Journal of the SURGICAL HUMANITIES

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SURGICAL HUMANITIES

COVER PAGE
Ojos que no ven, corazon que no siente
(76" x 46" - oil on canvas)
Marcelo Suaznabar

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EDITORIAL

More than two centuries ago, the English poet Alexander Pope (1688-1744) proclaimed, "the proper study of mankind, is man."

The study of man, woman and child in their own cultural contexts is not only an instructive and rewarding exercise in the broadening of our view of the world, it is of vital importance in the practice of medicine. One need not visit the great cities of the world to realize that migration and globalization have had the effect of rapidly and irrevocably dispelling the Victorian notion of distant people, with exotic cultures, in far away places. New York, Toronto, Vancouver, London, Paris, even New Delhi and Beijing are now themselves home to these once "distant" cultures. The phenomenon is already very real in our medium sized cities and towns and very soon, inevitably, in our villages as well. Multiculturalism is at our doorsteps. Sometimes, it is part of our homes and families.

The article by Gautham Suresh and Sienna Craig (pgs 8-15) from Dartmouth College, is a landmark article in the manner in which it addresses a subject in the practice of modern medicine, that has hitherto either been largely and willfully ignored or else, addressed inconsequentially with a very superficial approach. Of course, it has also been swept under a very small carpet, pretending it does not exist! If we are to pay more than lip service to Francis Peabody's immortal words, "one of the essential qualities of the clinician, is interest in humanity, for the secret of the care of the patient is in caring for the patient," we must also choose to become culturally competent in our practice of medicine. We will then understand the human story better, better empathize with it and better be able to respond to our patients' hopes, needs and fears. In short, we would be better doctors and nurses.

Many understand culture in terms of exotic food and colourful festivals. Many others weave their own, private webs of fantasy around other groups of people different form themselves and extrapolate these fantasies into their day to day lives and behaviours. The results are tragic for themselves and for the other culture. It is also bad medicine and will soon reflect in the "ratings" that patients are increasingly giving us in our digitized, interconnected world.

A study of the art, poetry, architecture, religion, beliefs and literature of another culture deepens our engagement with the culture in a way that simply reading a newspaper article about "the festivals of Hong Kong," for example, cannot. The revolutions and movements for social change that swept across South America in the last century can be studied dispassionately and reasonably thoroughly through an examination of these events in Wikipedia, or even in the "CIA Fact-book." But such a study would fail to see into the Soul of a nation or a people during these turbulent times. To do so, we must read the poems of Pablo Neruda (1904-1973), if only in translation. Or examine the murals of Diego Riviera (1886-1957).

In a very similar way, engaging with the Chinese novelists or the African poets or the Arab classics or the Indian epics in translation, is a far better education in cultural competence than simply learning to say "hello" in Chinese. It is also more respectful of the culture.

Suresh and Craig's article in this issue of the journal, has a section in which the authors suggest practical ways in which health care workers can meaningfully enhance their cultural competence. We believe that these suggestions, if taken on board, have the potential to transform the care of patients who belong to a culture other than our own. This journal's suggestion, of incorporating a study of the art and literature of these other cultures in this education, is one more highly effective method we believe, of enhancing our cultural competence and in this way, becoming better doctors, nurses and human beings.

Francis Christian
Editor-in-Chief

MARCELO SUAZNABAR: Surrealist From The Andes

About our cover artist and his work...

Ivar Mendez, MD, PhD, FRCSC, FACS
Fred H. Wigmore Professor and Unified Head
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As I contemplate an image of a delicate brain emerging from a cube that serenely floats on a pale yellow background, I cannot help but think about the human mind escaping from conventional constraints and launching into its flight of creativity and innovation. These are in fact common elements of the minds of artists and scientists that Marcelo Suaznabar has depicted masterfully in his painting "brain". I first encountered Marcelo's art in an article in a Bolivian newspaper on my last trip to its capital La Paz perched in the Andes at 12,000 feet above sea level. I was impressed by his outstanding surrealist style – a style that immediately brought to my memory two masterpieces that I had seen on opposite sides of the world.

The first, a group of 4 large oil canvases that hang on the 400 year old walls of a colonial stone church in the small community of Carabuco nestled in the Andean plateau close to the azure waters of Lake Titicaca. These paintings depict a terrifying vision of the afterlife represented by scenes of the final judgment, purgatory, hell and heavenly glory. These gigantic canvases were painted in 1684 by a talented indigenous artist. The second masterpiece is the famous triptych of Hieronymus Bosh depicting the Garden of Earthly Delights treasured at the Museo Prado in Madrid, Spain. Although these two paintings are worlds apart in distance and time, their surrealistic approach in portraying biblical scenes have an uncanny resemblance to each other. In an intriguing but very real way, these fantastic works are a fitting framework in which to describe Marcelo Suaznabar's art, as a surrealist from the Andes.

CICLO, oil on canvas, 76X96 Inches, 2014 by Marcelo Suaznabar

About our cover artist...

NATURALEZA FRAGIL, oil on canvas , 48x36 Inches, 2014 by Marcelo Suaznabar

BRAIN, oil on board 10x 10 Inches, 2014 by Marcelo Suaznabar

As I inquired more about Marcelo, I was pleasantly surprised to find that he makes his home just north of Toronto in Aurora, Ontario. On my return to Canada, I contacted him and visited his studio in Aurora. Marcelo moved to Canada about 15 years ago and has become a well-known painter in Ontario. He is represented by several galleries in Ontario, USA and Mexico. Marcelo is soft spoken but has a strong sense of identity and commitment to his art.

Although his Bolivian roots are expressed in his paintings in subtle but recognizable forms, the grand themes of this paintings are universal and profound. Time, birth and death are recurring concepts represented by clocks, eggs and skulls. Symmetry, order and proportionality are also frequently encountered in cubes, alternating black and white squares and floating 3 dimensional geometric forms. His technically superb resin covered oil paintings, usually of smaller format, have playful surrealist characters riding old fashion bicycles or walking on long legs as well as fantastic hybrid creatures that combine animal and human components - the products of the rich and creative surrealistic imagination of Marcelo's brain.

Marcelo's painting "ojos que no ven, corazon que no siente" translated from Spanish meaning "if your eyes do not see, your heart does not feel" that graces the cover of this issue of The Journal of the Surgical Humanities connects the heart and the eyes beyond the merely anatomical or physiological. It brings the uniquely human connectivity of feeling and emotion to what we see or don't see. Suaznabar's surrealism displays the essential spirit of the surgical humanities that goes beyond the science and art of surgery.

EL PASEO, oil on board, 30.5x23 Inches 2012 by by Marcelo Suaznabar

CULTURE IN THE CLINICAL ENCOUNTER

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As a way of illustrating how aspects of culture have important influences in the clinical encounter, we first describe a patient in whose care we were both involved in our respective roles as a neonatologist and a medical anthropologist, and through which we were drawn together in new ways as colleagues.

Our story begins when a chaplain at our large teaching hospital approached Dr. Suresh, a neonatologist of South Asian origin, about a toddler of Hindu immigrants who had been diagnosed with a rare genetic disorder and who would likely die from this disease within months. The chaplain was seeking guidance on how Hindus approach the issue of child death. Dr. Suresh recognized the chaplain's good intentions – a desire to provide culturally sensitive support for a family who was navigating a devastating medical situation and who would soon be experiencing a terrible loss. However, he took this moment to first explain that there are many different kinds of Hindus, and suggested that the chaplain learn more about the family. The child's

kin were not from Dr. Suresh's native India, but were immigrants from Bhutan; they had spent much of their lives as refugees in Nepal and had been resettled to the United States recently.

Dr. Suresh knew that Dr. Craig had spent many years in Nepal and spoke Nepali, the first language of this couple and their extended family. Although the parents were able to speak English and although an official medical interpreter had been provided, the chaplain and Dr. Suresh thought that speaking with someone who knew at least something of their experience but who was also comfortable within the culture of northern New England and the culture of our medical center would be helpful, particularly as the child's health continued to decline. Dr. Craig arranged to visit the family, not in a formal capacity but as someone who could help to be a culture broker – who could speak with the chaplain and healthcare providers in charge of caring for this very sick child as well as to the family. Indeed, although visiting with the family seemed to bring them some joy, the most useful points of 'cultural competence' intervention actually came from sharing with the child's caregivers an overview of how this family fit into a larger history of exile, civil war, and resettlement as well as basic understandings of Hindu Nepali death rituals and core cultural concepts, including karma, the dynamics of moral action, of cause and effect.

The genuine curiosity and care displayed by the chaplain for this family was contagious. Through her example and from guidance by each of us and others, the hospital staff navigated this difficult situation with grace. They were able to work within the rules of the hospital but to know how and when to bend these rules to allow for truly culturally competent care. Such moments included spaces where tradition was honored and also where adaptive forms of care were sanctioned. For example, the chaplain's advocacy facilitated not only immediate family members but also extended family and friends from this immigrant community to sit beside and provide support for the dying child and her parents. Monitors were turned away from the family such that they could be seen by hospital staff but did not over-medicalize the intimacy of a mother and father lying in bed with their dying child. Space and time were created in the hospital chapel for an important ritual prior to the child's death, which involved the child's elder relatives who were Brahmin priests. The family was allowed to ritually bathe and dress the child's body once she had passed away without interference. Having come to understand that the child's parents, especially the mother, was fasting as her child made the great transition from life to death, hospital staff were able to provide better auxiliary care to her, as she became dehydrated and suffered from exhaustion. The chaplain advocated for the family such that the child did not spend time in the hospital morgue but that she be taken immediately to be cremated, as is culturally desired.

And yet not all experiences surrounding this untimely death were culturally competent, for reasons of both medical bureaucracy and bias. For example, only after the deceased child had been prepared for cremation and her body was ready to be discharged did hospital staff realize that her identification tag had slipped off. This necessitated that the family wait in suspended grief while a new computer ID tag was generated and put on the body. As the family was escorting the child to the hearse, hospital discharge staff struggled with the pronunciation of the parents' foreign names and

created undue stress at a moment that could have been avoided by asking the chaplain or a primary attending caretaker to clarify which person was the mother and which the father on their paperwork.

When Dr. Craig first came to the hospital to meet the family, she was briefed by the chaplain that some of the care providers did not think that the child's parents and grandparents understood what having a genetic disorder meant, since they seemed reticent to "accept" or talk about with assuredness the inevitability of death. She explained that in a cultural context where thinking or speaking were agentive acts, discussing death as a "when" instead of an "if" event could prove counterproductive, even traumatic. Still, at one point a hospital resident felt the need to call this family "clueless" when, after reviewing the nature of the genetic disorder in question, the family did not want to publicly acknowledge that the child would soon die. Far from clueless, they knew that speaking of the possibility of death could, in effect, hasten a negative outcome, given the dynamics of karma, cause and effect. They owed it to the child to have faith.

Fortunately, the child's primary attending physician was able to speak clearly on this topic to the resident, and it became a learning experience toward improved communication, respect, and cultural competence. And yet the parents' grief was complicated by the specter that they now knew they were carriers of a rare, recessive genetic disorder. How had their bodies produced this unimaginably sad experience? It is not that they didn't comprehend what "genes" meant. Both had been college educated in Nepal. But they resisted a singular way of understanding the double helix of genetic and karmic inheritance. They may continue to struggle with these issues as they consider whether or not to conceive another child.

