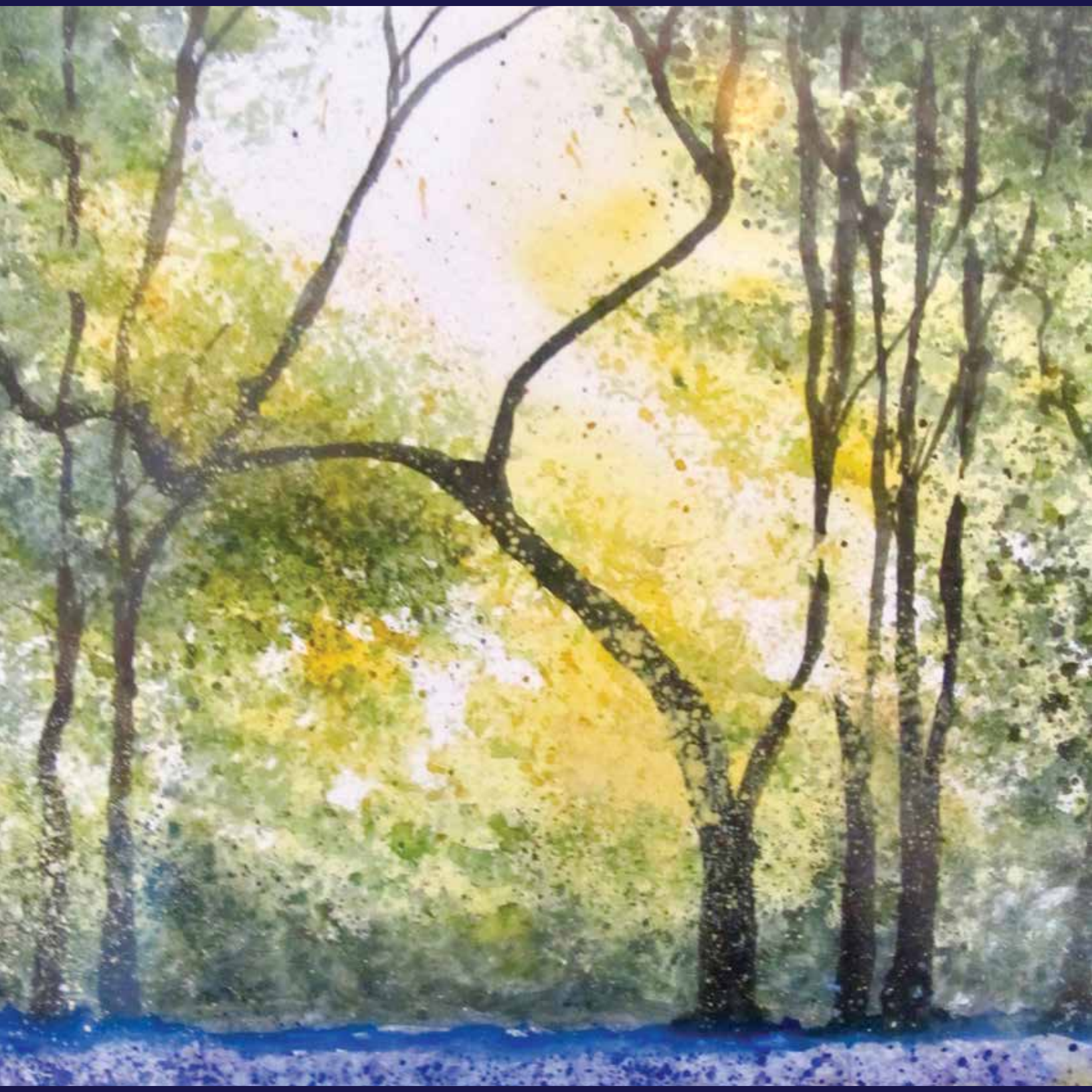
Journal of the SURGICAL HUMANITIES



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Journal of the
SURGICAL HUMANITIES

COVER PAGE
Alone
Syed Hasan

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EDITORIAL

Francis Christian, FRCSEd, FRCSC
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Without taking political sides, it was still possible to discern a certain pall of silence that had descended upon and taken hold of physicians throughout the 2016 American election season. A particular candidate's views could not be discussed, except in hushed whispers in deserted hospital corridors.

It was impossible to talk, much less agree about any of this candidate's views, without at the same time having to condemn the candidate's personality, candidature and the total and naive stupidity of the American nation that had selected such a candidate! Almost always, apocalyptic terms of disapproval would be used - and the conversation would be brought to an abrupt halt. No more than two or three sentences were possible if one of the company agreed with any of this candidate's views. Of course, if all were in agreement about the "vile" qualities of this candidate, a merry verbal lynching issued forth of the candidate and his millions of American supporters.

A few colleagues have told me how they were rapidly shut down when they expressed even a superficial agreement with any of this candidate's views. This had the chilling effect of stifling a consequential discussion and instilling fear, even dread, in the apparent minority that viewed at least some of this candidate's ideas with admiration or even a healthy curiosity - not only could they not talk openly about their views, some of them were even subjected to a crescendo of progressive ridicule that left them bruised and battered.

Could it be that we, of the inheritors of free speech, the values of the Enlightenment and of the supreme principle of individual worth … are in fact living in a dystopian world where all of us are expected to conform to a certain way of thinking? Winston, in Orwell's "1984" was one of only a very few individuals who realized that the people of "Oceania" were all under the thrall of the "party line." Most of us who have read Orwell's book remember being frightened out of our wits not so much at the party line itself, but at the nonchalant indifference of Oceania's inhabitants who go about their daily tasks expecting benevolent "Big Brother" to teach them how to think and gladly accepting this instruction without ever expecting the chance to consider alternatives.

An engagement with the humanities can help dispel the intolerable fog of conformed, uniform belief. It is convenient and easy for human beings to accept, for the sake of "simplicity," a certain point of view and to use a very superficial understanding of its merits to consciously and subconsciously resist any challenge to its validity. The danger, of course, is that this supposedly "uncomplicated" view removes the ability to debate opposite views, to thresh out and winnow the chaff and to cherish the robust grain of human progress that remains. A fear of not being able to defend one's views against other, perhaps equally valid views lies behind much of the desire to shut down conversation - and this of course, applies to both or any sides in a debate.

The humanities have the ability to probe the depths of man in a way that science alone cannot - and one of its abiding values is its ability to teach us about the frailties, the foibles, and the imperfections of human beings and of our imperfect, incomplete world. Our engagement with history and poetry and literature and music can broaden our view of the world and even of presidential candidates we do not agree with, but who must nevertheless get a fair hearing, in the grand tradition of Aristotle's Lyceum, the Bhagavad Gita or St. Paul's letter to the Romans.

To the incoming, 2016 class of freshmen and women, Jay Ellison, Dean of Students at Chicago University wrote: *"Once here, you will discover that one of the University of Chicago's defining characteristics is our commitment to freedom of inquiry and expression. Members of our community are encouraged to speak, write, listen, challenge and learn, without fear of censorship. You will find that we expect members of our community to be engaged in rigorous debate, discussion and even disagreement.*

Our commitment to academic freedom means that we do not support so-called "trigger warnings," we do not cancel invited speakers because their topics might prove controversial, and we do not condone the creation of intellectual "safe spaces" where individuals can retreat from ideas and perspectives at odds with their own."

Do we agree with the Dean? Can those who hold supporting and opposing views discuss his letter freely, without fear of ridicule or censorship? Surely, such a discussion would be at the very core of the idea of a University and at the heart of a true engagement with the humanities.

Francis Christian
Editor-in-Chief

Winter in Saskatoon (2016)
I. Mendez

Dispatches from the Middle East:
MEDICINE IN THE WEST BANK

Eldad Kisch, MD, Endocrinologist
Physicians for Human Rights, Israel

The "Physicians for Human Rights" (PHR) organization was founded some 25 years ago in Israel out of a deep political conviction that the medical profession cannot remain silent in the face of many injustices that surround us. This conviction was from the start accompanied by a practical humanitarian application to alleviate the problems at hand. To date, PHR has around 900 members; out of this number some ten percent participate actively in the aims of the organization, which are:

- Medical help for minorities within Israel, who often have no medical insurance and accordingly no access to organized medical care. This includes also a large body of foreign workers, who stay illegally in Israel, and have no status at all. PHR operates a general medical clinic and arranges access to specialists for the benefit of this group. Medication is offered free of charge, as available.
- Since its inception, PHR has maintained an active interest in the medical services in prisons, in general and for political prisoners.

Visits for our medical volunteers are arranged as necessary. This activity was even more pronounced during the not infrequent hunger-strikes, where PHR physicians serve as a kind confidence-MD for the strikers.
- In addition, during all these years, PHR has operated mobile clinics staffed by volunteer doctors, nurses and interpreters in the Palestinian territories in cooperation with local medical organizations, even during the worst of the Intifadas; these day-long activities take place in the West-Bank only, since to date the Gaza-strip is essentially inaccessible to our teams. Even so, from time to time small selected teams, consisting of Arab-Israelis only, have been allowed to enter Gaza by the Israeli authorities, mostly during week-ends, and often a series of operations are then performed in the local hospitals with doctors from Gaza attending.

The weekly clinics, manned by general practitioners and specialists, are mobile, and convene on an ad hoc basis where there is

a concentrated need for help and intervention as assessed by our coordinator, and set out on the day of rest here in Israel, on Saturdays. As mentioned, all this is planned and executed in close cooperation with local organizations, the Palestinian Red Crescent, voluntary associations such as "Palestinian Medical Relief Committee" and "Patients' Friends Society". The clinics are accompanied by a pharmacy and staffed by a volunteer pharmacist; the work is all on a voluntary basis, but considerable costs are incurred for coordination, transportation and medicine. A sizable proportion of the member-doctors in our teams are Arab-Israelis, a fact which of course facilitates contact with the population in need. Many of the Jewish-Israeli MD's work through interpreters, both volunteer nurses and para-medical persons, or medical students, from Israel (who translate into Hebrew) and local Palestinian health personnel (translating in English).

