian when told to go wash in Jordan and be clean. You know those composite tools to be bought for 50 cents, with one handle to fit a score or more of instruments ... the boy has one, the chauffeur slips one into his box, and the sailor into his kit, and there is one in the odds-and-ends drawer of the pantry of every well-regulated family. It is simply a handy thing about the house, to help over the many little difficulties of the day. Of this sort of philosophy I wish to make you a present – a handle to fit your life tools.

My message is but a work, a Way, and easy expression of the experience of a plain man whose life has never been worried by any philosopher higher than that of the shepherd in *As You Like It*. I wish to point out a path in which the wayfaring man, though a fool, cannot err; not a system to be worked out painfully only to be discarded, not a formal scheme, simply a habit as easy – or as hard! – to adopt as any other habit, good or bad.

Life is a habit," a succession of actions that become more or less automatic. This great truth, which lies at the basis of all actions, muscular or psychic, is the keystone to the teacher of Aristotle, to whom the formation of habits was the basis of moral excellence. "In a word, habits of any kind are the result of actions of the same kind; and so what we have to do, is to give a certain character to these particular actions" (Ethics). Lift a seven months old baby to his feet – see him tumble to his nose. Do the same at twelve months – he walks. At two years he runs. The muscles and the nervous system have acquired the habit. One trial after another, one failure after another, has given him power. The same great law reaches through mental and moral states. "Character," which partakes of both, in Plutarch's words, is "long-standing habit."

Now the way of life that I preach is a habit to be acquired gradually by long and steady repetition. It is the practice of living for the day only, and for the day's work, Life in day-tight compartments. "Ah," I hear you say, "that is an easy matter, simple as Elisha's advice!" Not as I shall urge it, in words which fail to express the depth of my feelings as to its value. I started life in the best of all environments – in a parsonage, one of nine children. A man who has filled Chairs in four universities, has written a successful book, and has been asked to lecture at Yale, is supposed popularly to have brains of special quality. A few of my intimate friends really know the truth about me,

as I know it! Mine, in good faith I say it, are of the most mediocre character. But what about those professorships, etc.? Just habit, a way of life, an outcome of the day's work, the vital importance of which I wish to impress upon you with all the force at my command.

Dr. Johnson remarked upon the trifling circumstances by which men's lives are influenced, "not by an ascendant planet, a predominating humour, but by the first book which they read, some early conversation which they have heard, or some accident which excited ardour and enthusiasm." This was my case in two particulars. I was diverted to the Trinity College School, then at Weston, Ontario, by a paragraph in the circular stating that the senior boys would go into the drawing-room in the evenings, and learn to sing and dance – vocal and pedal accomplishments for which I was never designed; but like Saul seeking his asses, I found something more valuable, a man of the White of Selborne type, who knew nature, and who knew how to get boys interested in it. The other happened in the summer of 1871, when I was attending the Montreal General Hospital. Much worried as to the future, partly about the final examination, partly as to what I should do afterwards, I picked up a volume of Carlyle, and on the page I opened there was the familiar sentence – "Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand." A commonplace sentiment enough, but it hit and struck and helped, and was the starting point of habit that has enabled me to utilize to the full the single talent entrusted to me.

The workers in Christ's vineyard were hired by the day; only for this day are we to ask for our daily bread, and we are expressly bidden to take no thought for the morrow. The chief worries of life arise from the foolish habit of looking before and after. As a patient with double vision from some transient unequal action of the muscles of the eye finds magical relief from well-adjusted glasses, so, returning to the clear binocular vision of to-day, the over-anxious student finds peace when he looks neither backward to the past nor forward to the future.

I stood on the bridge of one of the great liners, ploughing the ocean at 25 knots. "She is alive," said my companion, "in every plate; a huge monster with brain and nerves, an immense stomach, a wonderful heart and lungs, and a splendid system of locomotion." Just at that moment a signal sounded, and all over the ship the water-tight

compartment were closed. "Our chief factor of safety," said the captain. "In spite of the Titanic," I said. "Yes," he replied, "in spite of the Titanic." Now each one of you is a much more marvelous organization than the great liner, and bound on a longer voyage. What I urge is that you can learn to control the machinery as to live with "day-tight compartments" as the most certain way to ensure safety on the voyage. Get on the bridge and see that at least the great bulkheads are in working order. Touch a button and hear, at every level of your life, the iron doors shutting out the Past – the dead yesterdays. Touch another and shut off, with a metal curtain, the Future – the unborn to-morrows. Then you are safe – safe for to-day!