Such an example of cultural competence in action – and all that can still prove difficult even with the best of intentions – illustrates the need for emotionally skillful, articulate, and culturally competent healthcare providers from the genetic counseling office to the NICU to the family practice clinic, and all the spaces in between.

Introduction

In modern healthcare, it is common for health professionals to encounter patients from a variety of cultures and ethnic backgrounds. Aspects of a patient's culture such as beliefs about the cause of diseases, pain relief, truth telling, religious concepts and practices, the organization of social units, decision making, and moral codes can impact interactions between patients and their treating physicians (Juckett 2005; Turner 2005).

Failure to appreciate the role of culture in the clinical encounter can result in a variety of adverse consequences, including difficulties with informed consent, miscommunication, inadequate understanding of diagnoses and treatment plans by patients and families, dissatisfaction with care, preventable morbidity and mortality, unnecessary child abuse evaluations, and disparities in prescriptions, analgesia, and diagnostic evaluations. (Flores 2000, Flores 2000, Flores 2002)

Every health professional too brings his or her own culture and beliefs to every clinical encounter. This becomes particularly important because in many healthcare institutions today, healthcare professionals come from a variety of countries, cultures and backgrounds. This increasing staff diversity has many benefits, but also raises challenges for healthcare institutions in ensuring that patients receive culturally sensitive care and that the cultural needs of staff are acknowledged and respected. Health professionals also have to recognize the important role of culture in interactions with each other.

Finally, conventional medicine is itself a cultural system, with its own set of rules, norms, and histories (Lock and Nguyen 2010). This culture of medicine has profound influences on the attitudes and behaviors of health professionals.

Therefore it is essential for all health professionals to engage with and respect the important role that culture plays in clinician-patient encounters. This will

allow them to provide healthcare that acknowledges, respects, and incorporates relevant aspects of the various cultures that patients bring to the clinical encounter, while at the same time becoming more aware of the challenges that emerge when medicine understands itself as a 'culture of no culture' (Taylor 2003). In formal terms, this effort at mutual recognition and understanding has been called 'cultural competence.'

In this article we focus primarily on how clinicians can understand the important role of their and their patients' culture during the clinical encounter, how they might identify what matters most to a patient, and provide healthcare that is respectful of, and customized to an individual patient's cultural needs (Kleinman and Benson 2006).

Terminology

Several key terms and concepts related to culture in the clinical encounter are important to understand:

Culture: While definitions of culture vary, most agree that, at a minimum, culture constitutes a set of behaviors and guidelines that individuals use to understand the world and how to live in it.

However, culture is dynamic, not static. It cannot be considered as a neatly packaged and separable whole that can be summed up simply enough for 'competence.' Helman has described culture as being "an increasingly fluid concept, which in most societies is undergoing a constant process of change and adaptation" (Helman 2006, Helman 2007).

There are some tangible and overt signs of culture, such as mode of dress, language, rituals and food. However most aspects of culture are intangible, implicit, emergent through language, and harder to visualize. These aspects of culture may include attitudes, beliefs, and explanatory models for illness and for other forms of misfortune. When health professionals hear the terms 'culture' in the context of 'cultural competence' or 'cultural sensitivity' as it bears on their patients, they may tend to think that these concepts describe the care of patients from exotic or unfamiliar places – a 'National Geographic' approach to understanding what this term means. Instead, they should learn to understand and pay attention to their own cultural patterns and assumptions as well as the culture of their patients, including people who on the surface might seem to be 'the same' as they are. For example, in the rural New England environment in which we live and work, it is often assumed that because patients and providers might both identify as white and speak English as their first languages that they are not culturally distinct, or that efforts expended on 'cultural competency' training should be geared toward regional refugee populations from Asia or Africa. But this obscures all sorts of differences.

Imagine the gaps that exist between an Ivy League-educated pediatrician and one of his patients, a child born into rural poverty with parents who struggle with combat-related PTSD or substance abuse. Culture does not equate to phenotype or Disney-ified images of difference, and distinct sub-cultures often exist within a larger seemingly homogenous society. As anthropology has taught us, the concept of culture cannot be "simply used to explain the ways of life and forms of understanding of distant societies, but refers to the dominant values, symbols, social practices, and interpretive categories of any community" (Turner 2005). Even within 'dominant' expressions of cultural norms, there remains further capacity for diversity or disagreement.

Cultural Competence

The term 'cultural competence' first emerged in the late 1980s and was defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross 1989). This concept has generated a great deal of support inasmuch as it points to efforts to improve care and transform stereotyped constructions of cultural difference into nuanced pathways to patient-

provider communication and better access to care for people from diverse backgrounds. Indeed, cultural competence was initially proposed as a concept that could "help reduce disparities by adjusting services and treatment options to account for ethnocultural differences" (Whitley 2007).

Even, so, the concept of 'cultural competence' – essentially a technique that resists standardizing tendencies – has become institutionalized as part of licensure and certification processes for healthcare providers. Through these and other processes, it runs the risk of reproducing stereotypes instead of improving health care communication or access (Lee and Farrell 2006).

As such, scholars and clinicians have called for a rethinking and nuancing of this vital concept, including emphases on ideas of 'cultural humility' (Kirmayer 2012) and the dynamic, contested nature of culture itself as well as emphasis on how culture intersects with structural inequalities and the social determinants of health and disease (Thakrah and Thompson 2013). Cultivating a diverse staff of health providers is another way to encourage meaningful cultural competence (Paez et al 2007). So, too, does cultivating tools and practices for new forms of self-awareness and inter-subjective reflection (Yan and Wong 2005).

Regulations & Requirements

In the United States, health professionals and healthcare organizations are required to provide culturally and linguistically appropriate healthcare (i.e., it is not optional) by authoritative and regulatory bodies such as the Joint Commission. The Office of Minority Health of the US department of Health and Human Services has a set of standards for Cultural and Linguistically Appropriate Services (CLAS) in healthcare – some of these are mandated (and Federally required); others are guidelines and some are recommendations. Cultural competence in health care has become firmly embedded in professional accreditation standards.

A Suggested Framework for Clinical Practice

We have attempted to represent cultural and related factors operating with the clinical encounter through a conceptual framework depicted in the Figure below. Health professionals and healthcare institutions might find this framework useful to conceptualize and promote cultural understanding, identify patients' cultural needs, and design approaches to providing culturally humble, aware, and sensitive care.

We recognize that health professionals vary in their level of knowledge, awareness, and acceptance of the role of culture (their own and the patient's) during the clinical encounter. Many may not accept cultural factors as valid health-related issues that affect clinical outcomes, even in the face of ample evidence to the contrary. One useful starting point for meaningful cultural competence can be summarized through the ASKED mnemonic (Campinha-Bacote, 2003). As a starting point for cultural competency, this rubric can help frame the need to develop awareness of one's own biases as well as practical and practiced skill for engaging in cross-cultural encounters in a sensitive and thoughtful manner; to consider what you do and do not know about patients and their families; to critically and honestly assess the number and diversity of cross-cultural encounters you have had, and build on that; and to reflect on your own desires, aversions, fears, etc. about what true cultural competence entails.

Understanding the Fluidity of Culture

When first studying or trying to understand a patient or colleague's cultural framework it is tempting to use broad definitions that categorize a person's culture into neat boxes. A common approach to cultural competence uses reductionist descriptions of typical characteristics, beliefs and behavior of different cultural/racial/ethnic groups to help health professionals understand patients and their families. Indeed, books and brochures are widely available that describe, for example, what patients from the Middle

East believe in, or the attitudes towards health of Vietnamese patients.

While such books and resources may be useful as a starting place for people to start learning about other cultures, they should not be used as rigid guides on how to interact with people across social difference. In fact, by portraying cultures of various peoples as uniform and monolithic, these sources can encourage a narrow, restrictive, view of culture that can ultimately become constraining if not overtly offensive and counterproductive. Cultural competence becomes dangerous when it is reduced to a list of stereotypical traits.

Therefore, instead of using stereotypes as the framework within which to approach culture, health professionals should use open-ended inquiry, respect, and flexibility as the key principles with which people from other cultures are approached. This requires that clinicians develop some of the skills of the ethnographer, paying attention to specific circumstances and the articulation of culture within particular socioeconomic or even political circumstances. This will allow them to recognize the intangible, hard-to-see aspects of culture. Ethnography "eschews the 'trait list approach'" in favour of understanding lived experience (Kleinman and Benson 2006).

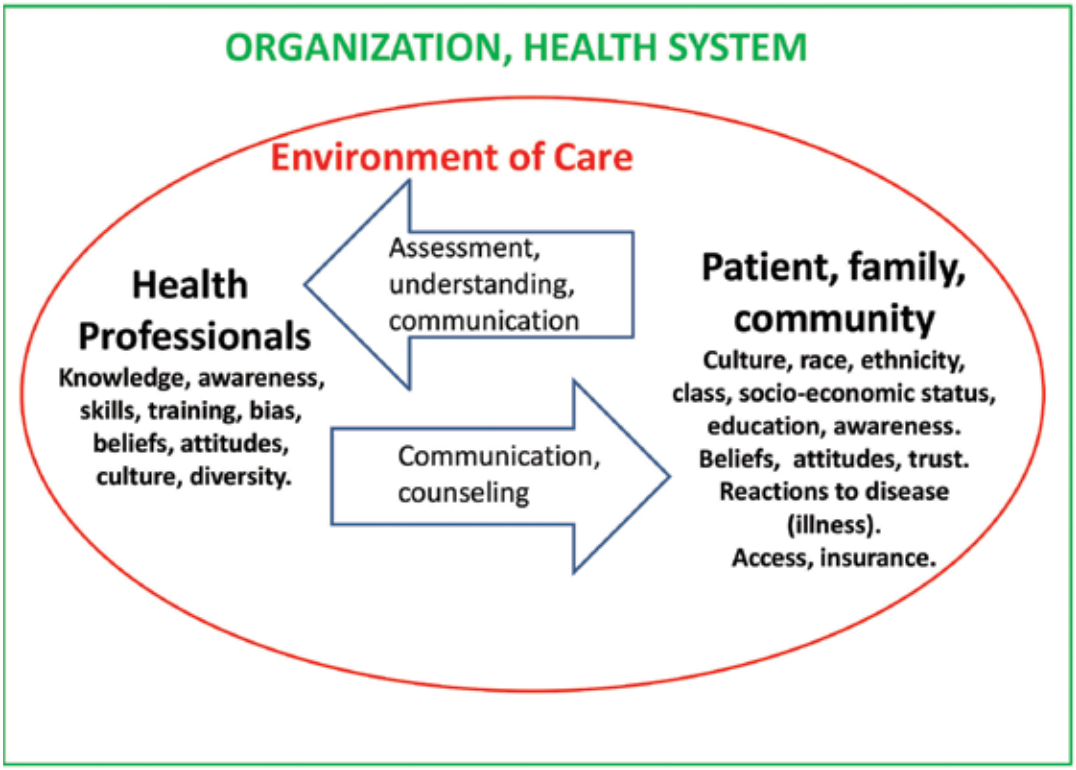
Some Practical Tips to Improve Cultural Competence

Both organizations and individual health professionals can take steps to promote cultural competence not as a 'check the box' approach, but as a nuanced and flexible strategy for communication toward improved care.

Healthcare organizations and systems can:

» Allow for cultural differences to be acknowledged and respected in the workforce.

» Provide access to programs to educate all their staff about the role of culture in healthcare and to train them in methods of asking good questions, becoming a participant-observer, eliciting 'insider' understandings, and building rapport with patients that then account for cultural needs in the care they provide. All employees should be strongly encouraged to undergo cultural competence training, but the nature of this training should also be carefully framed and evaluated.