Some Israeli specialists from the surgical professions come and perform operations in Palestinian facilities on the West Bank, together with their Palestinian colleagues; this is of direct benefit for the patients and a learning experience for the local medical personnel.

My own experience as an endocrinologist consists of at least one monthly visit to cities or large villages in the West-Bank. These consultations are held in school-buildings, since the local clinics are too small for our teams. Such visits attract hundreds of patients from miles around in the surroundings, who have made great efforts to be present at the clinics, in the face of serious travel restrictions for the Palestinian population.

Patients are ideally referred by their local physicians, but they mostly hear about the clinics and arrive on

their own initiative, if only to get a free second opinion. An added attraction is the free medication that we hand out.

My main occupation is to deal with diabetic patients, very often children. The level of diabetes control I get to see is appalling by any Western standard. The stories I hear from patients, or the mothers, are hair-raising for somebody as "spoiled" as I am with all modern amenities available, practically without restriction.

The typical problems are manifold. Their most recent blood glucose determination may be a couple of months old. A glycated hemoglobin value is rarely measured. The first and foremost concern is the absence of a steady supply of insulin. Often patients, or the mother, cannot get sufficient insulin to last until the next visit. Therefore patients inject "half the ordered dose" in order to make the insulin last. Or their own prescribed insulin is no longer available, and they get some other type (no, you read correctly, not another brand – a different type) of insulin, which is conscientiously injected in the prescribed dosage. Small wonder that when we check blood sugars on site, we encounter blood glucose values of 300 or 400 mg/dl. Practically none of the patients own glucose-meters for self-monitoring. Financial constraints play an overwhelming role here. When I initially asked the patients whether they had consulted a dietitian, I drew blank faces. I soon stopped asking; there are no such luxuries available. I have not seen a single insulin pen-injection device, neither are insulin pumps in use. Disposable insulin syringes are available, yet I was afraid to ask how often they are used in order to cut cost. I have not encountered a single patient who used an insulin analog. I assume that the price is the limiting factor. The degree of diabetes control in type 1 patients can be guessed. In contrast, those Palestinians, who are 'lucky' enough to be classified refugees, have access to the very extensive medical coverage under the aegis of UNWRA and this

group is not plagued by these shortcomings. So things can look very different, from patient to patient, in the same region.

It would be very desirable for a local colleague to be present at the time of our weekly clinic rounds, so that some form of continuity in treatment can be assured. For some reason this never materialized. Also in my field this never happens, possibly since there just are very few endocinologists/diabetologists in the occupied West-Bank. Even the presence of the local general practitioner would be most helpful in this respect, and this I achieved on a separate track with much help from PHR during many years by coming on a weekday to several selected sites in rotation, thus assuring the much needed continuity and at the same time training the local doctor where his knowledge is lacking.

We realize that we operate in a very sensitive situation, and there is a feeling that the local doctors possibly think of our clinics as an expression of superior knowledge (which is certainly not our intention). Another stumbling block is the possible adverse impression that any form of cooperation might be seen as a sign of tacit approval of the occupation by Palestinian doctors.

Yet there is a ray of hope. We arrange from time to time for day-long seminars in the major cities of the West Bank covering all fields of medicine, and specifically also on diabetes, for our Palestinian colleagues. These seminars are held in cooperation with the local chapters of the Palestinian Medical Association and PHR. Over 100 doctors from the area eagerly attend such seminars, with the official greetings and backing of local dignitaries.

In view of the lack of basic necessities such as an uninterrupted supply of insulin, we often do not know what comes of our advice, even though all patients leave the consultation with a short report, written in English for us who do not know Arabic, intended to be handed by the patient to their general practitioner.

Most patients have some sort of very minimal medical insurance through the Palestinian Authority, but although this apparently covers insulin, the supplies are certainly not always sufficient or uninterrupted. We from the PHR organization, on the other hand, do not carry perishable medicines in our field pharmacy, so no insulin is brought in with our mobile pharmacy.

In conversations with Palestinians who are knowledgeable, I was told that the flow of insulin to the territories is controlled by Israeli authorities at the different border checkpoints; for the least irregularity in the attendant paperwork, the shipment is held up, sometimes outside in the sun. At best storage conditions there are sub-optimal, so that any bureaucratic delay causes loss of insulin. A chronic lack of funds, due to misappropriation of available money, is also cited as a source of scarcity of medicines.

Complicated cases may be referred by us to Israeli hospitals. Yet this is not as simple as it sounds.

There is the matter of payment for the service rendered, and it is no easy task to get this problem solved. Another serious hurdle is the political situation surrounding the prospective patient. If he, or a close relative, is in the faintest way involved with subversive activities or leanings, as understood by the security services, he will not be permitted to enter Israel. Another obstacle is caused by the frequent 'closures'. Amongst our Palestinian partners there is a feeling of helplessness in their situation.

I reiterate that the level of diabetes treatment that I have encountered, is not acceptable by any standard. There are many reasons for this. Local doctors have been trained at different locations, at different levels of excellence. Therefore, there is no uniform outlook on medical problems and their possible solutions. Also, through lack of basic amenities, like absence of glucose meters for the patients for home use, the task of the local doctors is practically impossible, even though it is to be hoped that our Palestinian colleagues have the basic knowledge to treat diabetes as well as we do. International medical help would be a possible solution to urgent problems, but this should be a continuing effort, with hands-on medical teams on site, in close cooperation with the local expertise and not another effort at raising money that not necessarily will reach those in need.

And then there is another side to this dismal picture. Israel has quietly, without public fanfare, offered medical solutions for the many patients who manage to come across the border during the ongoing upheavals in neighboring Syria. A military field hospital was set up adjacent to the Syrian border, specifically for the many wounded there from the warring factions and more difficult cases have been referred to Israeli hospitals in the North of Israel, no questions asked, whether combatants or civilians. These are treated as all the Israeli patients, on the same wards as the Jewish population, with the same care. This also pertains within Israel, where Arab Israelis are treated, as a matter of course, side by side with Jewish Israelis in the same clinics and on the same wards. Any observer who has visited Israel knows this, and one should only inspect our university campuses, including our medical schools, to see that no Apartheid is in force in these areas. By the way, the Arab Israelis make fine doctors, who are eagerly employed in all Israeli hospitals.

Finally, I was asked how these medical interventions, in my opinion, bear on the possibility to a solution to our long-standing conflicts in the area. One point of advantage is that many children who accompany their parents to our mobile clinics, see here for the first time in their lives, Israeli's who do not look at them through the sights of a gun, but are civilians who come voluntarily across the "Green Line" on their free day off and have a friendly word and a smile for them. That is a success not to be belittled. Clearly, the patients in our clinic and in the Israeli hospitals are very grateful for the treatment. On the other hand, my opinion is that peace is not reached from below, but from the top, by leaders with a vision. Regretfully, those leaders are non-existent in these parts.

Dr. Eldad Kisch was born, raised and trained in the Netherlands. After graduation he settled in Israel and specialized in endocrinology. Now retired. after more than forty years working in hospitals and sick-funds in that specialty, with much exposure to diabetes. He is a long-time member of the organization “Physicians for Human Rights”, and has been active 'in the field' for many years. He writes very often about his experience with his work as a PHR doctor and in general about the vicissitudes of the Israeli peace movement (in Dutch) and these columns are read extensively in the Netherlands through a mailing list, websites and several journals.

«««« *Dr. Eldad Kisch (Photo by Iemke Ruige)*

THE SURGEON AS ARTIST

Our cover artist and his art...

Syed Hasan, MD, FRCS
Truro, England

When I first took up painting, several years ago, it was not unlike the feeling a resident gets when he or she first takes up the knife – there is a certain eager expectation, but also a trepidation as the first incision is made. There was a trepidation and even a sense of awe and inadequacy when I first took up the brush! And then, just as with experience and application, the young surgeon learns the art of his craft, so too with painting, I became more confident and less anxious as my years as an artist rolled by.

And then, from being a practitioner of the art of surgery which is of its very nature a precise exercise (you have to be neat, you have to be exact with your sutures and you have to tightly control the end result), I had to learn to be a "loose" artist – to be less concerned with precise borders, to be bold in merging colors; and rather than "painting by numbers," I had to learn to apply a dash of green there a blush of blue here, with a certain, loose freedom. There is no such thing as "poetic license" for the surgeon – you cannot take the liberty to simply join any two ends of the bowel together, for example! But an artist is compelled to use poetic license to interpret the art in different, varying

Self-portrait (Detail)
Syed Hasan

and ever-changing ways. Therefore, from being in the precise world of the surgeon, I had to move with faltering steps to the "loose" world of the artist, until at last, I knew I had "arrived." This journey in fact took me all of ten years.

But there is a real (though not at first apparent) advantage to moving to the less controlled world of the artist – it made me more creative, an attribute that flowed back from my art to the rest of my life, including my life as a surgeon. I realized that art and science in this way become indispensable to each other.

Initially, I took up painting since I wanted a creative interest to occupy my retirement years. Painting had unique advantages for the surgeon – I could start a painting, attend to a call, or carry out an operation … and then come right back to the same painting, without any sense of "loss." I could not, for example, leave a golf course, on hole 7 and go off to attend a call, without forfeiting the game! It also helped that I considered surgery to be a type of artistic pursuit as well, since a surgeon likes to look at his work and take satisfaction at the finished task of an operation.

Poppies (Detail)
Syed Hasan

Also, from the precise and orderly way I arranged my instruments and the controlled movements I made as a surgeon, I was able to arrange my brushes and colors and canvases in neat, orderly rows – and to this day, my teachers compliment me for my neatness!