Shut out the yesterdays, which have lighted fools the way to dusty death, and have no concern for you personally, that is, consciously. They are there all right, working daily in us, but so are our livers and our stomachs. And the past, in its unconscious action on our lives, should bother us a little as they do. The petty annoyances, the real and fancied slights, the trivial mistakes, the disappointments, the sins, the sorrows, even the joys – bury them deep in the oblivion of each night. Ah! but it is just then that to so many of us the ghosts of the past,

*Night-riding Incubi*  
*Troubling the fantasy,*

come in troops, and pry open the eyelids, each presenting a sin, a sorrow, a regret. Bad enough in the old and seasoned, in the young three demons of the past sins may be a terrible affliction, and in bitterness of heart many a one cries with Eugene Aram, "Oh God! Could I so close my mind, and clasp it with a clasp." As a vaccine against all morbid poisons left in the system by the infections of yesterday, I offer "a way of life." "Undress," as George Herbert says, "your soul at night," not by self-examination, but by shedding, as you do your garments, the daily sins whether of omission or of commission, and you will wake a free man, with a new life. To look back, except on rare occasions for stock-taking, is to risk the fate of Lot's wife. Many a man is handicapped in his course by a cursed combination of retro- and intro-spection, the mistakes of yesterday paralysing the efforts of to-day, the worries of the past hugged to his destruction, and the worm Regret allowed to canker the very heart of his life. To die daily, after the manner of St. Paul, who makes each day the epitome of life... *End of Part I. Part II to follow in the next issue of the JSH!*



# Poetry Corner

## SHE'S SO FRAGILE

She's So Fragile  
Please treat her with care  
For those who attempt to abuse her  
Must beware.....

She's my angel from heaven, a brilliant flash of light  
She melts in my memory and fills my every thought  
with delight

Do I have the right to want her?  
.....I dare not say  
Do I have the right to possess her?  
.....Though there must be a way

If given the chance  
I would love her forever  
And make sure only love comes her way  
For she is so fragile .... like flower petals she could  
suddenly float away.

This issue's poet is **Erick McNair**.

Originally from Washington DC., after graduating from Georgetown and Howard Universities, Erick trained as a perfusionist at the Cleveland Clinic. He is now part of the Cardiothoracic team at the Royal University Hospital in Saskatoon, an Assistant Professor and Research Scientist at the University of Saskatchewan.

# PERFUSIONIST ON CALL

Three o'clock in the morning  
I slumber so soundly  
The pager goes off so loudly!  
Six inches of snow  
Don't they realize its 30 below?.....

Someone's been stabbed?  
A heart attack? AAA?  
Or an MVA??  
Doesn't really matter.... I'm on my way!

Twenty years ago  
My pager would go off...  
I was so excited!  
Now all I do is scoff!

I drive to work being careful....  
Not get caught speeding....  
But time is of the essence if a patient is bleeding

On pump...off pump  
Balloon pump...cell saver  
LVAD, RVAD.....BiVAD  
ECMO...Don't know got to go!

In the OR...we know the routine  
We just perform it faster...unlike a machine  
Our eyes don't meet until we get to the unforeseen  
Sometimes I still wonder at the brilliance as I look around the room  
Most times the patient pulls through but every so often.....gloom

I make it back home and slip into bed  
Trying to forget the last few intense hours still dancing in my head.  
More calls .....tonight I dread!

# ZHIVAGO: The Doctor in Literature

**T**he doctor not only writes poetry, novels, essays and short stories - he or she also lives in them. This column will celebrate works of literature that celebrate (or denigrate) a physician and his or her work. Its authors will only uncommonly be physicians - it would surely be a fallacious presumption to assume that only a doctor can comment on his or her own life and manners. Indeed, it may be argued that those who gaze upon our lives and times from without are better equipped to discern the wood from the trees; and that they are free of the biases that human beings are subject to when describing other, similar, human beings.