» Hire diverse and multilingual staff and reward staff who have documented fluency in languages spoken by the patient communities served by the institution. Language is at once an expression of and a pathway into culture. The importance of being able to speak directly to people, even in a limited manner, and especially at moments of medical crisis cannot be underestimated.

» Provide access to qualified and certified interpreters for patients who are not proficient in the dominant language of

the healthcare system. Such interpreters can provide their services in person, or over the telephone (through conference calls).

» Ensure that the signs in the hospital, instruction sheets, brochures, patient handouts, consent forms, and prescription labels in the hospital or office are written in multiple languages in addition to the dominant language of the region. The exact languages to be used will depend on the languages spoken in that region, and on specific languages used by patients that the organization serves. Such signs should also be designed with attention to diverse cultural cues, without the assumption that something that is easily recognizable in one sociolinguistic context will necessarily 'translate' to another.

» Make structural accommodations to serve the cultural, religious and social needs of patients served. Examples of these are : employing persons to provide religious support for hospitalized patients of different religions (in addition to chaplains, priests and pastors); providing magazines in hospital and clinic waiting rooms that are in the languages of communities served; modifying hospital rooms to accommodate patients' cultural, social or religious preferences; providing culturally appropriate cuisine; culturally diverse wall decorations in public areas; and linguistically appropriate television programs for hospitalized patients and in waiting rooms. While none of these efforts in themselves have the capacity to enable 'culturally competent care' they will help put people at ease, increasing the capacity for trust, curiosity, careful listening, and improved communication on all sides.

» Invite patients, families, and members from communities that the organization serves to participate in the design of healthcare programs, services and structures.

» Educational institutions such as medical schools, nursing schools and schools of pharmacy should incorporate education drawing from the disciplines of medical anthropology, medical sociology, history of medicine, the medical humanities, ethics, and transcultural psychiatry as a core part of their curriculum.

Individual health professionals can:

» Do a self-assessment of their own cultural values and attitudes, either through written or verbal means.

» Through guided experiences as well as self-reflection, learn to recognize, and respect diversity and understand how organizations and communities are made stronger when they accept individuals from very different backgrounds with different insights, choices, beliefs, and points of view.

» Participate in programs that raise their awareness of cultural aspects of care as well as how culture relates to socioeconomic inequality and experiences of marginalization, trauma, and oppression.

» Learn to be open to feedback about their own cultural biases and their provision of culturally appropriate care.

» Learn about the cultural groups represented in the communities they serve, or may be deployed to serve in. This may include developing collections of information which identify facts about each of the

different cultures, and identifying sources of additional information as required, but should not stop there. Providers should be encouraged to engage directly with community members in new ways, and not only at times of medical crisis but also in moments of joy, such as the birth of a healthy child, or celebration.

» Cultivate respectful relationships with 'cultural ambassadors', i.e., people who are familiar with aspects of a community's diversity and comfortable interacting with representatives of the healthcare system. Such individuals can help clinicians understand the cultural context and needs of a specific situation. Often, language interpreters can also serve as cultural ambassadors.

» Encourage patients to describe what matters most to them and why. This may include overtly 'cultural' discussions – e.g. about appropriate last rites – but it may also include pressing economic, psychological, or social-ecological concerns that bear on diagnosis, treatment, and other patterns of caregiving.

Conclusion

Cultural competence education and training programs aim to bridge the divides that often exists between health professionals and patients. If done with nuance and a focus on how to listen, ask questions, be respectful, and intuit social cues that may be different than what one is used to, such training can improve the quality of the interaction between health professionals and patients, the utilization of healthcare services, and health outcomes. Cultural competence can enhance good clinical care, is an important element of patient centered care, and therefore, when done well, contributes to the overall quality of care (Betancourt 2006) Promoting cultural competence in health professionals and in healthcare organizations and systems is one way to reduce healthcare disparities, although it is not a panacea. Ultimately, culturally competent care is a vital component of high-quality healthcare that can improve patient outcomes, costs, and patient satisfaction with the quality of care.

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A MOVEABLE FEAST OF COLOUR

How my life inspires and informs my work as an artist...

Kasandra LeRand, RN, BSN
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My "other" profession of an operating room nurse and the practical, everyday experiences in the operating room has exposed me to many, rich and varied cultures over the course of forty two years. My colleagues – surgeons, anesthesiologists and nurses – have been excellent "sounding boards" and sources of information for cultural issues I have questions about. My understanding of the essence of a human being and his or her cultural context has been greatly enhanced by the ten years I spent working and living in Saudi Arabia and by numerous travels around the world.

Our wonderful, multicultural nation has presented me with many opportunities of interaction with patients of different cultures and backgrounds. For example, my experience in the Gulf and my knowledge of Arabic usually elicits surprised and grateful reactions from patients and co-workers. Praying with the patient and his or her family is vital for Muslims, which I do, whenever possible.

Just as a sculptor uses his hands and finishing tools to express his or her artistic soul, I do so with my series of paint brushes, paints, mixtures of paints and tools.

I see the human face as a sublime inspiration for the artist. The painting I have chosen and submitted is my painting of a Tibetan Monk and represents many of the wonderful and mysterious features of the human face

Kasandra LeRand

which inspire and drive me - his knowledgeable gaze, the creases on his forehead, neck, face and eyes. Note if you will, his weathered countenance – this and the light falling softly on his surface are a challenging and joyful thing to paint.

A subject's heritage and "DNA" are reflected the facial structures, hair and skin. My preference in the last five years has been "people of colour." I look forward to painting people from one end of the globe to the other. I have a painting in progress of our Royal University Hospital operating room perfusionist Victor Uppal and his beautiful bride.

The University year began a few weeks ago, for my class in Advanced Painting. Watercolour painting will occupy my spring semester as this fall class is in oil painting. The "effect" of waterolours is immediate. On the other hand, the art of the oil painter is intricately tied with that of a "mixologist" and much work and imagination goes into pigment mixing.

Each of us in the surgical team has a creative talent and I believe we each have to explore our human, artistic side of life. Whenever we do so, we learn something invaluable. Whether your passion is writing, painting, sculpture, music or some other pursuit, go for it! Keep an open mind!

Tibetan Monk, oil on canvas by Kasandra LeRand

Kasandra LeRand
BIOGRAPHY

as told to the Editor...

" I started painting in Grade 4, when growing up in Ontario; by Grade 5, I had painted and lined up various insects on the school wall and later that year I drew the American Presidents in pencil ... about this time, my father said: "she really has some talent!"

"I wanted to attend an interior design school, but my parents would not allow it; I became a nurse instead, but art and painting is so much a part of me, I would never let it go. Later in Saskatoon, I studied under the famous painter Hans Herold.

"I spent 10 years in Saudi Arabia as an operating room nurse. In the city of Jeddah, I was in charge of the OR and Recovery Room, together with labor and delivery. During this time, I painted a huge mural in the dining room of a leading Sheikh (who had numerous horses and stables!). This is how it happened ...

"I was painting murals for the villa of an American hairdresser who is turn knew a plastic surgeon (trained in McGill) whose wife was an interior designer. This interior designer knew that the Sheikh needed a gigantic mural for his summer retreat and my American hairdresser immediately suggested me.

"I painted a huge 18th century mural in the wall of the dining room which in turn had a massive table, seating 30 people. The 18th century painting was of a forest, but because of Islamic beliefs, the painting did not include animals or people.

"I painted the mural is such a way that the rays of the rising and setting sun complimented it and brought out its colours and luminescence.

"It turned out that I was the first female muralist! I was up on ladders and had to work with recessed lighting!

"Recently, I completed a University of Saskatchewan Arts and Design Certificate program. My paintings were exhibited in the University art hall."

This JUST-IN

INSIDE, LOOKING OUT & OUTSIDE, LOOKING IN

Justine Pearl
Senior Neurosurgery Resident
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The patient was sick. He was coming from Northern Saskatchewan to our hospital. He was found unconscious. No one knew for how long. He was rapidly transported to Prince Albert where he was intubated and had imaging done. The CT head findings were not reassuring. He had a large right sided acute subdural hematoma and other foci of blood. The midline shift was considerable. The Attending Neurosurgeon on call got the phone call in the early afternoon. He alerted the residents to the incoming transfer and we looked at the imaging. The plan was very clear: the patient would need a wide trauma craniotomy and evacuation of the hematoma.

The patient arrived several hours later. He was in bad shape. I was on call and went to assess. The OR team had been notified earlier of this patient's eventual arrival and was ready. The ICU knew too. We swiftly took the patient to the operating room. The surgery was uneventful and the patient was transferred to the ICU in a hemodynamically stable condition.

It occurred to me as I entered the hospital that night that we had been thinking about this patient for a while. So many health care professionals knew about him and knew the plan. A plan that had been devised hours before the patient even landed in Saskatoon. And I wondered if anyone else could possibly have any idea how much we think about our patients before they even arrive under our care.

To this unfortunate man's family, it may have looked like our thought processes started when he was rolled into the resuscitation bay. The Emergency room staff might have thought the first I heard of this patient was when I initially laid eyes on him. The reality is though, that doctors think about their patients near constantly.

As residents, it feels like we never get enough face to face time with our patients. Early morning rounds are charged with the daunting task of seeing everyone on a busy service before the mornings' cases commence. This allows for only a few short moments at the bedside. With time, we become adept at fishing out the salient points of the history, testing the highest yield

points on the physical exam, and succinctly relaying to the patient the plan for the day. An outsider only sees those few brief moments at the bedside. But what about all the moments that they don't see?

Before rounds, every patient gets discussed and each facet of their care analyzed, all the way from their primary problem, down to feeding, therapy and disposition. After rounds, plans are solidified and the needs of that patient underlined. Throughout the day, as things inevitably evolve, plans are changed, scans are ordered, medications are discontinued. And at the end of the day, the process starts all over again, fresh discussions are had, new plans are made, and we try to settle that patient in for what we hope will be an uneventful night.

It doesn't even end there. No resident I know doesn't think about their patients after the workday "ends." Sometimes it is through the form of a concerned text to the resident on call, asking if that post-operative patient's pressure came down, or making sure the EVD (External Ventricular Drain) is working well. Maybe it is even in the back of the resident's mind as they eat dinner, remembering the operation he or she performed, or the physical finding on that morning's exam that gave cause for concern. Often it is how hard it was to have that family meeting and break bad news, or reveal the results of the pathology report that arrived after days of worry and concern and nervous anticipation. This part, however, is all behind the scenes. No one at work and no family members know about this thinking process - the number of hours that are spent thinking and worrying about the patients, despite being far away from the bedside. It is some of this behind the scenes pondering that occupies much of a resident's free time.

Luckily, many patients improve. Their head injury starts to heal, they start mobilizing after a long and painful spine surgery, they clear the vasospasm window and everyone breathes a sigh of relief. They are waiting for Rehab, for a transfer to their home hospital, or for a few more things in their care plan to align before they can leave the hospital for good. Those patients invariably don't need a Neurosurgeon or Neurosurgery residents as much anymore. Their care goals have shifted. What ends up happening is those patients see much more of the other dedicated health care professionals who were previously unable to exercise their craft with the patient due to that patient's limitations. But does that mean the resident stops thinking about that patient?