The life of an artist also makes you a proper student of nature and therefore enhances your powers of observation. I remember the first scene my Art Instructor asked me to draw – I was to draw the meadow, the trees and the sky before me. And as if on cue, I drew a green meadow, somewhat greener trees and a blue sky. My teacher then took me properly to task – the sky that I thought was blue, was in fact a greying pink; and the trees were several different shades of green, with some purple and yellow thrown in, with the meadow being green only in parts. I learned afterwards that a mountain is almost never brown or black – but several, rich, varying, overlapping shades, merging into one another.

I took up watercolor for several reasons – firstly, my Instructor was a watercolor artist; but also, I liked the fact that watercolor was less forgiving than oil and mistakes could not easily be corrected or painted over – perhaps this was the surgeon in me! In addition, watercolor was simple to set up, with a minimum of equipment (which was relatively much cheaper) and with the ability to "clean up" easily afterwards. Perhaps

it is for similar reasons that great artists of the past have preferred watercolor! For the aspiring artist reading this article, I should add that there is now available a very good water soluble acrylic paint for artists, which you can use instead of oil paint (of which I do not yet have first-hand experience).

It is in the world of light and color that the artist lives and dreams. Different shades of color merge into different shades and intensities of light and the public will judge every painting based upon the artist's skill and vision in bringing light and color together in actual and imaginative forms.

My life as an artist has been exceedingly rewarding – and it has been immensely satisfying to share my engagement with the humanities with both students and patients. The surgeon is uniquely positioned to be a champion for the humanities, since he or she is every day confronted with the human story.

Delicious
Syed Hasan

Stormchaser (Detail)
Syed Hasan

Do You See What I See
Syed Hasan

ABOUT OUR ARTIST:

Syed Hasan completed his training in cardio-thoracic surgery in London and Leeds in the U.K. In 1983, he started a distinguished twenty year career in Truro, Cornwall, in the South-West of England. The majority of his work was in pulmonary and esophageal oncological surgery and in cardio-thoracic trauma. After his retirement in 2003, he taught at the Plymouth Medical School for a further 8 years, using problem based learning modules to teach clinical medicine and surgery and teaching anatomy and the humanities to third and fourth year medical students.

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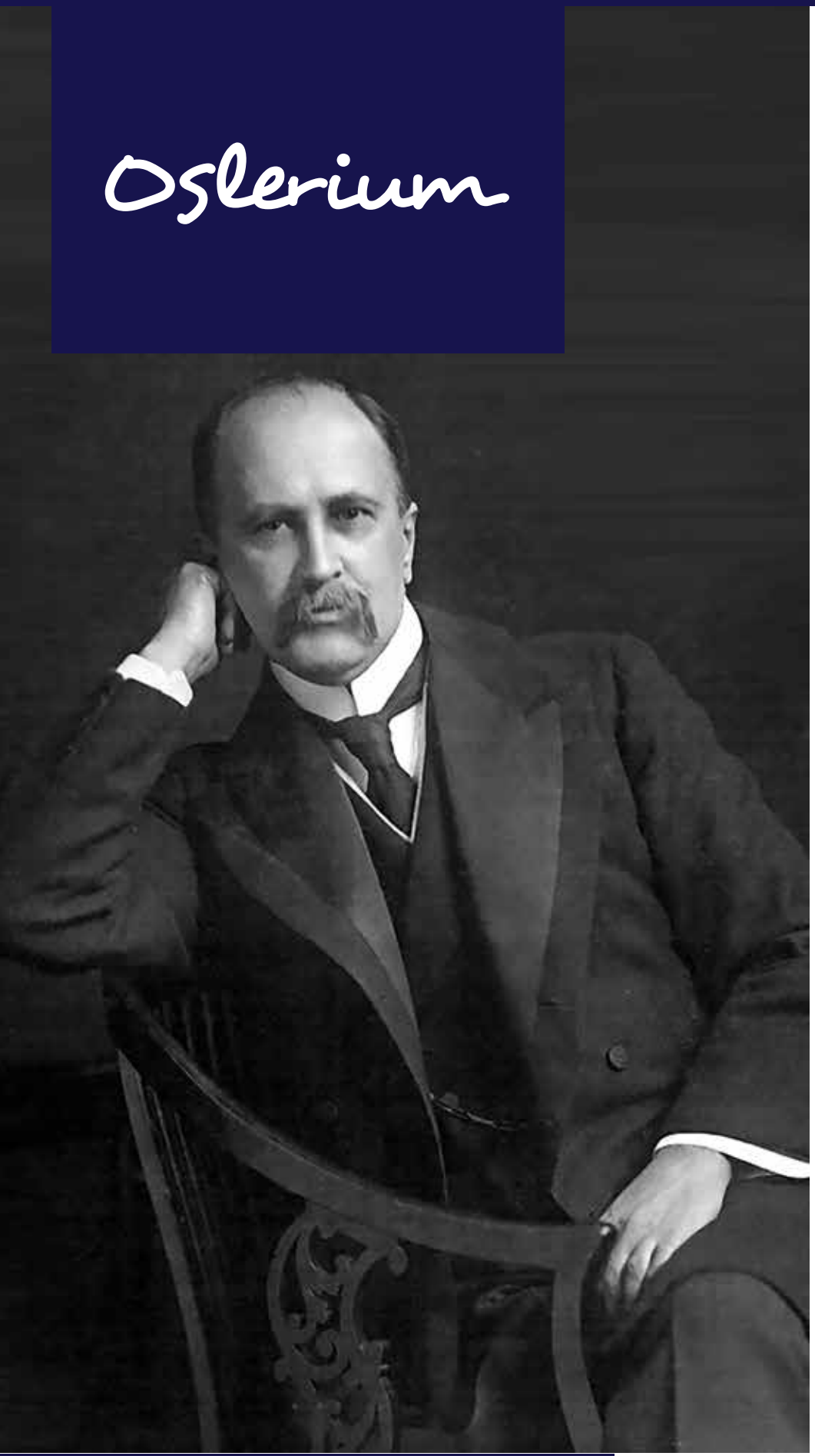


Every issue of "Surgical Humanities" carries an excerpt from the works of the pre-eminent Canadian physician Sir William Osler (1849-1919).

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

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

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

About SIR WILLIAM OSLER

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

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

In 1884, Osler was appointed to the staff of the University of Pennsylvania as Professor of clinical medicine and this was the start of a 21 year period of work and achievement in the United States. His appointment to the founding professorship and staff of the new John Hopkins Medical School in Baltimore in 1888 marked the beginning of a very fruitful association with the "Big Four" - the pathologist William Welch, surgeon William Halstead, gynecologist Howard Kelly (and Osler himself). Together, the "big four" would introduce far reaching changes in medical education that are still felt today - the clinical clerkship for medical students and the residency system of training were both products of this association. About this time, Osler also began a series of brilliant speeches and addresses whose impact would be felt far beyond the audiences for whom they were intended. The "Principles and Practice of Medicine," a monumental treatise, was published in 1892.

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

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

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

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

Sources:

"Osler - A Life in Medicine" by Michael Bliss. Hardcover, by University of Toronto Press, 1999. Also available for Kindle.

Note:

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

In 1905, the University of Oxford offered Osler the prestigious appointment of "Regius Professor of Medicine." After a short period of consideration (Harvard University had also offered him a job), and largely at the urgings of his wife, Osler accepted the offer and then began a farewell tour of North America.

Although this speech – given to Canadian and American medical students and faculty at McGill University in 1905 – was titled, "The Student Life," Osler included all medical professionals in all stages of their careers in his speech. Again and again, and in numerous essays, speeches and letters, Osler points out that no matter what stage of seniority a physician reaches in his/her career, he/she continues to be a student. Thus, our modern, narrow definition of a student in our profession being defined as an undergraduate medical or nursing student, was alien to Osler's thinking. He points out in this speech that consultant staff are to regard themselves as "senior students," whose duty it is to help their juniors.

This issue of the Journal of The Surgical Humanities carries Part 3 of Osler's address.

F.C.

The value of experience is not in seeing much, but in seeing wisely.

Sir William Osler

THE STUDENT LIFE

Sir William Osler

In the days of probation the student's life may be lived by each one of you in its fullness and in its joys, but the difficulties arise in the break which follows departure from college and the entrance upon new duties.

Much will now depend on the attitude of mind which has been encouraged. If the work has been for your degree, if the diploma has been its sole aim and object, you will rejoice in a freedom from exacting and possibly unpleasant studies, and with your books you will throw away all thoughts of further systematic work. On the other hand, with good habits of observation you may have got deep enough into the subject to feel that there is still much to be learned, and if you have had ground into you the lesson that the collegiate period is only the beginning of the student life, there is a hope that you may enter upon the useful career of the student-practitioner.

Five years, at least, of trial await the man after parting from his teachers, and entering upon an independent course – years upon which his future depends, and from which his horoscope may be cast with certainty. It is all the same whether he settles in a country village or goes on with hospital and laboratory work; whether he takes a prolonged trip abroad; or whether he settles down in practice with a father or a friend – these five waiting years fix his fate so far as the student life is concerned. Without any strong natural propensity to study, he may feel such a relief after graduation that the effort to take to books is beyond his mental strength, and a weekly journal with an occasional textbook furnish pabulum enough, at least to keep his mind hibernating. But ten years later he is dead mentally, past any possible hope of galvanizing into life as a student, fit to do a routine practice, often a capable, resourceful man, but without any deep convictions, and probably more interested in stocks or in horses than in diagnosis or therapeutics.

But this is not always the fate of the student who finishes his work on Commencement Day. There are men full of zeal in practice who give good service to their fellow creatures, who have not the capacity or the energy to keep up with the times. While they have lost interest in science, they are loyal members of the profession, and appreciate their responsibilities as such.