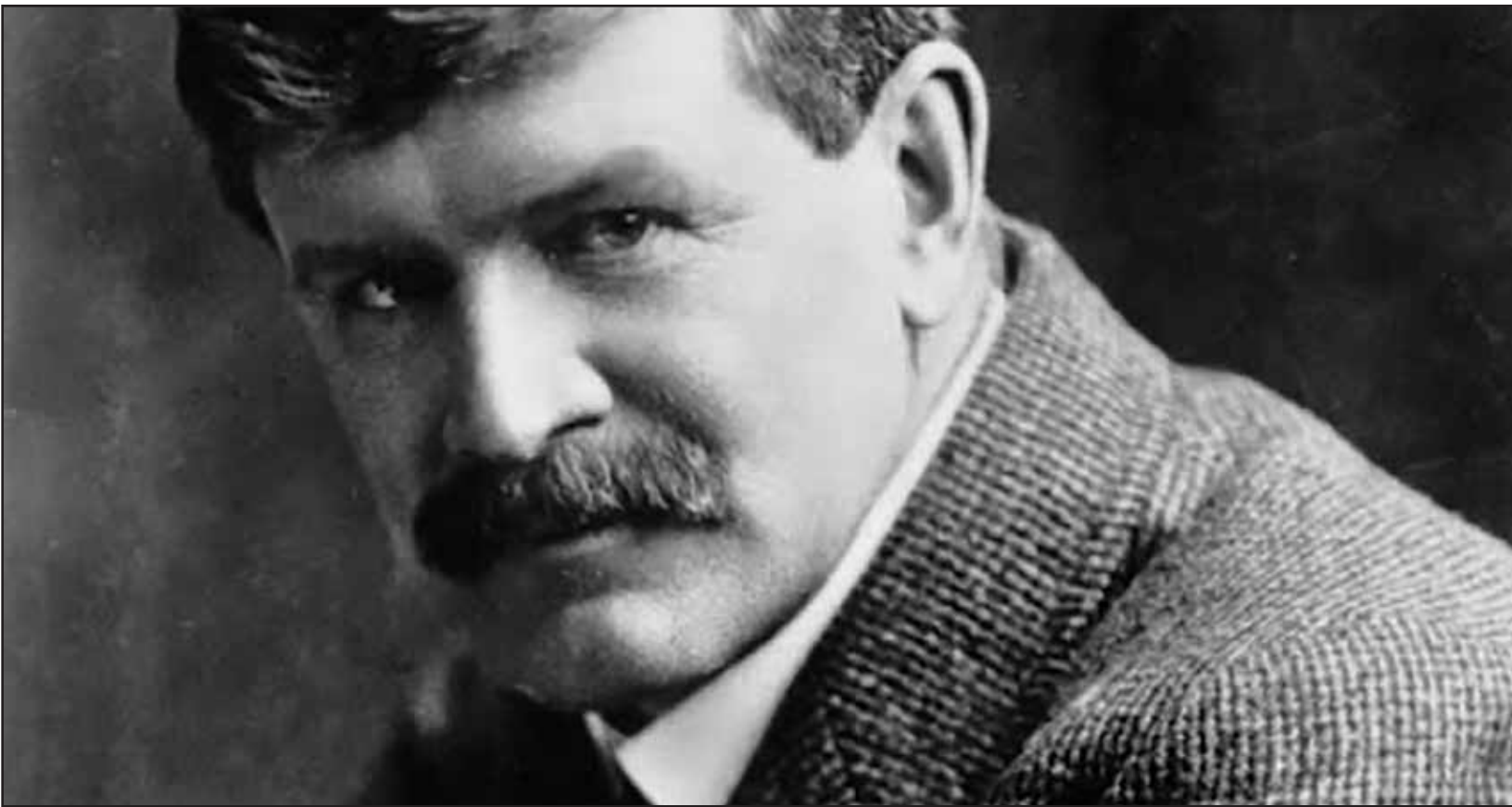
The title is from Russian novelist Boris Pasternak's immortal, lyrical novel, "Dr. Zhivago." The film, bearing the same name was directed by David Lean and starred Omar Sharif and Julie Christie.