Mrs. P had a bad tumour and a bad surgical outcome. In the days following her surgery, nothing could go right. There was always a complication that needed to be dealt with. Her family didn't leave the bedside. Our team hardly did either. The toll on her family was palpable. As the days turned into weeks and the weeks into months, it was exceedingly hard on everyone on the team to watch and deal with the bad things that can happen when things don't go as planned. We supported Mrs P and her family as best as we could. After many months, she joined the group of patients who didn't really require a Neurosurgeon anymore. One day, her sister took our group aside in tears. She had noticed that we weren't constantly at the bedside as we had once been. She was worried we had forgotten about her sister.

The truth is, it was impossible to forget about her sister. We talked about her every day. We brainstormed things we could do to try and improve her condition. We scanned, consulted and referred. We were thinking about her all the time. But an outsider looking in couldn't possibly know that. So we told her. She was relieved, grateful and reassured. The whole experience made me realize how important perception is in Medicine.

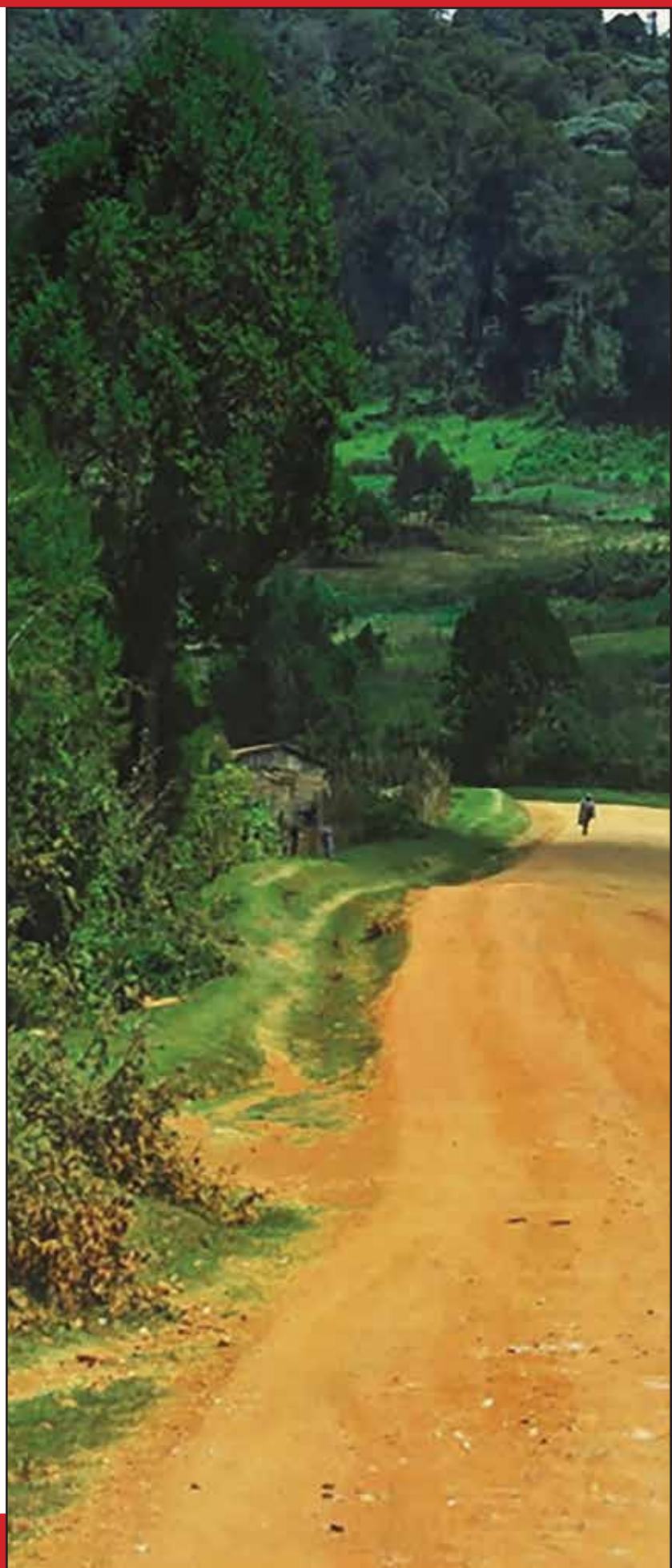
An elective surgery on the regular slate, an appointment in the clinic. We residents likely won't know when that was booked. What we do know, is that this patient was thought of long before that appointment ever came. Maybe the Neurosurgeon received a referral and thought about what pathology was responsible for the symptoms, and how it was impacting that patient's life. Perhaps he or she went home that night and pondered what approach would be best to treat that patient's spine problem. It could also be that a colleague was

consulted for a second opinion. One thing is for certain, when a Surgeon walks into that encounter with the patient, the case has been thought about and pondered long before any words are even uttered.

A surgical resident, like anyone else, has a lot of things to think about. Career, family, relationships, health, friends, and so much more. Part of being a resident means sacrificing time spent on these things in favour of the patients he or she is treating. It is a good way to serve the patients and a way to remind oneself the great responsibility entrusted to us. Sir William Osler once said, "The good physician treats the disease; the great physician treats the patient who has the disease." In the end I have come to realize that one way we learn most about who our patients are, is by devoting our thoughts to them. And then, the hope is that the next time we see them, even if it is just for a few moments, they will sense that they are thought of and cared for.

Will the "outsiders" of Medicine ever know about the behind the scenes thinking that transpires in a resident's mind? Probably not. Will the patients?

I'm not sure. I'll have to give it some thought.



TWO MONTHS IN AFRICA

Experiences and reflections after an elective in Kenya...

Nathan Ginther
R4 Resident in General Surgery
University of Saskatchewan

Recently, my long-held dream turned reality. Along with my wife and 8-month old daughter, I travelled to a little place called Kapsowar, in rural Kenya, for a two month elective in international surgery. Long desired but deferred due to feelings of inadequacy, third year residency seemed, finally, to be the right time to go. And it was...

Two months in Africa by Nathan Ginther

People may engage in international work for many reasons: altruism, desire for a cultural experience, adventure, religious beliefs, and others. Some go abroad in hopes of "practicing" their skills in a way they can't at home, although thankfully those days of unsupervised residents practicing beyond their ability are largely over. My own reason for going was to explore possibilities for the future, a kind of trial run for what might become a lifetime involvement.

I need hardly state that general surgery in Kapsowar is very different from Canada- in a word, it truly is general. Consequently, much of my time there consisted of continually feeling unprepared! Intramedullary femur nails, fracture plating, open prostatectomies, hysterectomies, and cesarean sections were more frequent than hernia repairs and cholecystectomies.

There's something distinctly unpleasant about perpetual inadequacy, akin to always feeling like it's your first day of residency. However, there are many lessons to be learned from practicing in a cross-cultural environment beyond the actual procedures themselves. I had the privilege to work with a superb American surgeon and long-term Kapsowar resident, Bill Rhodes, whose guidance and instruction in technical, cultural, and philosophical matters was excellent. Dr. Rhodes is a singularly skilled surgeon, but even more impressive is the 18 years of grueling work he has given to that community.

For me, one of the greatest challenge was transitioning to a resource-poor environment. All supplies must be carefully used and accounted for, as you may not be able to get any more of that perfect suture material. Patients are billed for all supplies, down to the milliliter of local anesthetic, necessitating awareness of need rather than convenience. Access to imaging is limited - x-rays are available most days, unless the department has run out of film. Ultrasound is free, if you perform your own sonography and interpretation. CT scans can be obtained two hours away, provided the patient can afford the cost and is able to travel. Consequently, surgery is often the only way of making a diagnosis- exploratory laparotomy is not ideal, but it will give you the answer. In trauma patients, sometimes a cranial burr hole was the only way to exclude a subdural hematoma- so you did it.

Blood was sometimes available, but more often than not whole blood donations were secured from family, and often enough, from the hospital staff and physicians. I distinctly remember one young man who died of acute blood loss. There was no lack of donors, but blood could not be collected because someone had not ordered blood bags. It was heartbreaking to watch as I stood helpless -unnecessary death resulting from mismanagement, resistance to change and administrative error.

Many Kenyans speak English, or at least have a family member who does, and this made communication somewhat easier. However, language was still a considerable barrier, and one of the more uncomfortable realities for me. I have frequently been asked whether communication made diagnosis and treatment more difficult. That is certainly true, but to a lesser extent than I expected and mostly because patients present with advanced diseases that are easily diagnosed.

Disease is regional, and profoundly influenced by culture. Nowhere has this been more obvious to me than in Kapsowar. Male circumcision occurs in the late teens, and is performed out in the forest with little more than a knife. Expectedly, there were many resultant complications. One young man was admitted to hospital with severe hypothermia from sitting in the cool mountain water all day, the only way he could relieve the severe pain. Circumcision wound sepsis and hemorrhage were common, and several required penile or scrotal reconstruction. Northeast Kenya remains one of the last bastions of trephination, and this horrible practice resulted in admissions for management of cerebral abscess. I remember distinctly one elderly man involved in an accident - he had sustained numerous lacerations and a depressed skull fracture. He was brought in to hospital by family only to have his lacerations sutured, not to manage the skull fracture - for that, they would take him home and a local "expert"

would perform a home craniotomy, likely to be followed by packing with cow dung!

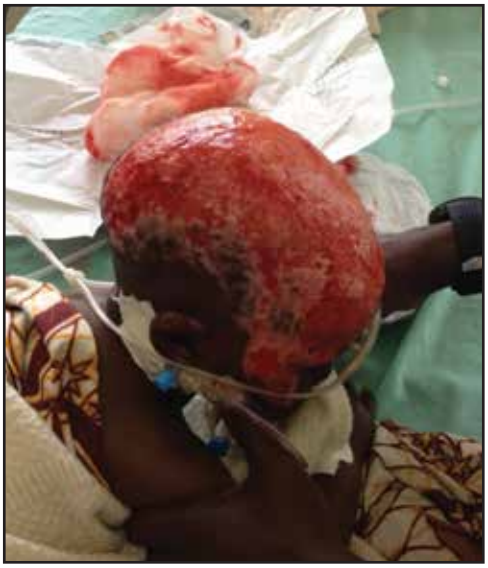
One of the great rewards (and burdens), is to witness the immediate and dramatic impact of your work in a way we uncommonly experience in Canada. Whether it is grafting a child's burns, or performing a C-section, there is immediate gratification knowing you have actually improved, even saved, another human being's life. The other side of that proximity is seeing the impact of the negative outcomes - and the weight of decision making can be very heavy indeed. One night we performed a hysterectomy for postpartum hemorrhage for a primigravida mother- her life was saved, but at a great cost to her. Unable to bear more children, her husband would almost certainly now take another wife, submitting the now infertile wife to second-place status. Limb amputations for trauma were sometimes necessary, but undertaken only with the heaviest consideration, knowing that you could literally cut off one's employability and mobility permanently, in a system that has much less state support than our own.