That fateful first lustrum ruins some of our most likely material. Nothing is more trying to the soldier than inaction, to mark time while the battle is raging all about him; and waiting for practice is a serious strain under which many yield. In the cities it is not so hard to keep up: there is work in the dispensaries and colleges, and the stimulus of the medical societies; but in smaller towns and in the country it takes a strong man to live through the years of waiting without some deterioration. I wish the custom of taking junior men as partners and assistants would grow on this continent. It has become a necessity, and no man in large general practice can do his work efficiently without skilled help. How incalculably better for

the seniors, how beneficial to the patients, how helpful in every way if each one of you, for the first five or ten years, was associated with an older practitioner, doing his night work, his laboratory work, his chores of all sorts. You would, in this way, escape the chilling and killing isolation of the early years, and amid congenial surroundings you could, in time, develop into that flower of our calling – the cultivated general practitioner. May this be the destiny of a large majority of you! Have no higher ambition! You cannot reach any better position in a community; the family doctor is the man behind the gun, who does our effective work. That his life is hard and exacting; that he is underpaid and overworked; that he has but little time for study and less for recreation – these are the blows that may give finer temper to his steel, and bring out the nobler elements in his character.

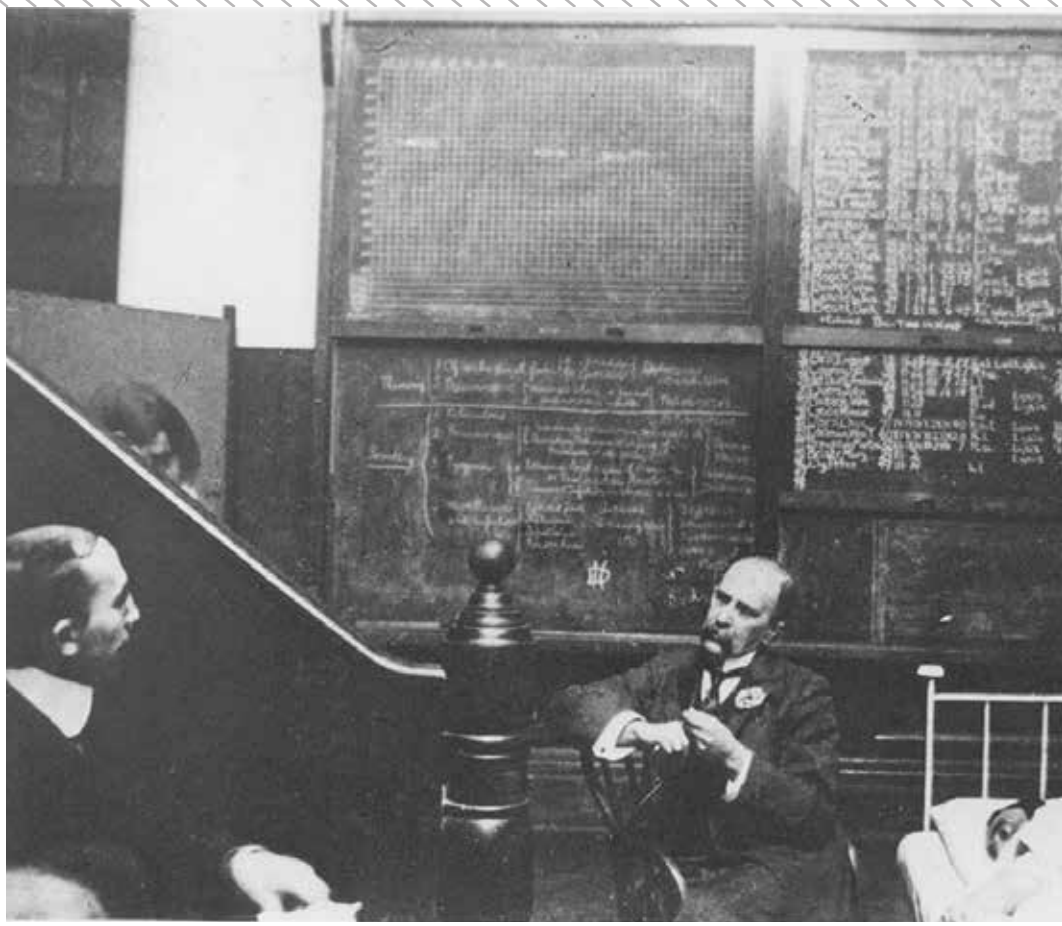
What lot or portion has the general practitioner in the student life? Not, perhaps, the fruitful heritage of Judah or Benjamin but he may make of it the goodly portion of Ephraim. A man with powers of observation, well trained in the wards, and with the strong natural propensity to which I have so often referred, may live the ideal student life, and even reach the higher levels of scholarship. Adams, of Banchory (a little Aberdeenshire village), was not only a good practitioner and a skilful operator, but he was an excellent naturalist. This is by no means an unusual or remarkable combination, but Adams became, in addition, one of the great scholars of the profession. He had a perfect passion for the classics, and amid a very exacting practice found time to read "almost every Greek work which has come down to us from antiquity, except the ecclesiastical writers." He translated the works of Paulus Aegineta, the works of Hippocrates, and the works of Aretaeus, all of which are in the Sydenham Society's publications, monuments of the patient skill and erudition of a Scottish village doctor, an incentive to everyone of us to make better use of our precious time.

Given the sacred hunger and proper preliminary training, the student-practitioner requires at least three things with which to stimulate and maintain his education - a notebook, a library, and a quinquennial (recurring every five years) braindusting. I wish I had time to speak of the value of note-taking. You can do nothing as a student in practice without it. Carry a small notebook which will fit into your waistcoat pocket, and never ask a new patient a question without notebook and pencil in hand. After the examination of a pneumonia case two minutes will suffice to record the essentials in the daily progress. Routine and system when once made a habit, facilitate work, and the busier you are the more time you will have to make observations after examining a patient. Jot a comment at the end of the notes: "clear case," "case illustrating obscurity of symptoms," "error in diagnosis," etc. The making of observations, may become the exercise of a jackdaw trick, like the craze which so many of us have to collect articles of all sorts. The study of the cases, the relation they bear to each other and to the cases in literature – here comes in the difficulty. Begin early to make a threefold category – clear cases, doubtful cases, mistakes. And learn to play the game fair, no self-deception, no shrinking from the truth; mercy and consideration for the other man, but none for yourself, upon whom you have

to keep an incessant watch. You remember Lincoln's famous mot about the impossibility of fooling all of the people all the time. It does not hold good for the individual who can fool himself to his heart's content all of the time. If necessary, be cruel; use the knife and the cautery to cure the intumescence and moral necrosis which you will feel in the posterior parietal region, in Gall and Spurzheim's centre of self-esteem, where you will find a sore spot after you have made a mistake in diagnosis. It is only by getting your cases grouped in this way that you can make any real progress in your post-collegiate education; only in this way can you gain wisdom with experience. It is a common error to think that the more a doctor sees the greater his experience and the more he knows. No one ever drew a more skilful distinction than Cowper in his oft-quoted lines, which I am never tired of repeating in a medical audience:

Knowledge and wisdom, far from being one,
Have oft-times no connexion. Knowledge dwells
In heads replete with thoughts of other men;
Wisdom in minds attentive to their own.
Knowledge is proud that he has learned so much;
Wisdom is humble that he knows no more.

What we call sense or wisdom is knowledge, ready for use, made effective, and bears the same relation to knowledge itself that bread does to wheat. The full



knowledge of the parts of a steam engine and the theory of its action may be possessed by a man who could not be trusted to pull the lever to its throttle. It is only by collecting data and using them that you can get sense. One of the most delightful sayings of antiquity is the remark of Heraclitus upon his predecessors – that they had much knowledge but no sense – which indicates that the noble old Ephesian had a keen appreciation of their difference; and the distinction, too, is well drawn by Tennyson in the oft-quoted line:

Knowledge comes but wisdom lingers.

Of the three well-stocked rooms which it should be the ambition of every young doctor to have in his house, the library, the laboratory, and the nursery – books, balances, and bairns – as he may not achieve all three, I would urge him to start at any rate with the books and the balances. A good weekly and a good monthly journal to begin with, and read them. Then, for a systematic course of study, supplement your college textbooks with the larger systems – Allbutt or Nothnagel – a system of surgery, and, as your practice increases, make a habit of buying a few special monographs every year. Read with two objects: first, to acquaint yourself with the current knowledge on the subject and the steps by which it has been reached; and secondly, and more important, read to understand and analyse your cases. To this line of work we should direct the attention of the student before he leaves the medical school, pointing in specific cases just where the best

articles are to be found, sending him to the Index Catalogue – that marvellous storehouse, every page of which is interesting and the very titles instructive. Early learn to appreciate the differences between the descriptions of disease and the manifestations of that disease in an individual – the difference between the composite portrait and one of the component pictures. By exercise of a little judgment you can collect at moderate cost a good working library. Try, in the waiting years, to get a clear idea of the history of medicine. Read Foster's Lectures on the History of Physiology and Baas's History of Medicine. Get the "Masters of Medicine" Series, and subscribe to the Library and Historical Journal.

Every day do some reading or work apart from your profession. I fully realize, no one more so, how absorbing is the profession of medicine; how applicable to it is what Michelangelo says: "There are sciences which demand the whole of a man, without leaving the least portion of his spirit free for other distractions"; but you will be a better man and not a worse practitioner for an avocation. I care not what it may be; gardening or farming, literature or history or bibliography, anyone of which will bring you into contact with books. (I wish that time permitted me to speak of the other two rooms which are really of equal importance with the library, but which are more difficult to equip, though of co-ordinate value in the education of the head, the heart, and the hand.)

The third essential for the practitioner as a student is the quinquennial braindusting, and this will often seem to him the hardest task to carry out. Every fifth year, back to the hospital, back to the laboratory, for renovation, rehabilitation, rejuvenation, reintegration, resuscitation, etc. Do not forget to take the notebooks with you, or the sheets, in three separate bundles, to work over. From the very start begin to save for the trip. Deny yourself all luxuries for it; shut up the room you meant for the nursery – have the definite determination to get your education thoroughly well started; if you are successful you may, perhaps, have enough saved at the end of three years to spend six weeks in special study; or in five years you may be able to spend six months. Hearken not to the voice of old "Dr. Hayseed," who tells you it will ruin your prospects, and that he "never heard of such a thing" as a young man, not yet five years in practice, taking three months' holiday. To him it seems preposterous. Watch him wince when you say it is a speculation in the only gold mine in which the physician should invest – Grey Cortex! What about the wife and babies, if you have them? Leave them! Heavy as are your responsibilities to those nearest and dearest, they are outweighed by the responsibilities to yourself, to the profession, and to the public. Like Isaphaena, the story of whose husband – ardent, earnest soul, peace to his ashes! – I have told in the little sketch of An Alabama Student, your wife will be glad to bear her share in the sacrifice you make.