*The Editor*

STEPHEN  
BUTLER  
LEACOCK

*Personally, I  
would sooner have  
written "Alice  
in Wonderland"  
than the whole  
Encyclopædia  
Britannica.*





**Stephen Butler Leacock** (1869-1941) was born in Hampshire, England and emigrated with his family to Canada when he was six years old.

The family settled on a hundred acre farm on the shores of Lake Simcoe in Ontario. This brave foray into farming was largely a failure, but the family found a few savings to send him to school in Upper Canada College in Toronto. Thereafter, he largely paid his way through university by working in various jobs - first he graduated from the University of Toronto, then earned a PhD in Political Economy from the University of Chicago.

Leacock started a career in economics with McGill University that was to last for most of his professional life. His book on political theory and economics was standard reading for several years.

But he achieved world-wide fame and recognition not for his academic work, but for his numerous essays and commentaries of literary humour. By the early twentieth century, he was a “best-selling” author and was wealthy enough to build a magnificent summer house in Orilla, Ontario. This is now the site of the Stephen Leacock museum. There is also an annual Stephen Leacock Humour Prize for the best book of humour published in Canada.

We are familiar with the notion that literary fame, if it is real, must last much beyond the author’s own time. Leacock has achieved this fame - his humorous works are still read, enjoyed and studied all over the English speaking world, several generations after his death in 1944.

In the preface to his collection of essays, “Sunshine Sketches of a Little Town,” Leacock writes:

*“Many of my friends are under the impression that I write these humorous nothings in idle moments when the wearied brain is unable to perform the serious labours of the economist. My own experience is exactly the other way. The writing of solid, instructive stuff fortified by facts and figures is easy enough. There is no trouble in writing a scientific treatise on the folklore of Central China, or a statistical enquiry into the declining population of Prince Edward Island. But to write something out of one’s own mind, worth reading for its own sake, is an arduous contrivance only to be achieved in fortunate moments, few and far between. Personally, I would sooner have written “Alice in Wonderland” than the whole Encyclopædia Britannica.”*

# HOW TO BE A DOCTOR

**Stephen Butler Leacock**

Certainly the progress of science is a wonderful thing. One can't help feeling proud of it. I must admit that I do. Whenever I get talking to anyone (that is, to anyone who knows even less about it than I do) about the marvellous development of electricity, for instance, I feel as if I had been personally responsible for it. As for the linotype and the aeroplane and the vacuum house-cleaner, well, I am not sure that I didn't invent them myself. I believe that all generous-hearted men feel just the same way about it.

However, that is not the point I am intending to discuss. What I want to speak about is the progress of medicine. There, if you like, is something wonderful. Any lover of humanity (or of either sex of it) who looks back on the achievements of medical science must feel his heart glow and his right ventricle expand with the pericardiac stimulus of a permissible pride.

Just think of it. A hundred years ago there were no bacilli, no ptomaine poisoning, no diphtheria, and no appendicitis. Rabies was but little known, and only imperfectly developed. All of these we owe to medical science. Even such things as psoriasis and parotitis and trypanosomiasis, which are now household names, were known only to the few, and were quite beyond the reach of the great mass of the people.

Or consider the advance of the science on its practical side. A hundred years ago it used to be supposed that fever could be cured by the letting of blood; now we know positively that it cannot. Even seventy years ago it was thought that fever was curable by the administration of sedative drugs; now we know that it isn't. For the matter of that, as recently as thirty years ago, doctors thought that they could heal a fever by means of low diet and the application of ice; now they are absolutely certain that they cannot. This instance shows the steady progress made in the treatment of fever. But there has been the same cheering advance all along the line. Take rheumatism. A few generations ago people with rheumatism used to have to carry round potatoes in their pockets as a means of cure. Now the doctors allow them to carry absolutely anything they like. They may go round with their pockets full of water-melons if they wish to. It makes no difference. Or take the treatment of epilepsy. It used to be supposed that the first thing to do in sudden attacks of this kind was to unfasten the patient's collar and let him breathe; at present, on the contrary, many doctors consider it better to button up the patient's collar and let him choke. In only one respect has there been a decided lack of progress in the domain of medicine, that is in the time it