While hospitals like Kapsowar are often supported by international donations,a tragic disconnect exists between actual and perceived needs, as evidenced by donations. Outside the hospital sat a large shipping container, full of medical supplies from the US - many had

Kapsowar Hospital - Men's Ward

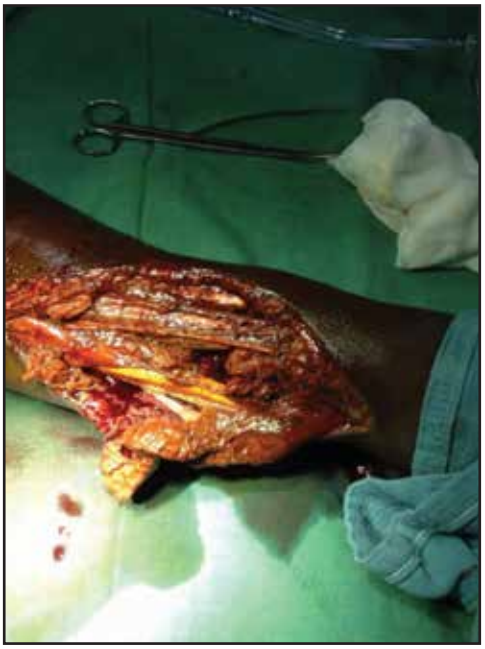
sat unused for years and the equipment was incompatible with local supplies, or simply unusable. Boxes of laparoscopic equipment for example, worth many thousands of dollars, sat completely unusable. Waste, in the midst of great need, is extremely sad.

Although the differences from Canada are many I was most struck with the sense of responsibility that the health care team at Kapsowar carried. The hospital is, for most people, the end of the road of options. They can go nowhere else, and their needs and care ultimately lie in your hands. There is no buck passing, no other service to consult, no referral to another center. This is a reality few of us ever really experience in the West.



Burns from cooking fires were very common.

In the West, health has become our highest value, the ultimate priority, seemingly worth more than freedom, morality, and spirituality.



Orthopedic and soft tissue injury was extremely common.

This was not possible in Kapsowar. Living next door to death as they do, illness, and injury seemed not to make people afraid of them but rather, to accept them as a natural part of life. To the people I got to know, relationships, community, family, and faith were of much greater importance. The acceptance of bad things was not fatalistic, but realistic, emphasizing the joyful aspects of humanity rather than focusing on only the hurtful experiences.

I contrast this to the Western practice of spending incredible amounts of time and money in order to prolong our lives by even a few days … and I wonder what difference could be made if we better accepted our mortality and gave away even a fraction of what we spend on our own health. International medical or surgical electives for trainees come with a host of ethical considerations, mostly related to consumption of resources and unsupervised practice. Great care and planning must be taking with close collaboration with a receiving site in order to ensure that visitors like me do not inadvertently consume hospital resources and make ourselves a liability. Due diligence must be taken to ensure we are contributors rather than consumers. We must treat patients in other cultures as our own family - accepting only the best possible care, and not view it as acceptable to "practice" our skills on them in a way that is unacceptable at home.

Performing a cranial burr hole via osteotome.

What did I learn? I gained an increased sense of personal responsibility for, and empathy with, my patients. Our ways and standards in the West are only one among many. Best practice is not universal, but is determined by geography and resources.

I appreciated that other cultures do some things better than us, especially coping with loss and grief. Our expectation to live without pain, sickness, or injury is false and should be changed. International training is worthwhile, but must be undertaken with contemplation and coordination to ensure we contribute rather than consume.

"Was it worth it?" is a question I have asked myself many times. The answer, for me, is and unequivocal yes. Working overseas was incredibly rewarding, an experience that has changed me and will continue to impact my life and practice for the long term. But how could I justify this? An elective such as this is costly - travel, insurance, housing, risk; HIV prophylaxis alone is very expensive. If I am the only one to benefit, then the answer must clearly be that the cost is not justified. I am certain that everyone in Kapsowar would have received treatment, as good or better, if I had not been there those two months. The lessons learned, however, have the potential for ongoing impact throughout my life. I believe I am now a better member of the human race than before - more aware of global issues, with increased empathy for the poor around the world, and committed to ongoing involvement in a way that will make positive changes. In an as yet undefined way, my time in Africa has made me a better physician and global citizen - and that certainly makes it worthwhile.

Baby Nathan - the first baby Dr. Nathan Ginther delivered by C-section.

Oslerium

William Osler at his desk at home, 13 Norham Gardens, Oxford, reading correspondence. Osler was Regius Professor of Medicine at Oxford University from 1905 to 1919.

SOURCE: Osler Library of the History of Medicine, McGill University, Montreal, QC

A WAY OF LIFE

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

The Spring 2014 issue of "Oslerium" contained the first part of the address that Sir William Osler gave to the graduating class of Yale University on April 20, 1913. This is the second part of that remarkable address...

The load of to-morrow added to that of yesterday, carried to-day, makes the strongest falter. Shut off the future as tightly as the past. No dreams, no visions, no delicious fantasies, no castles in the air, with which, as the old song so truly says, "hearts are broken, heads are turned." To youth, we are told, belongs the future, but the wretched to-morrow that so plagues some of us has no certainty, except through to-day. Who can tell what a day may bring forth? Though its uncertainty is a proverb, a man may carry its secret in the hollow of his hand. Make a pilgrimage to Hades with Ulysses, draw the magic circle, perform the rites, and then ask Tiresias the question. I have had the answer from his own lips. The future is to-day – there is no to-morrow! The day of a man's salvation is now – the life of the present, of to-day, lived earnestly, intently, without a forward-looking thought, is the only insurance for the future. Let the limit of your horizon be a twenty-four hour circle. On the title page of one of the great books of science, the Discours de la Methode of Descartes (1637), is a vignette showing a man digging in a garden with his face towards the earth, on which rays of light are streaming from the heavens; above him is the legend "Fac et Spera" 'Tis a good attitude and a good motto. Look heavenward, if you wish, but never to the horizon – that way danger lies. Truth is not there, happiness is not there, certainty is not there, but the falsehoods, the frauds, the quackeries, the ignis fatui which have deceived each generation – all beckon from this horizon, and lure the men not content to look for the truth and happiness that tumble out at their feet.

Waste not energy, mental distress, nervous worries dog the steps of a man who is anxious about the future. Shut those, then, the great fore and aft bulkheads, and prepare and cultivate the habit of a life of Day-Tight Compartments. Do not be discouraged – like every other habit, the acquisition takes time, and the way is one you must find for yourselves.

Now, for the day itself! What first? Get into touch with the finite, and grasp in full enjoyment that sense of capacity in a machine working smoothly. Join the whole creation of animate things in a deep heartfelt joy that you are alive that you see the sun, that you are in this glorious earth which nature has made so beautiful, and which is yours to conquer and to enjoy. Realize, in the words of Browning, that "There's a world of capability for joy and spread round about us, meant for us, inviting us." What are the morning sensations? – for they control the day. Some of us are congenitally unhappy during the early hours; but the young man who feels on awakening that life is a burden or a bore has been neglecting his machine, driving it too hard, stoking the engines too much, or not cleaning out the ashes and clinkers. To have a sweet outlook on life you must have a clean body. As I look on the clear-cut, alert, earnest features, and the lithe, active forms of our college men, I sometimes wonder whether or not Socrates and Plato would find the race improved. I am sure they would love to look on such a gathering as this. Make their ideal yours – the fair mind in the fair body. The one cannot be sweet and clean without the other, and you must realize, with Rabbi Ben Ezra, the great truth that flesh and soul are mutually helpful.

To keep the body fit is a help in keeping the mind pure, and the sensations of the first few hours of the day are the best test of its normal state. The clean tongue, the clear head, and the bright eye are birthrights of each day. Just as the late Professor Marsh would diagnose an unknown animal from a single bone, so can the day be predicted from the first waking hour. The start is everything, as you well know, and to make a good start you must feel fit. In the young, sensations of morning slackness come most often from lack of control of the two primal instincts – biologic habits – the one concerned with the preservation of the individual, the other with the continuance of the species. Yale students should by this time be models of dietetic propriety, but youth does not always reck the rede of the teacher; and I dare say that here, as elsewhere, careless habits of eating are responsible for much mental disability. My own rule of life has been to cut out unsparingly any article of diet that had the bad taste to disagree with me, or to indicate in any way that it had abused the temporary hospitality of the lodging which I had provided.

The other primal instinct is the heavy burden of the flesh which Nature puts on all of us to ensure a continuation of the species. To drive Plato's team taxes the energies of the best of us. One of the horses is a raging, untamed devil, who can only be brought into subjection by hard fighting and severe training. This much you all know as men; once a bit is between his teeth the black steed Passion will take the white horse Reason with you and the chariot rattling over the rocks to perdition.

With a fresh, sweet body you can start alright without those feelings to inertia that so often, as Goethe says, make the morning's lazy leisure usher in a useless day. Control of the mind as a working machine, the adaptation in it of habit, so that its action becomes almost as automatic as walking, is the end of education – and yet how rarely reached! It can be accomplished with deliberation and repose, never with hurry and worry. Realize how much time there is, how long the day is. Realize that you have sixteen waking hours, three or four at least should be devoted to making a silent conquest of your mental machinery. Concentration, by which is grown gradually the power to wrestle successfully with any subject, is the secret of successful study. No mind however dull can escape the brightness that comes from steady application. There is an old saying, "Youth enjoyeth not, for haste"; but worse than this, the failure to cultivate the power of peaceful concentration is the greatest single cause of mental breakdown. Plato pities the young man who started at such a pace that he never reached the goal. One of the saddest of life's tragedies is the wreckage of the career of the young collegian by hurry, hustle, bustle and tension – the human machine driven day and night, as no sensible fellow would use his motor.

Es bildet ein Talent sich in der Stille, but it need not be for all day. A few hours out of the sixteen will suffice, only let them be hours of daily dedication – in routine, in order and in system, and day by day you will gain in power over the mental mechanism, just as the child does over the spinal marrow in walking, or the musician over the nerve centres. Aristotle somewhere says that the student who wins out in the fight must be slow in his movements, with voice deep, and slow speech, and he will not be worried over trifles which make people speak in shrill tones and use rapid movements. Shut close in hour-tight compartments, with the mind directed intensely upon the subject in hand, you will acquire the capacity to do more and more, you will get into training; and once the mental habit is established you are safe for life.

Do not worry your brains about the bugbear Efficiency, which, sought consciously and with effort, is just one of those elusive qualities very apt to be missed. The man's college output is never to be gauged at sight; all the world's coarse thumb and finger may fail to plumb his most effective work, the casting of the mental machinery of self-education, the true preparation for a field larger than the college campus. Four or five hours daily – it is not much to ask; but one day must tell another, one week certify another, one month bear witness to another of the same story, and you will acquire a habit by which the one-talent man will earn a high interest, and by which the ten-talent man may at least save his capital.

Steady work of this sort gives a man a sane outlook on the world. No corrective so valuable to the weariness, the fever and the fret that are so apt to wring the heart of the young. This is the talisman, as George Herbert says,

The famous stone
That turneth all to gold,

and with which, to the eternally recurring question, What is Life? you answer, I do not think – I act it; the only philosophy that brings you in contact with its real values and enables you to grasp its hidden meaning. Over the Slough of Despond, past Doubting Castle and Giant Despair, with this talisman you may reach the Delectable Mountains, and those Shepherds of the Mind – Knowledge, Experience, Watchful and Sincere. Some of you may think this to be a miserable Epicurean doctrine – no better than that so sweetly sung by Horace: –

Happy the man – and Happy he alone,
He who can call to-day his own,
He who secure within can say,
To-morrow, do thy worst – for I have lived to-day.

I do not care what you think, I am simply giving you a philosophy of life that I have found helpful in my work, useful in my play.
In this way of life each one of you may learn to drive the straight furrow and so come to the true measure of a man.