With good health and good habits the end of the second lustrum should find you thoroughly established – all three rooms well furnished, a good stable, a good garden, no mining stock, but a life insurance, and, perhaps, a mortgage or two on neighbouring farms. Year by year you have dealt honestly with yourself; you have put faithfully the notes of each case into their proper places, and you will be gratified to find that, though the doubtful cases and mistakes still make a rather formidable pile, it has grown relatively smaller. You literally "own" the countryside, as the expression is. All the serious and dubious cases come to you, and you have been so honest in the frank acknowledgment of your own mistakes, and so charitable in the contemplation of theirs, that neighbouring doctors, old and young, are glad to seek your advice. The work, which has been very heavy, is now lightened by a good assistant, one of your own students, who becomes in a year or so your partner.

This is the type of man we need in the country districts and the smaller towns. He is not a whit too good to look after the sick, not a whit too highly educated – impossible! And with an optimistic temperament and a good digestion he is the very best product of our profession, and may do more to stop quackery and humbuggery, inside and outside of the ranks, than could a dozen prosecuting county attorneys. Nay, more! such a doctor may be a daily benediction in the community – a strong, sensible, whole-souled

man, often living a life of great self-denial, and always of tender sympathy, worried neither by the vagaries of the well nor by the testy waywardness of the sick, and to him, if to any, may come (even when he knows it not) the true spiritual blessing – that "blessing which maketh rich and addeth no sorrow." The danger in such a man's life comes with prosperity. He is safe in the hard-working day, when he is climbing the hill, but once success is reached, with it come the temptations to which many succumb. Politics has been the ruin of many country doctors, and often of the very best, of just such a good fellow as he of whom I have been speaking. If you live in a large town, resist the temptation to open a sanatorium. It is not the work for a general practitioner, and there are risks that you may sacrifice your independence and much else besides. And, thirdly, resist the temptation to move into a larger place. In a good agricultural district, or in a small town, if you handle your resources aright, taking good care of your education, of your habits, and of your money, and devoting part of your energies to the support of the societies, etc., you may reach a position in the community of which any man may be proud. There are country practitioners among my friends with whom I would rather change places than with any in our ranks, men whose stability of character and devotion to duty make one proud of the profession.

Curiously enough, the student-practitioner may find studiousness to be a stumbling-block in his career. A bookish man may never succeed; deep-versed in books, he may not be able to use his knowledge to practical effect; or, more likely, his failure is not because he has studied books much, but because he has not studied men more. He has never got over that shyness, that diffidence, against which I have warned you. I have known instances in which this malady was incurable; in others I have known a cure effected not by the public, but by the man's professional brethren, who, appreciating his work, have insisted upon utilizing his mental treasures.

It is very hard to carry student habits into a large city practice; only zeal, a fiery passion, keeps the flame alive, smothered as it is so apt to be by the dust and ashes of the daily routine. A man may be a good student who reads only the book of nature. Such a one I remember in the early days of my residence in Montreal – a man whose devotion to patients and whose kindness and skill quickly brought him an enormous practice. Reading in his carriage and by lamplight at Lucina's bedside, he was able to keep well informed; but he had an insatiable desire to know the true inwardness of a disease, and it was in this way I came into contact with him. Hard pushed day and night, yet he was never too busy to spend a couple of hours with me searching for data which had not been forthcoming during life, or helping to unravel the mysteries of a new disease, such as pernicious anaemia.

The Final Part of this address will be carried in the next issue of this journal ...

This Just-In

DISPATCHES FROM FLINT, MICHIGAN

Justine Pearl, MD
Neurosurgeon
Insight Institute of Neurosurgery and Neuroscience
Flint, Michigan

It's going to be a quiet Saturday. I figure that means it's a good day to try the new breakfast place in Flint that everyone says is the best. That's right! I work in Flint, Michigan now. What everyone calls the "armpit of America" ended up being my dream come true–but more on that later. I have been around Flint, but really only the revitalized part. That part is really nice. It's shiny and new and full of money. I quite nearly have to catch my breath every time I walk into our clinic - it is so clean, professional, and luxurious; with anything you could ever want. The University of Michigan-Flint campus is stunning. Each time I drive by, I remind myself to find time to walk the rolling fields of green that span as far as I can see. The downtown is cobblestoned which reminds me of my glory days in Montreal, navigating Prince Arthur Street with my friends in high heels, carefree. But enough of that. I'm hungry. I program the GPS and I'm on my way.

As I leave the peaceful, serene beauty of the nearby non-Flint suburb I reside in, I notice that things have started to look different. I realize, this could be the Flint everyone has been talking about. I guess I'm supposed to be scared? However, it's 9 am, bright as day, and the diner is packed.

I know I'm OK, and I walk in. I'm new and different, in what is obviously a sea of regulars, but I'm greeted warmly like I'm family. "Anywhere's good?" I ask the cook. "You bet," he replies with a warm smile. He also has a left sided black eye and a bit of a raccoon eye on the right. I resist my ridiculous urge to get a history and physical, and sit down at a big table with worn chairs. Immediately, another waiter comes over and says hello. I tell him I heard this place was the best, and he immediately starts recounting all the things they have done for the community. It's true–the walls

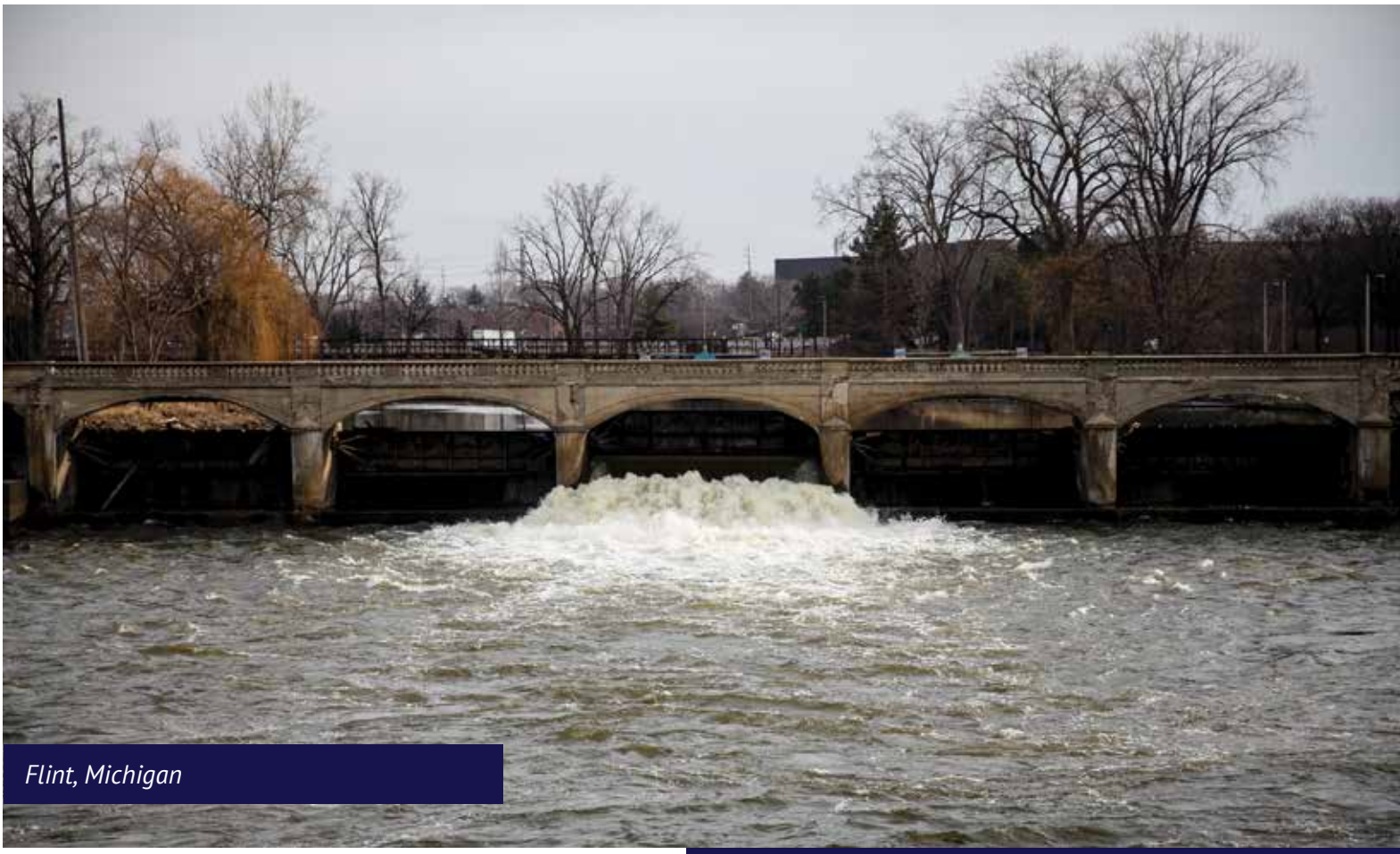
are plastered with newspaper articles and awards for service. My heart is warming; his sense of pride is contagious.

I quickly glance over the big menu and order my usual breakfast fare. He confirms I want coffee and water. I smile and say yes. Water, in Flint.