takes to become a qualified practitioner. In the good old days a man was turned out thoroughly equipped after putting in two winter sessions at a college and spending his summers in running logs for a sawmill. Some of the students were turned out even sooner. Nowadays it takes anywhere from five to eight years to become a doctor. Of course, one is willing to grant that our young men are growing stupider and lazier every year. This fact will be corroborated at once by any man over fifty years of age. But even when this is said it seems odd that a man should study eight years now to learn what he used to acquire in eight months.

However, let that go. The point I want to develop is that the modern doctor's business is an extremely simple one, which could be acquired in about two weeks. This is the way it is done.

The patient enters the consulting-room. "Doctor," he says, "I have a bad pain." "Where is it?" "Here." "Stand up," says the doctor, "and put your arms up above your head." Then the doctor goes behind the patient and strikes him a powerful blow in the back. "Do you feel that," he says. "I do," says the patient. Then the doctor turns suddenly and lets him have a left hook under the heart. "Can you feel that," he says viciously, as the patient falls over on the sofa in a heap. "Get up," says the doctor, and counts ten. The patient rises. The doctor looks him over very carefully without speaking, and then suddenly fetches him a blow in the stomach that doubles him up speechless. The doctor walks over to the window and reads the morning paper for a while. Presently he turns and begins to mutter more to himself than the patient. "Hum!" he says, "there's a slight anaesthesia of the tympanum." "Is that so?" says the patient, in an agony of fear. "What can I do about it, doctor?" "Well," says the doctor, "I want you to keep very quiet; you'll have to go to bed and stay there and keep quiet." In reality, of course, the doctor hasn't the least idea what is wrong with the man; but he DOES know that if he will go to bed and keep quiet, awfully quiet, he'll either get quietly well again or else die a quiet death. Meantime, if the doctor calls every morning and thumps and beats him, he can keep the patient submissive and perhaps force him to confess what is wrong with him.

"What about diet, doctor?" says the patient, completely cowed.





The answer to this question varies very much. It depends on how the doctor is feeling and whether it is long since he had a meal himself. If it is late in the morning and the doctor is ravenously hungry, he says: "Oh, eat plenty, don't be afraid of it; eat meat, vegetables, starch, glue, cement, anything you like." But if the doctor has just had lunch and if his breathing is short-circuited with huckleberry-pie, he says very firmly: "No, I don't want you to eat anything at all: absolutely not a bite; it won't hurt you, a little self-denial in the matter of eating is the best thing in the world."

"And what about drinking?" Again the doctor's answer varies. He may say: "Oh, yes, you might drink a glass of lager now and then, or, if you prefer it, a gin and soda or a whisky and Apollinaris, and I think before going to bed I'd take a hot Scotch with a couple of lumps of white sugar and bit of lemon-peel in it and a good grating of nutmeg on the top." The doctor says this with real feeling, and his eye glistens with the pure love of his profession. But if, on the other hand, the doctor has spent the night before at a little gathering of medical friends, he is very apt to forbid the patient to touch alcohol in any shape, and to dismiss the subject with great severity.

Of course, this treatment in and of itself would appear too transparent, and would fail to inspire the patient with a proper confidence. But nowadays this element is supplied by the work of the analytical laboratory. Whatever is wrong with the patient, the doctor insists on snipping off parts and pieces and extracts of him and sending them mysteriously away to be analysed. He cuts off a lock of

the patient's hair, marks it, "Mr. Smith's Hair, October, 1910." Then he clips off the lower part of the ear, and wraps it in paper, and labels it, "Part of Mr. Smith's Ear, October, 1910." Then he looks the patient up and down, with the scissors in his hand, and if he sees any likely part of him he clips it off and wraps it up. Now this, oddly enough, is the very thing that fills the patient up with that sense of personal importance which is worth paying for. "Yes," says the bandaged patient, later in the day to a group of friends much impressed, "the doctor thinks there may be a slight anaesthesia of the prognosis, but he's sent my ear to New York and my appendix to Baltimore and a lock of my hair to the editors of all the medical journals, and meantime I am to keep very quiet and not exert myself beyond drinking a hot Scotch with lemon and nutmeg every half-hour." With that he sinks back faintly on his cushions, luxuriously happy.