With body and mind in training, what remains?
Do you remember that most touching of all incidents in Christ's ministry, when the anxious ruler Nicodemus came by night, worried lest the things that pertained to his everlasting peace were not a part of his busy and successful life? Christ's message to him is His message to the world – never more needed than at present: "Ye must be born of the spirit." You wish to be with the leaders – as Yale men it is your birthright – know the great soul that make up the moral radium of the world. You must be born of their spirit, initiated into their fraternity, whether of the spiritually-minded followers of the Nazarene or of that larger company, elect from every nation, seen by St. John.

Begin the day with Christ and His prayer – you need no other. Creedless, with it you have religion; creed-stuffed, it will leaven any theological dough in which you stick. As the soul is dyed by the thoughts, let no day pass without contact with the best literature of the world. Learn to know your Bible, though not perhaps as your fathers did. In forming character and in shaping conduct, its touch has still its ancient power. Of the kindred of Ram and sons of Elihu, you should know its beauties and its strength. Fifteen or twenty minutes day by day will give you the fellowship with the great minds of the race, and little by little as the years pass you extend your friendship with the immortal dead. They will give you faith in your own day. Listen while they speak to you of the fathers. But each age has its own spirit and ideas, just as it has its own manners and pleasures. You are right to believe that yours is the best University at its best period. Why should you look back to be shocked at the frowsiness and dullness of the students of the seventies or even of the nineties? And cast no thought forward, lest you reach a period where you and yours will present to your successors the same dowdiness of clothes and times. But while change is the law, certain great ideas flow fresh through the ages, and control us effectually as in the days of Pericles. Mankind, it has been said, is always advancing, man is always the same. The love, hope, fear and faith that make humanity, and the elemental passions of the human heart, remain unchanged, and the secret of inspiration in any literature is the capacity to touch the cord that vibrates in a sympathy that knows nor time nor place.

The quiet life in day-tight compartments will help you to bear your own and others' burdens with a light heart. Pay no heed to the Batrachians who sit croaking idly by the stream.

I quoted Dr. Johnson's remark about the trivial things that influence. Perhaps this slight word of mine may help some of you so to number your days that you may apply your hearts unto wisdom.

Poetry Corner

BACKGROUND to the poem BABY BLUE

by Joy Mendel

I have worked as an ethicist for many years, currently at St. Paul's Hospital in Saskatoon and previously at Mater Health Services in Brisbane, Australia. During my time working in clinical ethics I have struggled with a variety of issues. Among them are the assumptions that are made in the field of medicine broadly and in specific specializations therein. The field of neonatology, particularly as it is applied to very premature babies has long interested me. It is perhaps the field in which questions of 'why are we pursuing this' come to mind for me most often.

The short poem 'Baby Blue' is a product of these musings. The child thrown as it were upon a stage in the theatre of the neonatal intensive care unit, relegated by developmental reality to the position of passivity, subjected to the intrusions of the medical interventions he or she must endure to satisfy the hopes others have for his or her survival.

Having worked in Australia with some of the big names in the area of neonatology for the extremely premature, I have often considered the urgency with which the technological imperative appears to have been adopted in this area. There appears to have been a normalization of advanced life support in the case of extreme prematurity that has developed from many sources.

The desire to save life, which has been suggested as a motivation for the choice of medicine as a career (for example, Becker, 1973, Nuland 1995) may be extremely compelling in the face of the possibility that a life that will be extremely short regardless of medical interventions. Further, it may be that paternalism seems more justified in the care of the premature newborn simply given the helplessness and vulnerability of the patient. Nevertheless, it is essential in the care of the newborn child, and indeed the care of children more broadly, that we act from a position of beneficence, that is, in the child's best interests.

From time to time, as with any area of medicine, health care decision-makers, usually the parents in the case of children and doctors may disagree as to which course is in the best interests of a child. Often it will be doctors who raise questions about ongoing interventions in the light of a decline in health or the results of a test. At other times parents will raise the issue of ongoing intervention and ask the question 'should we be doing this'. It is important to realise that struggling with ethical questions and issues is not confined to the province of the treating physician. Where questions are raised by any party involved, the parents, grandparents, nursing staff or others, it becomes evident that some degree of moral distress is occurring for at least one party when it comes to the question of the child's best interests.

Baby Blue was written, I now believe as an attempt to define some of the ways in which I have struggled with ethical questions associated with advanced interventions in extremely premature infants. The reference to a "fair innings" in the second stanza comes from a love of the sport of cricket in my home country. The term is sometimes used to describe a life which deceases when the individual in question is of mature years.

REFERENCES

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BABY BLUE

By Joy Mendel

Thrown upon a pre-staged scene sixteen weeks ahead of time,
veins blue, snake beneath a blotched translucency.
Tiny, laboured breath of mechanical existence
held underneath the spotlight's glare
tethered by a technological imperative
and decisions taken some thirty years before your arrival.

For yours cannot be to rage as you cringe supine
among a nuanced tangle of steel and plastic tubing,
the imagined justice of a 'fair innings'
the emotive hopes of your twenty year old parents
too young, perhaps, to have known a close mortality.

And if you could tell us of your suffering, would we listen
or would that inevitable position which
masquerades as sanctity
claim its usual victim
and through these months attempt the definition of your
years?

ABOUT JOY MENDEL

Joy Mendel is Bioethicist for St. Paul's Hospital in Saskatoon and formerly for Mater Health Services in Brisbane, Australia. After early studies and work in the social sciences, health sciences and research, she completed her Masters of Bioethics at Monash University, Melbourne, Victoria. Her PhD in applied ethics in the Department of Philosophy, 'Promise and Prejudice: Why medicines from plants, animals and fungi should be further researched' was undertaken at the Australian National University. The dissertation focused on the promise of effective medicines for infectious diseases, cardiovascular disease, cancer and other illnesses, the reasons why such research is infrequently pursued, the import of this research to humanity at the global level and proposed a range of mechanisms to promote such research, including the use of multilateral funding. Her research interests include informed consent, ethics and evidence based medicine, redressing barriers of access to health care and providing ethical health care to socially disadvantaged and vulnerable groups. As a bioethicist in health care Joy often ponders the role of moral agency in the multi-stakeholder environment of contemporary health care. She is a strong exponent of taking the time to consider the questions that are being raised about direction of care and other ethical concerns raised by members of health care teams, patients and health care decision-makers.

ZHIVAGO: The Doctor in Literature

The doctor not only writes poetry, novels, essays and short stories - he or she also lives in them. This column celebrates 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. The title is from Russian novelist Boris Pasternak's immortal, lyrical novel, "Dr. Zhivago." This selection for Zhivago, is taken from Melville's novel, "White Jacket" (1850) which draws heavily upon his own experiences on board the US Navy frigate, "United States." Melville castigates the cruel treatment of ordinary seamen aboard the naval ships of the time and the novel may be regarded as a gigantic satire on the day to day workings on board ship. The novel was significant in US legal history, for it led indirectly, to the banning of flogging as a means of punishment, by the US Congress.

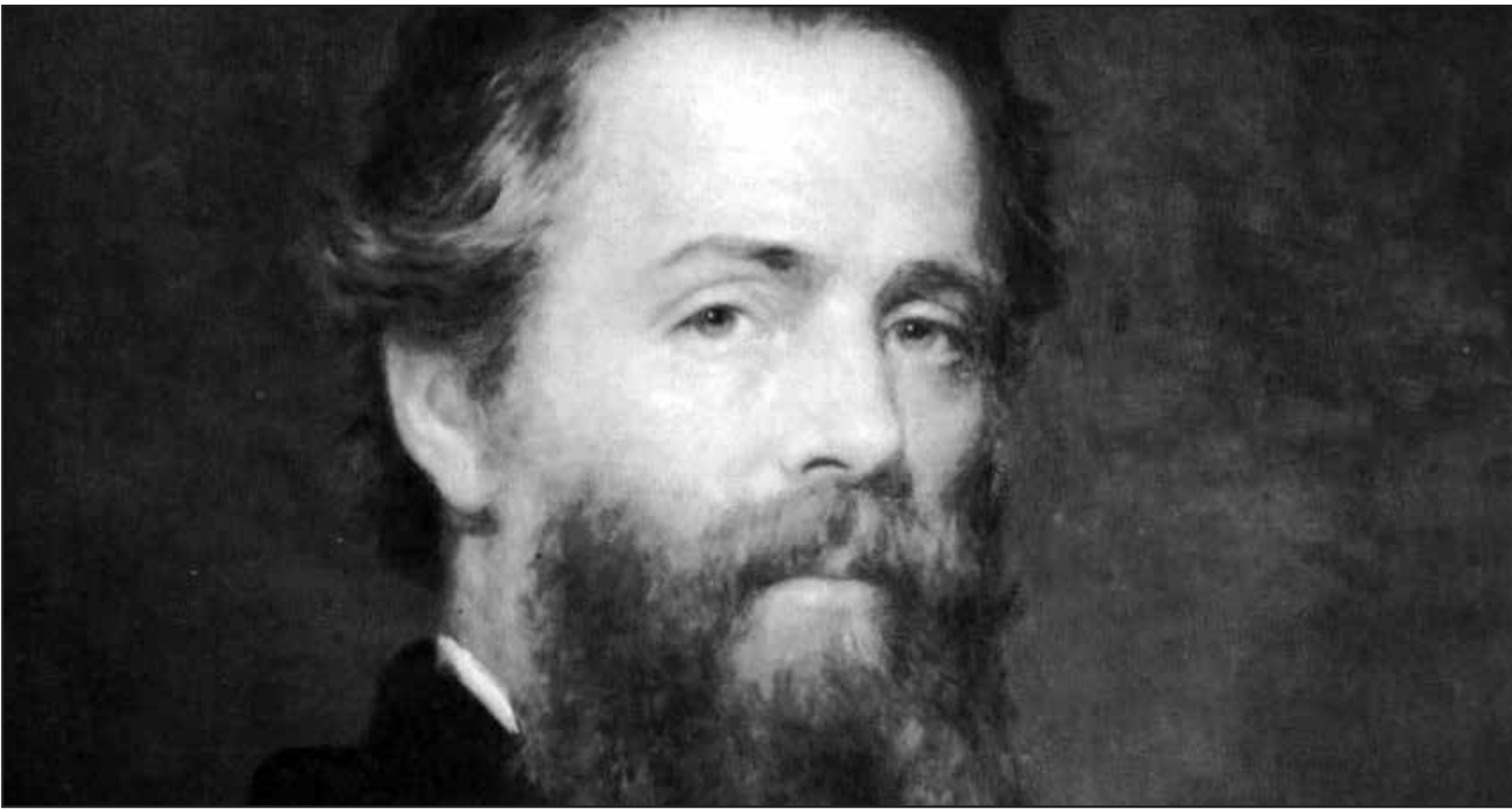
The extract chosen is the part from the novel where a critically injured ordinary seaman undergoes a major amputation (before the days of anaesthesia) on the deck of the ship. It is quite likely that the description in the novel is a recounting, in modified fashion, of the author's own experience of an operation performed by the "Surgeon of the fleet" during one of Melville's own voyages.

F. C.

HERMAN MELVILLE

"It is better to fail in originality, than to succeed in imitation. He who has never failed somewhere, that man can not be great. Failure is the true test of greatness."

Melville



Herman Melville (1819-1891) wrote the quintessentially American novel, "Moby Dick" and is regarded, together with his much more flamboyant contemporary Mark Twain (1835-1910) as the greatest American novelist.

Throughout his life, Melville struggled with poverty, first on account of regularly failing family businesses, then because the literary world and public did not give him anything close to the recognition that would have secured him a comfortable livelihood.