Basically, if you don't know, (and if you don't know, turn off Netflix for 45 seconds and watch the news), there's a water crisis in Flint. I am extremely well versed on the details–since long before I moved to Michigan–but when I think about it too much, my blood boils. So, in the interest of protecting my cardiac health, for now I will simply say that the pipes are not OK, they need replacing, and thousands and thousands of Flint residents just don't have safe water. Let that sink in.

When you go to that little room next to the OR Lounge to fill up your Nalgene, remember that. This morning when you showered, you probably had a lot on your mind. No one's life is easy, but, I feel like I can safely assume that you weren't thinking about how the poison in that water might worsen the rash it gave you, or how are you really supposed to bathe your one year old baby in water that has been shown to make children sick? Yeah, kids get sick. I'm a doctor, so I know this for sure. But, you probably weren't worried you would have to choose between buying cream for your baby's excoriated skin or groceries that week. Alas, as I have a tendency to do when I talk about the Water Crisis, I digress.

So, some restaurants have managed to get safe water, and a sign is displayed in the door. "Safe water here," or something like this. One of my favorite pubs downtown, one that I learned really helped revitalize the downtown, has a sign in the window, "Water — lead free." Other places do not have that luck. So, my basic strategy is to always say yes to the water, because I can't bear the thought of hurting anyone's feelings and pointing out the ugly elephant in the room. I try to pretend it isn't obvious that the glass remains untouched. It's all for naught though, as my



Flint, Michigan

Flint, Michigan

lovely waiter brings me a bottle of spring water and a straw. In a diner no bigger than Theatre 11. My heart is suddenly broken. This is reality. But, that's me. I knew I could only hide out at the chic wine bar downtown, or at the gorgeous Flint Farmer's Market for so long before I had enough of the smoke and mirrors.

When we were kids trying to get into medical school, a lot of my friends went off to Africa or equally remote places to volunteer. At the time, I thought it was great for them. But, it was never for me. I was too preoccupied with trying to help those in my backyard, and maybe after that I could worry about those further away. To that end, I did any possible rotation I could in Medical School in remote or rural locations–and, I can say with certainty, all of these experiences were wonderful. When I learned I would have the honour of joining the clinic here in Flint, I thought to myself this was quite in line with who I am–these individuals are marginalized, stereotyped, and could use a helping hand. I couldn't wait to move, but, it isn't always easy. Not everyone is running here to help.

When I left the busy downtown streets of Toronto early one morning and drove to Michigan, I didn't know what to expect! What I received was beautiful warm welcomes from people from all walks of life and backgrounds. As it turns out, it's really fun to smile so much.

I remember reading about the crisis online, watching CNN, and shaking with rage and fear. Rage that something like this could happen and be allowed to happen, and fear that the situation would never be fixed. "But, I don't understand," I'd "say" (whine, like a small, naive child) to my father. "Why doesn't the government just give them the money they need to sort this out? This is water! It's a basic right!" "It doesn't work that way," he'd respond in his pragmatic, kind way. "You will understand more when you get there and see the lay of the land."

Guess what? My father was right (as usual). However, what I began to see, experience, and embrace was that the people of Flint and the friends of Flint were not

taking their situation lying down. They were banding together–as a community–and fighting. They were rallying and organizing, within themselves, to make sure those who didn't have access to clean water (the situation has improved tremendously, but isn't perfect yet), got what they needed, and for free if they couldn't pay.

They got their water for free if they couldn't afford to pay for water. My sincere hope is 1) you are actually reading my article, and 2) you are doing it while you wait for your 5 dollar latte at Starbucks.) Prominent and influential people around the world–some rich, some famous, some rich and famous–donated bottles and bottles of water, and piles of money to help out. It seemed to be that Flint had a decision–sink or swim (in nasty water, mind you)–and they chose neither. They chose to band together and prosper.

Breakfast is over, so this article has to wrap up before I enter into the food coma that follows any delicious meal. I finish up my water. In these parts, I feel like to leave even a drop would be a huge slap in the face. As I go up to the counter to pay, Tony (the owner), my waiter, and I chat a bit. They let me know that there is a "Fenton Road Cleanup" happening this weekend. "OK…what's that?" I ask. Well, it's one of Tony's many initiatives in the community. He tells me, "Basically, we will all meet here at 11 am, we'll get the grill going in case people are hungry, and we will clean up our street. We'll wash off the graffiti. We'll tidy the trash. We will have games so the kids have something to do." I look at the flier. It is asking for donations of paint and yard tools, etc., but also for helping hands and time. I look back at Tony (who, incidentally, has denied any severe headaches, CSF otorrhea, or rhinorrhea—sorry, I really can't help myself), and fight back the tears I feel coming. "Well, I'm not super great with yard work or painting, but I have time and 2 hands, and I would work very hard," I say. He beams. He thinks he has another volunteer for the day, so he's happy. What he doesn't know, is what he really got was someone desperate to make a difference in the lives of those less fortunate, and desirous to belong to her new community–and make it better–for everyone.

As I leave the diner, I can't stop smiling. I figure I'll go to the office for a few hours and catch up on my paperwork. (In residency, your Staff are always telling you about paperwork, but you don't really know. Yeah.) As I walk into the gorgeous clinic where I have the honour of working, I take a quick stock of all my blessings. I realize we could take a lesson from these folks here in Flint. They have faced every obstacle possible, copious injustice, and living conditions that are just unacceptable, but, they're okay. Tony and the gang are smiling. We'll clean up a road tomorrow. I'll stop at Kroeger on my way and pick up as much water as I can fit in the car. And, if I am very, very lucky, I will remember to learn from these experiences. I will remember that, at the end of the day, all you need is people caring about each other, taking care of one another, and unconditionally loving their neighbour. Why? Because, that's the way they roll in Flint, Michigan. This type of consideration for your fellow man is something I have sought my whole life. I have finally found it.

I can buy all the water I want. I can't buy that.

Justine Pearl completed her Neurosurgery residency at the University of Saskatchewan in 2014 and a Neurosurgical Oncology Fellowship at the University of Toronto in 2015.

She is now neurosurgeon and Director of Neuro-Oncology at the Insight Institute of Neurosurgery and Neuroscience (IINN) in Flint, Michigan.

Poetry Corner

This issue's poet is **Burl Horniachek**.

Burl currently lives in Toronto, ON, where he works as an online high school teacher.

He graduated from the University of Toronto with a degree in Ancient Near Eastern Studies, and also has degrees from the University of Alberta and York University. At the UofA, he studied creative writing with Nobel laureate Derek Walcott.

His poems and translations have appeared in such places as Literary Imagination, Poetry International, The Dark Mountain Project, Translit, and K1N.

Fragility
- by Burl Horniachek

Death, that quiet visitor, knocks softly
on the door when he, not we, would will.
Virus and bacteria, those savage bandits,
are always testing the body's perimeter;
bone and organ flirt openly with cancer's mutiny;
blood, cut from the leash of vein and vessel,
would calmly stroll through the wound's wide gate.
All these things are uncertain. We cannot know
if the body's timber is sound, nor when
harsh fate has planned our end.
We sail these rough seas in a fragile boat.

Author's Note: I am married to Angela Schellenberg, a surgeon, and the poem was partly inspired by some of the terminal patients she has treated: the thirty year old mother with three kids, or the forty-something businessman who just made his fortune. You can't take any of that with you. The poem was also partly inspired by the niece of the poet Alice Major, Monica Ellis, who suffered from FSHD and died at age 39 in March 2015. I identified with her because she was almost exactly my age; it was a reminder that I am no longer young enough to take life and health for granted.

The images of the poem take note of three threats to human life: infection, cancer, and trauma. But there are many ways that the body can cease to function. Life is indeed very fragile and uncertain.

The Surgeon's Art

- by Burl Horniachek

For Angela

Your scalpel writes lines of a vicious compassion;
its edge strums a meter of salving wounds;
your sutures close rhymes of trauma, and fashion
a poem of healing from dissonant sounds.

You put on your mask, sound each note of incision;
you know all the body's tune by heart.
Though this waltz has many a, many a part,
you conduct them all with the utmost precision.

But these sober tunes are not the best of your art.
They compare not at all to the chords of affection
that rise and fall while we both sing our part,
two voices in fugue that make up their reflection.

For this art has made us so intertwined
one cannot know the other, 'til the first is defined.

Author's Note: I wrote the first stanza because I wanted to highlight the paradox of surgery, that it is an infliction of violence, with the goal of healing. Perhaps something of T.S. Eliot's lines were the inspiration here:

The wounded surgeon plies the steel
That questions the distempered part;
Beneath the bleeding hands we feel
The sharp compassion of the healer's art

However, I wanted to move beyond that to the analogy between surgery and various art forms. My wife is a surgeon, I am a writer, and I wanted to bring those together and explore the similarities. In a sense, all forms of skill are analogous. In the third stanza and the final couplet, I wanted to enrich the analogy of art with love, exploring both the differences and similarities which go into a rich relationship.

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 and times. 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." The film, bearing the same name was directed by David Lean and starred Omar Sharif and Julie Christie.

The Editor

Last year, we were graciously granted permission to serialize the life story and memoir of one of the preeminent surgeons of our time, Professor R.M. Kirk .

Raymond Maurice Kirk ("Jerry" Kirk to his friends) is perhaps best known to most surgeons and surgical trainees throughout the world on account of "Kirk's General Surgical Operations" – the textbook of operative General Surgery that has been the standard in Britain and in many other parts of the English speaking world. Now into its 6th Edition (2013), it is available in both print form and (as some of our residents know) for the ipad as well.

His other books are almost equally well known and Prof. Kirk's elegant, practical and pithy writing style and editorship are widely recognized and admired.

Professor Kirk's career as Consultant academic Surgeon was spent almost continuously at the Royal Free Hospital and Medical School in London. Many innovators and pioneers in medicine and surgery worked in the ferment of intellectual activity that was the Royal Free (including the pioneer hepatologist Sheila Sherlock) and Prof. Kirk made widely recognized contributions to surgery of the stomach and esophagus. During the seven years that he was Editor of the Annals of the Royal College of Surgeons of England, the journal rose even further in standing and ranking among the surgical journals of the world.