And yet, isn't it funny?

You and I and the rest of us--even if we know all this--as soon as we have a pain within us, rush for a doctor as fast as a hack can take us. Yes, personally, I even prefer an ambulance with a bell on it. It's more soothing.

For wide circulation, all types of artistic endeavour of necessity had to be chiefly in written form. This was always an artificial construct, since it was well realized that music and visual art were equally valid forms of artistic expression.

Submissions to the Journal will be accepted in two categories:

- **Written Work:** poetry, essays and historical vignettes.
- **Visual and Musical Work:** submissions in digital reproductions, of paintings, photographs, music and sculpture.

All submissions must be accompanied by a cover letter in Microsoft (MS) Word format, with a short (300 words) biography of the author, name, address and telephone number.

All submissions should be sent in by email to [surgical.humanities@usask.ca](mailto:surgical.humanities@usask.ca)

If you wish to submit by traditional mail, please address your submission to:

*The Editor,  
Surgical Humanities  
Department of Surgery  
University of Saskatchewan  
Saskatoon, SK S7N 0W8*



# SUBMISSION GUIDELINES

## WRITTEN WORK

- May include poetry, short stories, essays or historical vignettes.
  - Submissions must not exceed 5,000 words.
  - All email submissions of written work must be in MS Word format, double spaced, 12-point font, with title and page numbers clearly marked.
  - The work submitted should not have been published previously.
- 

## PAINTING

- Photographic digital reproductions of the painting submitted must be in high definition JPEG or TIFF formats (300 dpi or above).
- 3 photographs must be submitted: the painting as a whole; an illustrative inset/detail of the painting; and a photograph of the artist at work.
- Each photograph must carry a title - captions are optional. Titles and captions can be submitted in a separate, MS Word document.
- An essay of approximately 1000 words must accompany the submission, in MS Word format, with a description of the painting and its story/meaning, as seen by the artist.

## SCULPTURE AND CRAFTWORK

- Photographic digital reproductions of the sculpture or craftwork submitted must be in high definition JPEG or TIFF images (300 dpi or above).
- A total of 4 photographs must be submitted:
- The sculpture/craftwork captured in at least 3 angles, each photograph addressing a different angle
- A photograph of the artist at work.
- Each photograph must carry a title - captions are optional. Titles and captions can be submitted in a separate, MS Word document.
- An essay of approximately 1000 words must accompany the submission, in MS Word format, with a description of the sculpture/craftwork and its story/meaning, as seen by the artist.

## PHOTOGRAPHY

- Up to 4 photographs may be submitted at a time, each of high definition, in JPEG or TIFF formats (300 dpi or higher).
  - The photographs may be linked by a similar theme, but this is not essential.
  - Each photograph must be titled appropriately - captions are optional; titles and captions may be submitted separately, in MS Word format.
  - An essay of approximately 1000 words to accompany the photographs must be submitted separately, in MS Word format. The essay can address the photographer's life and motivations.
- 

## PERFORMANCE

- Music may be of any genre, provided the performer recognizes his/her performance as a serious art form.
- Submissions must be accompanied by an essay of approximately 1000 words on the performance itself or on the importance of music in the performer's life. A YouTube link to the performer must be clearly included in the essay.

## COMPOSITION

- The composition may be in any genre of music, with the composer's musical score sheet, in musical notation, forming the centrepiece of the submission.
- The musical score sheet need not be in classical music notation - but the reader must be able to reproduce the music by following the score sheet.
- Singer-songwriters can submit their compositions, with the music in musical notation and the words of the song accompanying the notation/chords.
- Submissions must be accompanied by an essay of approximately 1000 words on the composition itself or on the importance of music in the performer's life. A YouTube link to the composition being performed must be clearly included in the essay.

# JOURNAL OF THE SURGICAL HUMANITIES

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