Partly in an attempt to escape poverty and to provide for his family in the American North-East (New England), Melville worked back-breaking but adventurous jobs on board several ships, including long whaling voyages that took him to the South Seas and Tahiti. At various times, he was captured by Tahiti natives, imprisoned as a mutineer and held below deck for subordination – each of these confinements lasting no more than a few months, but providing for him a wealth of experience upon which he drew, when writing his novels.

Moby Dick on the surface, is about a monstrous, white whale by that name, pursued relentlessly (and ultimately to his death) by "Ahab," the Captain of the ship. But in its evocation of universal themes of justice, revenge, suffering, evil, ambition and mortality, it rises at times, to the level of Shakespeare.

F. C.

THE OPERATION

From Herman Melville's novel, "White Jacket"

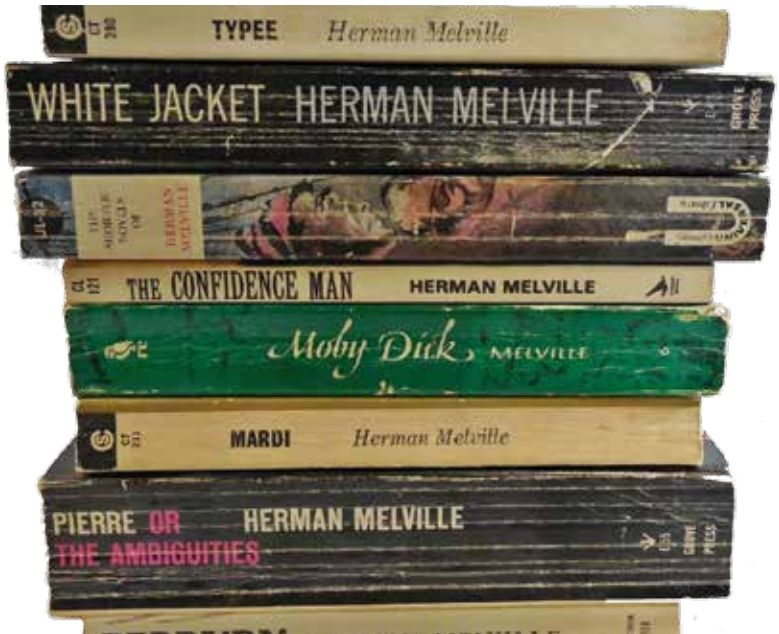
Cadwallader Cuticle, M. D., and Honorary Member of the most distinguished Colleges of Surgeons both in Europe and America, was our Surgeon of the Fleet. Nor was he at all blind to the dignity of his position; to which, indeed, he was rendered peculiarly competent, if the reputation he enjoyed was deserved. He had the name of being the foremost Surgeon in the Navy, a gentleman of remarkable science, and a veteran practitioner.

He was a small, withered man, nearly, perhaps quite, sixty years of age. His chest was shallow, his shoulders bent, his pantaloons hung round skeleton legs, and his face was singularly attenuated.

Next morning, at the appointed hour, the surgeons arrived in a body. They were accompanied by their juniors, young men ranging in age from nineteen years to thirty. Like the senior surgeons, these young gentlemen were arrayed in their blue navy uniforms, displaying a profusion of bright buttons, and several broad bars of gold lace about the wristbands. As in honour of the occasion, they had put on their best coats; they looked exceedingly brilliant.

The whole party immediately descended to the half-deck, where preparations had been made for the operation. A large garrison-ensign was stretched across the ship by the main-mast, so as completely to screen the space behind. This space included the whole extent aft to the bulk-head of the Commodore's cabin, at the door of which the marine-orderly paced, in plain sight, cutlass in hand.

Upon two gun-carriages, dragged amidships, the Death-board (used for burials at sea) was horizontally



placed, covered with an old royal-stun'-sail. Upon this occasion, to do duty as an amputation-table, it was widened by an additional plank. Two match-tubs, near by, placed one upon another, at either end supported another plank, distinct from the table, whereon was exhibited an array of saws and knives of various and peculiar shapes and sizes; also, a sort of steel, something like the dinner-table implement, together with long needles, crooked at the end for taking up the arteries, and large darning-needles, thread and bee's-wax, for sewing up a wound. At the end nearest the larger table was a tin basin of water, surrounded by small sponges, placed at mathematical intervals. From the long horizontal pole of a great-gun rammer—fixed in its usual place overhead—hung a number of towels, with "U.S." marked in the corners.

All these arrangements had been made by the "Surgeon's steward," a person whose important functions in a man-of-war will, in a future chapter, be entered upon at large. Upon the present occasion, he was bustling about, adjusting and readjusting the knives, needles, and carver, like an over-conscientious butler fidgeting over a dinner-table just before the convivialists enter.

But by far the most striking object to be seen behind the ensign was a human skeleton, whose every joint articulated with wires. By a rivet at the apex of the skull, it hung dangling from a hammock-hook fixed in a beam above. Why this object was here, will presently be seen; but why it was placed immediately at the foot of the amputation-table, only Surgeon Cuticle can tell.

While the final preparations were being made, Cuticle stood conversing with the assembled Surgeons and Assistant Surgeons, his invited guests.
"Gentlemen," said he, taking up one of the glittering knives and artistically drawing the steel across it; "Gentlemen, though these scenes are very unpleasant, and in some moods, I may say, repulsive to me—yet how much better for our patient to have the contusions and lacerations of his present wound—with all its dangerous symptoms—converted into a clean incision, free from these objections, and occasioning so much less subsequent anxiety to himself and the Surgeon. Yes," he added, tenderly feeling the edge of his knife, "amputation is our only resource. Is it not so, Surgeon Patella?" turning toward that gentleman, as if relying upon some sort of an assent, however clogged with conditions.

"Certainly," said Patella, "amputation is your only resource, Mr. Surgeon of the Fleet; that is, I mean, if you are fully persuaded of its necessity."

The other surgeons said nothing, maintaining a somewhat reserved air, as if conscious that they had no positive authority in the case, whatever might be their own private opinions; but they seemed willing to behold, and, if called upon, to assist at the operation, since it could not now be averted.

The young men, their Assistants, looked very eager, and cast frequent glances of awe upon so distinguished a practitioner as the venerable Cuticle.
"They say he can drop a leg in one minute and ten seconds from the moment the knife touches it," whispered one of them to another.

"We shall see," was the reply, and the speaker clapped his hand to his fob, to see if his watch would be forthcoming when wanted.

"Are you all ready here?" demanded Cuticle, now advancing to his steward; "have not those fellows got through yet?" pointing to three men of the carpenter's gang, who were placing bits of wood under the gun-carriages supporting the central table.

"They are just through, sir," respectfully answered the steward, touching his hand to his forehead, as if there were a cap-front there.

"Bring up the patient, then," said Cuticle.

"Young gentlemen," he added, turning to the row of Assistant Surgeons, "seeing you here reminds me of the classes of students once under my instruction at the Philadelphia College of Physicians and Surgeons.

Ah, those were happy days!" he sighed, applying the extreme corner of his handkerchief to his glass-eye.

"Excuse an old man's emotions, young gentlemen; but when I think of the numerous rare cases that then came under my treatment, I cannot but give way to my feelings. The town, the city, the metropolis, young gentlemen, is the place for you students; at least in these dull times of peace, when the army and navy furnish no inducements for a youth ambitious of rising in our honourable profession. Take an old man's advice, and if the war now threatening between the States and Mexico should break out, exchange your navy commissions for commissions in the army. You will hardly believe it, Surgeon Bandage," turning to that gentleman, "but this is my first important case of surgery in a nearly three years' cruise. I have been almost wholly confined in this ship to doctor's practice prescribing for fevers and fluxes. True, the other day a man fell from the mizzen-top-sail-yard; but that was merely an aggravated case of dislocations and bones splintered and broken. No one, sir, could have made an amputation of it, without severely contusing his conscience. And mine—I may say it, gentlemen, without ostentation is—peculiarly susceptible."

And so saying, the knife and carver touchingly dropped to his sides, and he stood for a moment fixed in a tender reverie but a commotion being heard beyond the curtain, he started, and, briskly crossing and recrossing the knife and carver, exclaimed, "Ali, here comes our patient; surgeons, this side of the table, if you please; young gentlemen, a little further off, I beg. Steward, take off my coat—so; my neckerchief now; I must be perfectly unencumbered, Surgeon Patella, or I can do nothing whatever."

These articles being removed, he snatched off his wig, placing it on the gun-deck capstan; then took out his set of false teeth, and placed it by the side of the wig; and, lastly, putting his forefinger to the inner angle of his blind eye, spirited out the glass optic with professional dexterity, and deposited that, also, next to the wig and false teeth.

Thus divested of nearly all inorganic appurtenances, what was left of the Surgeon slightly shook itself, to see whether anything more could be spared to advantage.

"Carpenter's mates," he now cried, "will you never get through with that job?"

"Almost through, sir—just through," they replied, staring round in search of the strange, unearthly voice that addressed them; for the absence of his teeth had not at all improved the conversational tones of the Surgeon of the Fleet.

With natural curiosity, these men had purposely been lingering, to see all they could; but now, having no further excuse, they snatched up their hammers and chisels, and—like the stage-builders decamping from a public meeting at the eleventh hour, after just completing the rostrum in time for the first speaker—the Carpenter's gang withdrew.

The broad ensign now lifted, revealing a glimpse of the crowd of man-of-war's-men outside, and the patient, borne in the arms of two of his mess-mates, entered the place. He was much emaciated, weak as an infant, and every limb visibly trembled, or rather jarred, like the head of a man with the palsy. As if an organic and involuntary apprehension of death had seized the wounded leg, its nervous motions were so violent that one of the mess-mates was obliged to keep his hand upon it.

The top-man was immediately stretched upon the table, the attendants steadying his limbs, when, slowly opening his eyes, he glanced about at the glittering knives and saws, the towels and sponges, the armed sentry at the Commodore's cabin-door, the row of eager-eyed students, the meagre death's-head of a Cuticle, now with his shirt sleeves rolled up upon his withered arms, and knife in hand, and, finally, his eyes settled in horror upon the skeleton, slowly vibrating and jingling before him, with the slow, slight roll of the frigate in the water.

"I would advise perfect repose of your every limb, my

man," said Cuticle, addressing him; "the precision of an operation is often impaired by the inconsiderate restlessness of the patient. But if you consider, my good fellow," he added, in a patronising and almost sympathetic tone, and slightly pressing his hand on the limb, "if you consider how much better it is to live with three limbs than to die with four, and especially if you but knew to what torments both sailors and soldiers were subjected before the time of Celsus, owing to the lamentable ignorance of surgery then prevailing, you would certainly thank God from the bottom of your heart that your operation has been postponed to the period of this enlightened age, blessed with a Bell, a Brodie, and a Lally. My man, before Celsus's time, such was the general ignorance of our noble science, that, in order to prevent the excessive effusion of blood, it was deemed indispensable to operate with a red-hot knife"—making a professional movement toward the thigh—"and pour scalding oil upon the parts"—elevating his elbow, as if with a tea-pot in his hand—"still further to sear them, after amputation had been performed."

"He is fainting!" said one of his mess-mates; "quick! some water!" The steward immediately hurried to the top-man with the basin.

Cuticle took the top-man by the wrist, and feeling it a while, observed, "Don't be alarmed, men," addressing the two mess-mates; "he'll recover presently; this fainting very generally takes place." And he stood for a moment, tranquilly eyeing the patient.