The story of how Jerry met Peggy is contained in the "life story" and will appear in due course, in the pages of this journal. Jerry and Peggy live in Hampstead, London, not far from where that other English surgeon John Keats lived and wrote his immortal, "Ode to A Nightingale."

The Editor is deeply grateful to Jerry for the privilege of allowing this Journal to carry serialized excerpts of his life story. And now for a continuation of Jerry's story, Chapter 4, in his own words ...

F. C.

LIFE STORY

Excerpts from the memoirs of R. M. Kirk

Chapter 4

Medical School

Rumours had circulated that the Government would pay for university courses for ex-service veterans. I had been unable to clarify the subject of funding from Malta. When I returned to Nottingham I enquired at the local Education Department, expecting to be greeted by civil servants reluctant to give service. A smiling man assured me, 'Yes, there are grants.' He handed me a large application form. As I turned to leave, he asked me which university I was attending before joining the forces. When I told him that I had not been to any higher education institution, he half reached out to take back the form. He told me that the grants were intended to support those who had their careers interrupted by their war service. Despondently, I offered back the form but he asked if I had volunteered or was a conscript. I told him that I was a volunteer and he now took back the form, saying, 'Well, let us have a go.' In his own handwriting he wrote, in the space available for entering details of previous university training, 'The war had started as I left school and I decided to defer my university education in order to volunteer to fight for King and Country.' He did not offer me a clean sheet. I was so embarrassed that I hardly thanked him. I owe that un-thanked man a grant to enter medical school. His writing stood like a sore thumb within my entries.

I had provisionally applied to King's College London and Charing Cross Hospital, both of which granted interviews. The Registrar at King's eventually gained me an initial year to study for the premedical course. The cynical Dean at Charing Cross Hospital asked what I had done during the war in addition to drinking gallons of 'pink' gin (spiced with bitters). Why did I not stay in the Navy and let the next candidate, a brilliant student with a Higher School Certificate, get on with his career. I rose to the bait, made stupid threats and insults – but was awarded a place.

The morning I received my acceptance at Charing Cross Hospital I dashed to the Public Library and searched for literature on medical studies. I found a slim book entitled 'So you want to be a Medical Student?' It was written by a Canadian academic who had been asked to sit on a committee which interviewed medical students who had either performed much better or much worse than expected from their previous reports. Two young men appeared from the same lodging house. One had joined with a glowing report of expectation but had failed, while the other, who had merely scraped in performed exceptionally well. They first considered the failure. He burst into tears of chagrin at working doggedly every evening reading every word of the books and recording the hours of his commitment. He bitterly resented that the successful

student who live above him seemed to spend so much time attending the evening dances yet produced such high marks. The successful student was then interviewed and indeed confirmed his enjoyment of the many dances he attended. Then when did he manage to work? He related his schedule, starting with securing a girl partner for the evening, followed by a day of commitment to learning. In the evening he allotted an hour to recalling what he had learned, jotting in a separate column items he could not recall

Charing Cross Hospital, London, UK

or on which he was uncertain. He looked these up then scanned through the book to assure himself that he had covered the subject. He then allotted a half hour to revising the previous day's subject in a similar manner and even the one previous that to that. On each revision the subsequent failure rate was reduced and the ability to recall past subjects was enhanced. He then showered, dressed and went to collect his 'date' for the dance. It was a wonderful illustration that effort is not of itself meritorious unless it is well directed. Passively reading information is not learning.

I began the pre-clinical course at Charing Cross Hospital Medical School in 1947. It was situated just north of the Strand. We learned basic anatomy, physiology and biochemistry before crossing the road to enter the hospital, built in 1834 by the distinguished Regency architect Decimus Burton who also designed the Athenaeum, a premiere gentlemen's club. It is now the Charing Cross Police Station. The Professor of Anatomy and Dean of the Medical School was an Ulsterman whom we referred to, out of his hearing, as 'Willie.' He had a loud voice which could set your teeth on edge like the screech of a skidding car as he called for his technician, 'Ernest.' Ernest took his time to respond. Our first encounter with the dead, formalin-preserved bodies was unremarkable for most of over-20 year old ex-service men. In retrospect I am impressed to remember how maturely the younger men and women faced the encounter. As with most unfamiliar experiences, the initial apprehension was soon overcome as dissection became routine. There was the added fascination at revealing the wonderful construction of the human body and then putting aside philosophical contemplation to concentrate on learning to memorize the many complex structures in three dimensions. Those, like myself, who had no knowledge of classics struggled to remember the Latin and Greek terms.

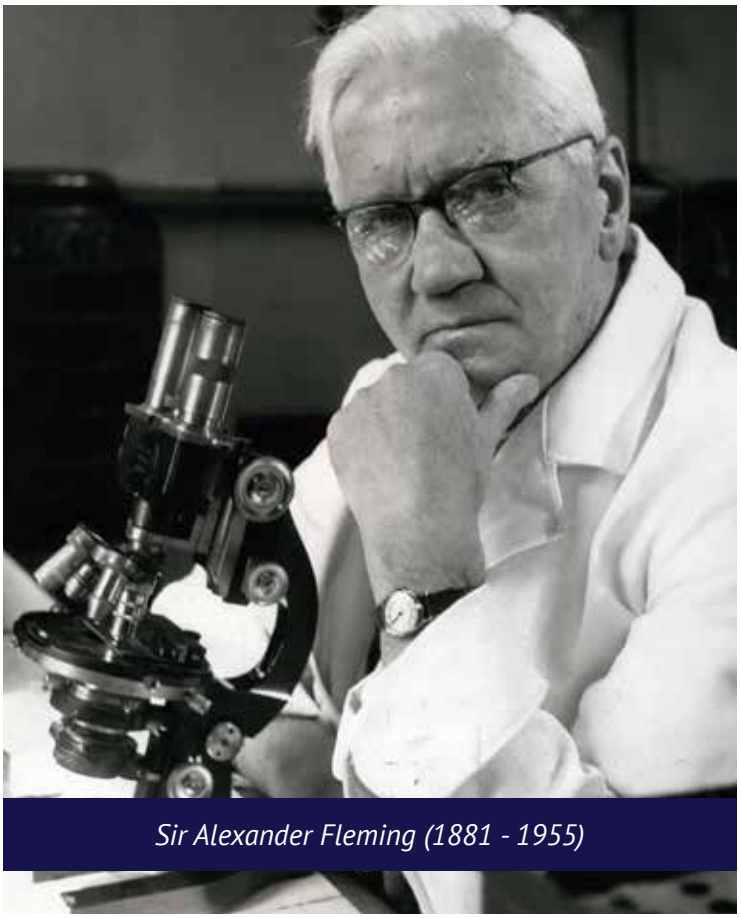
One of the women immediately attracted me and I was pleased that in the anatomy dissecting room we were allocated to the same group ranged round the body of a body, identified from his wrist band as Mr Squibbs. Five years later we would jokingly refer to him as our shadkhin (Yiddish matchmaker). I am perpetually astonished at our instinctive choices of people we meet – why we are attracted to some and reject others. It is an emotional, intuitive judgement not rational. I still encounter groups of strangers, rapidly identifying some to whom I am attracted as by a magnet, others who I instinctively avoid. Of course, our choices are sometimes mistaken – confidence thieves succeed in convincing us of their trustworthiness to our cost. A few totally lack or ignore any sense of morality; their victims rendered exposed by sheer incomprehension. Physical attraction is a factor but not solely so and it may be merely transient. It is with pride that I declare myself to have been, on at least this one occasion, a superlative judge, based on a near 70 year experience after meeting Margaret (Peggy) Schafran.

We were introduced to Physiology – the science of function rather than structure, to Pathology – the ways in which things go wrong and succeed or fail to be corrected. The teaching was delivered by lecturers of varying knowledge and teaching skills and we wrote voluminous notes, aspiring but not always subsequently achieving revision. One immensely successful student in the year ahead of me influenced me not to take lecture notes but to listen closely to the lecturer. At the end of the session the listener should then take a notebook or even an old envelope and recall the essentials of the lecture. It was in accordance with the advice contained in the book written by the Canadian advocate of the method. I did not invariably follow the method but when I did so, I better remembered the content, sometimes also the specific details.

Although I did not recognize it at the time, I was gaining an education outside beyond the facts that were being fed to me in lectures, textbooks and demonstrations. One particular lesson that has remained was the value of gentleness when examining patients. It was emphasized by the treatment I received when I developed an infected chalazion (G for hailstone), in a meibomian gland in the eyelid, described by the German anatomist Heinrich Meibom. It was intensely painful. I was sent to the ophthalmic surgeon for treatment. The consultant was on leave and his assistant dealt with it. He was rough and clumsy, causing excruciating pain. It did not resolve and I was forced to return. I did so apprehensively. It was unnecessary. The consultant had returned. He was gentle, slow, deliberate, reassuring – and successful in curing me. As I watched other clinicians examining and treating patients, the lesson was reinforced. It is not necessary to prod tender areas, instead allowing the examining hand to hover or lightly touch the suspect focus of interest, while watching the patient's face. The incipient tautening of the eyelids provides all the necessary evidence.

The hospital stood in the middle of theatre land, next door to the London Coliseum where the musical 'Annie get your Gun,' with music by Irving Berlin ran for more than a 1300 performances. Most of the students were, like me, ex-service men. There were a few women. Peggy and I enjoyed the amenities of free tickets for the West End theatres, amphitheatre 'slips' (side) at Covent Garden opera house for 5 shillings and sailing at the United Hospitals Sailing Club at Burnham on Crouch, Essex. We did not sit together in lectures, Peggy preferring the back and I sat at the front. On the suggestion of the Professor of Anatomy, Willy Hamilton, an apparent tyrant but with a soft heart, we started an 'Other things besides,' Society. Distinguished people were invited to talk on non-clinical aspects of life.