Now the Surgeon of the Fleet and the top-man presented a spectacle which, to a reflecting mind, was better than a church-yard sermon on the mortality of man.

Here was a sailor, who four days previous, had stood erect—a pillar of life—with an arm like a royal-mast and a thigh like a windlass. But the slightest conceivable finger-touch of a bit of crooked trigger had eventuated in stretching him out, more helpless than an hour-old babe, with a blasted thigh, utterly drained of its brawn. And who was it that now stood over him like a superior being, and, as if clothed himself with the attributes of immortality, indifferently discoursed of carving up his broken flesh, and thus piecing out his abbreviated days. Who was it, that in capacity of Surgeon, seemed enacting the part of a Regenerator of life? The withered, shrunken, one-eyed, toothless, hairless Cuticle; with a trunk half dead—a memento mori to behold!

And while, in those soul-sinking and panic-striking premonitions of speedy death which almost invariably accompany a severe gun-shot wound, even with the most intrepid spirits; while thus drooping and dying, this once robust top-man's eye was now waning in his head like a Lapland moon being eclipsed in clouds—Cuticle, who for years had still lived in his withered tabernacle of a body—Cuticle, no doubt sharing in the common self-delusion of old age—Cuticle must have felt his hold of life as secure as the grim hug of a grizzly bear. Verily, Life is more awful than Death; and let no man, though his live heart beat in him like a cannon—let him not hug his life to himself; for, in the predestinated necessities of things, that bounding life of his is not a whit more secure than the life of a man on his death-bed. To-day we inhale the air with expanding lungs, and life runs through us like a thousand Niles; but to-morrow we may collapse in death, and all our veins be dry as the Brook Kedron in a drought.

"And now, young gentlemen," said Cuticle, turning to the Assistant Surgeons, "while the patient is coming to, permit me to describe to you the highly-interesting operation I am about to perform."

"Mr. Surgeon of the Fleet," said Surgeon Bandage, "if you are about to lecture, permit me to present you with your teeth; they will make your discourse more readily understood." And so saying, Bandage, with a bow, placed the two semicircles of ivory into Cuticle's hands.

"Thank you, Surgeon Bandage," said Cuticle, and slipped the ivory into its place.

"In the first place, now, young gentlemen, let me direct your attention to the excellent preparation before you. I have had it unpacked from its case, and set up here from my state-room, where it occupies the spare berth; and all this for your express benefit, young gentlemen. This skeleton I procured in person from the Hunterian department of the Royal College of Surgeons in London. It is a masterpiece of art. But we have no time to examine it now. Delicacy forbids that I should amplify at a juncture like this"—casting an almost benignant glance toward the patient, now beginning to open his eyes; "but let me point out to you upon this thigh-bone"—disengaging it from the skeleton, with a gentle twist—"the precise place where I propose to perform the operation. Here, young gentlemen, here is the place. You perceive it is very near the point of articulation with the trunk."
"Yes," interposed Surgeon Wedge, rising on his toes, "yes, young gentlemen, the point of articulation with the acetabulum of the os innominatum."

"Where's your Bell on Bones, Dick?" whispered one of the assistants to the student next him. "Wedge has been spending the whole morning over it, getting out the hard names."

"Surgeon Wedge," said Cuticle, looking round severely, "we will dispense with your commentaries, if you please, at present. Now, young gentlemen, you cannot but perceive, that the point of operation being so near the trunk and the vitals, it becomes an unusually beautiful one, demanding a steady hand and a true eye; and, after all, the patient may die under my hands."

"Quick, Steward! water, water; he's fainting again!" cried the two mess-mates.

"Don't be alarmed for your comrade; men," said Cuticle, turning round. "I tell you it is not an uncommon thing for the patient to betray some emotion upon these occasions—most usually manifested by swooning; it is quite natural it should be so. But we must not delay the operation. Steward, that knife—no, the next one—there, that's it. He is coming to, I think"—feeling the top-man's wrist. "Are you all ready, sir?"

This last observation was addressed to one of the Never-sink's assistant surgeons, a tall, lank, cadaverous young man, arrayed in a sort of shroud of white canvas, pinned about his throat, and completely enveloping his person. He was seated on a match-tub—the skeleton swinging near his head—at the foot of the table, in readiness to grasp the limb, as when a plank is being severed by a carpenter and his apprentice.

"The sponges, Steward," said Cuticle, for the last time taking out his teeth, and drawing up his shirt sleeves still further. Then, taking the patient by the wrist, "Stand by, now, you mess-mates; keep hold of his arms; pin him down. Steward, put your hand on the artery; I shall commence as soon as his pulse begins to—now, now!" Letting fall the wrist, feeling the thigh carefully, and bowing over it an instant, he drew the fatal knife unerringly across the flesh. As it first touched the part, the row of surgeons simultaneously dropped their eyes to the watches in their hands while the patient lay, with eyes horribly distended, in a kind of waking trance. Not a breath was heard; but as the quivering flesh parted in a long, lingering gash, a spring of blood welled up between the living walls of the wounds, and two thick streams, in opposite directions, coursed down the thigh. The sponges were instantly dipped in the purple pool; every face present was pinched to a point with suspense; the limb writhed; the man shrieked; his mess-mates pinioned him; while round and round the leg went the unpitying cut.

"The saw!" said Cuticle.

Instantly it was in his hand. Full of the operation, he was about to apply it, when, looking up, and turning to the assistant surgeons, he said, "Would any of you young gentlemen like to apply the saw? A splendid subject!"

Several volunteered; when, selecting one, Cuticle surrendered the instrument to him, saying, "Don't be hurried, now; be steady."

While the rest of the assistants looked upon their comrade with glances of envy, he went rather timidly

to work; and Cuticle, who was earnestly regarding him, suddenly snatched the saw from his hand. "Away, butcher! you disgrace the profession. Look at me!"
For a few moments the thrilling, rasping sound was heard; and then the top-man seemed parted in twain at the hip, as the leg slowly slid into the arms of the pale, gaunt man in the shroud, who at once made away with it, and tucked it out of sight under one of the guns.

"Surgeon Sawyer," now said Cuticle, courteously turning to the surgeon of the Mohawk, "would you like to take up the arteries? They are quite at your service, sir."

"Do, Sawyer; be prevailed upon," said Surgeon Bandage.

Sawyer complied; and while, with some modesty he was conducting the operation, Cuticle, turning to the row of assistants said, "Young gentlemen, we will now proceed with our Illustration. Hand me that bone, Steward." And taking the thigh-bone in his still bloody hands, and holding it conspicuously before his auditors, the Surgeon of the Fleet began:

"Young gentlemen, you will perceive that precisely at this spot—here—to which I previously directed your attention—at the corresponding spot precisely—the operation has been performed. About here, young gentlemen, here"—lifting his hand some inches from the bone—"about here the great artery was. But you noticed that I did not use the tourniquet; I never do. The forefinger of my steward is far better than a tourniquet, being so much more manageable, and leaving the smaller veins uncompressed. But I have been told, young gentlemen, that a certain Seignior Seignioroni, a surgeon of Seville, has recently invented an admirable substitute for the clumsy, old-fashioned tourniquet. As I understand it, it is something like a pair of calipers, working with a small Archimedes screw—a very clever invention, according to all accounts. For the padded points at the end of the arches"—arching his forefinger and thumb—"can be so worked as to approximate in such a way, as to—but you don't attend to me, young gentlemen," he added, all at once starting. Being more interested in the active proceedings of Surgeon Sawyer, who was now threading a needle to sew up the overlapping of the stump, the young gentlemen had not scrupled to turn away their attention altogether from the lecturer. A few moments more, and the top-man, in a swoon, was removed below into the sick-bay. As the curtain settled again after the patient had disappeared, Cuticle, still holding the thigh-bone of the skeleton in his ensanguined hands, proceeded with his remarks upon it; and having concluded them, added, "Now, young gentlemen, not the least interesting consequence of this operation will be the finding of the bullet, which, in case of non-amputation, might have long eluded the most careful search. That ball, young gentlemen, must have taken a most circuitous route. Nor, in cases where the direction is oblique, is this at all unusual. Indeed, the learned Henner gives us a most remarkable—I had almost said an incredible—case of a soldier's neck, where the bullet, entering at the part called Adam's Apple—"

"Yes," said Surgeon Wedge, elevating himself, "the pomum Adami."

"Entering the point called Adam's Apple," continued Cuticle, severely emphasising the last two words, "ran completely round the neck, and, emerging at the same hole it had entered, shot the next man in the ranks. It was afterward extracted, says Renner, from the second man, and pieces of the other's skin were found adhering to it. But examples of foreign substances being received into the body with a ball, young gentlemen, are frequently observed. Being attached to a United States ship at the time, I happened to be near the spot of the battle of Ayacucho, in Peru. The day after the action, I saw in the barracks of the wounded a trooper, who, having been severely injured in the brain, went crazy, and, with his own holster-pistol, committed suicide in the hospital. The ball drove inward a portion of his woollen night-cap——"

"In the form of a cul-de-sac, doubtless," said the undaunted Wedge.

"For once, Surgeon Wedge, you use the only term that can be employed; and let me avail myself of

this opportunity to say to you, young gentlemen, that a man of true science"—expanding his shallow chest a little—"uses but few hard words, and those only when none other will answer his purpose; whereas the smatterer in science"—slightly glancing toward Wedge—"thinks, that by mouthing hard words, he proves that he understands hard things. Let this sink deep in your minds, young gentlemen; and, Surgeon Wedge "—with a stiff bow—"permit me to submit the reflection to yourself. Well, young gentlemen, the bullet was afterward extracted by pulling upon the external parts of the cul-de-sac—a simple, but exceedingly beautiful operation. There is a fine example, somewhat similar, related in Guthrie; but, of course, you must have met with it, in so well-known a work as his Treatise upon Gun-shot Wounds. When, upward of twenty years ago, I was with Lord Cochrane, then Admiral of the fleets of this very country"—pointing shoreward, out of a port-hole—"a sailor of the vessel to which I was attached, during the blockade of Bahia, had his leg——" But by this time the fidgets had completely taken possession of his auditors, especially of the senior surgeons; and turning upon them abruptly, he added, "But I will not detain you longer, gentlemen"—turning round upon all the surgeons—"your dinners must be waiting you on board your respective ships. But, Surgeon Sawyer, perhaps you may desire to wash your hands before you go. There is the basin, sir; you will find a clean towel on the rammer. For myself, I seldom use them"—taking out his handkerchief. "I must leave you now, gentlemen"—bowing. "To-morrow, at ten, the limb will be upon the table, and I shall be happy to see you all upon the occasion. Who's there?" turning to the curtain, which then rustled.

"Please, sir," said the Steward, entering, "the patient is dead."

"The body also, gentlemen, at ten precisely," said Cuticle, once more turning round upon his guests. "I predicted that the operation might prove fatal; he was very much run down. Good-morning;" and Cuticle departed.

"He does not, surely, mean to touch the body?" exclaimed Surgeon Sawyer, with much excitement.

"Oh, no!" said Patella, "that's only his way; he means, doubtless, that it may be inspected previous to being taken ashore for burial."

The assemblage of gold-laced surgeons now ascended to the quarter-deck; the second cutter was called away by the bugler, and, one by one, they were dropped aboard of their respective ships.

The following evening the mess-mates of the top-man rowed his remains ashore, and buried them in the ever-vernal Protestant cemetery, hard by the Beach of the Flamingoes, in plain sight from the bay.

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*

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.

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 photographs, or be a story of the photographer's life and motivations.

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.

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.

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