The Nobel laureate Sir Alexander Fleming (1881-1955), talked on the discovery of penicillin. We thought he presented himself as the sole contributor. We knew that he had not made the essential translational step of making the benefits available for patients. We knew of Howard Florey's immense search for possible methods of treating infection during the Second World War, the identification of Fleming's papers, the recruitment of Ernst Chain and the eventual isolation, concentration, testing and development of culturing methods. These were passed over to the Americans since Britain did not then have the capability to develop the large amounts required during wartime. Perhaps we were unjust to Fleming.



Sir Alexander Fleming (1881 - 1955)

Marie Stopes (1880-1958), the pioneer birth control advocate was a dominant 'character.' She had overcome great resistance in trying to provide a means for women to decide for themselves about conception. The gynaecologist who chaired the meeting had hardly taken his seat before the flowery dressed Marie embarked on a description of possible methods. She held up a vaginal suppository as she denounced the use of harmful methods, declaiming, 'I never use such

Dr. Marie Stopes (1880 - 1958)

substances. I always say you should not put anything into the vagina what you would not put into the mouth.' With that gesture she instantly thrust a suppository into the mouth of the chairman so swiftly that he had no time to resist. He choked. She dismissed his effort at rejection with, 'It's pure coconut butter, you know!'

Arthur Dickson Wright (1897-1976), was a talented, gregarious, some would say egregious, sarcastic London surgeon, wit and superb after-dinner speaker. He entitled his talk, 'How to pass examinations.' So anxious were we to hear, we would have hung from the chandeliers. He spoke of his experiences as an examiner in surgery, embellished with many anecdotes about candidates who had lied, blackmailed, threatened and exaggerated in the forlorn hope of convincing the examiners. He drew from his pocket a crumpled sheet of paper, claimed to be illegally torn from an examination answer sheet. It was the response to, 'Discuss the aetiology, diagnosis and management of dislocation of the shoulder.' Dickson Wright simulated reading the student's actual answer, 'In answer, I wish to recount a personal experience. I was telephoned by my good friend the Maharajah of Rapoda. He was visiting England and enquired if there was any chance of a game of polo. I reassured him that on Sunday my team was playing against the team led by Prince Philip at Smith's Lawn on Windsor Great Park. I offered him a choice from my large stable of ponies. During the second chukka his Highness had the misfortune to fall from his mount, landing heavily on his shoulder, where he lay, groaning in agony. Leaping from my steed and tossing the reins to a waiting servant, I rushed to him. I noted that the bulge of his powerful deltoid muscle had disappeared from the affected side. Indeed, I was able to place my polo stick touching his acromion and his external humeral epicondyle. I removed one shoe of my polo boots. After placing my stockinged foot in his axilla as counter pressure (with his Highness's permission), I pulled on the arm, then released it. The anatomical appearance was restored. Indeed, his Highness was able to continue into the third and even fourth chukkas.'

Polo game in progress

The examiners were profoundly impressed that a candidate should be so affluent and on such friendly terms with eminent members of society. Having identified his number they watched entrants for his forthcoming viva voce examination. A tall, gangling candidate appeared, dressed in an outgrown schoolboy suit with frayed cuffs and wearing worn, cracked (but highly polished), shoes.

The National Health Service had been inaugurated in 1948 as we started our clinical training. Whatever the associated changes, they did not impinge on us since we knew nothing of the previous state. In retrospect the facilities were sparse. The quality of teaching varied, the curriculum was unstructured. There was a short lecture course from a distinguished neurologist, covering the whole of medicine in outline while we hurriedly made notes. He instructed us in the steps of a thorough clinical history-taking and examination of every patient except for exceptional circumstances. We acquired textbooks but many of them proved to be out of date. We were allocated to join 'firms,' usually under two consultants within a ward laid out in what was referred to the Victorian pattern, with beds side by side down the length of the room. We were each allocated patients to 'clerk.'

As an ex-service veteran I walked along to find the correct bed number, full of self-assuredness. It sank like a stone as I faced my first patient. She was a ravishingly beautiful, late teen-age girl. I do not remember us being given any advice or instructions on chaperonage. On this occasion I did not need any. I sought my fellow student Peggy to stand with me.

Yes, I took a full history and carried out a complete examination. But I never had eye contact … I went through all the correct motions but what they signified I had no idea. Suave, mature Jerry Kirk? No. More like little boy with a wet nappy. I did eventually grow up but can never claim to myself that I am unshakable. Like most others, I just get better at maintaining a confident facade.

It is astonishing to look back and remember some of the seemingly medieval practices still retained. A member of the pharmacy staff regularly fed a leech each week by placing it on his forearm. I witnessed a patient who suffered from quaternary (neurosyphilis), being treated by having an anopheles mosquito applied to his skin under an inverted glass beaker in the hope of giving him malaria, producing bouts of hyperpyrexia.

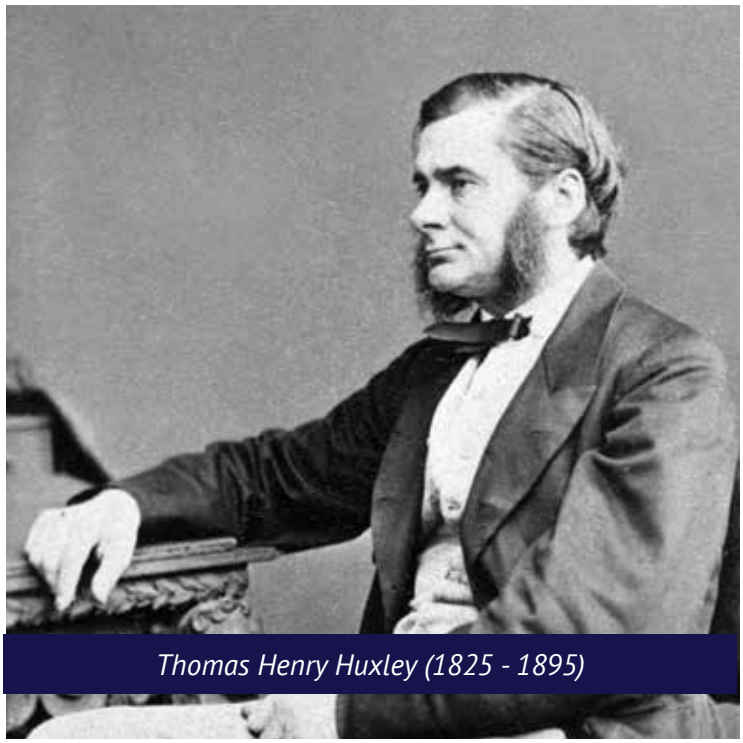
An Austrian physician Julius Wagner-Jauregg had been awarded the Nobel Prize in 1927 for championing the treatment. I witnessed the use of another archaic substance after noting a patient who had developed

Austrian Nobel Prize winner Julius Wagner-Jauregg

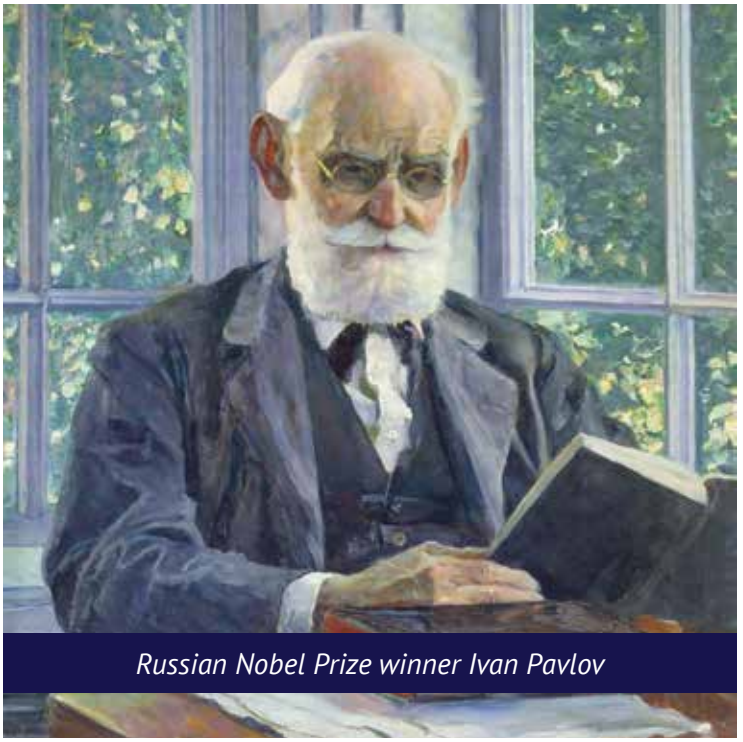
enormous abdominal distension following an abdominal operation. He displayed no local signs of complications. We awaited advice from the consultant when he conducted his weekly ward round but none came. As he was about to leave the ward, we asked, 'What shall we do to relieve Mr ….?' Over his shoulder, as he was leaving, he called, 'Oh, give him an ox-bile enema.' I went to the chief pharmacist who had never heard of it but he called into the basement to an elderly assistant who, after a deep basement search, triumphantly emerged, displaying an ancient carton labelled, 'ox-bile.' We followed the instructions. Detumescence was resounding – it might have been likened to the sound of an inter-stellar rocket at the instant of 'lift off.'

Students were given remarkable freedom to perform unsupervised operations and anaesthetics. At a weekly clinic we injected varicose veins and haemorrhoids, applied various splints and excised cysts under local or inhaled (nitrous oxide), 'gas and oxygen,' anaesthesia. Surgically inclined students revelled in the opportunities available, including suturing wounds, assisting at operations, setting wrist fractures and stabilizing them with plaster-of-Paris splinting. The consultants held weekly clinics and ward rounds, and the surgeons usually operated once a week.

There were two senior surgeons, originally thought to be contemporary. Norman Lake (1888-1966), served in the Medical Corps during the First World War, carrying out studies on 'Trench foot,' a condition resulting from standing in wet, cold conditions. It caused extensive suffering and loss of otherwise fit, fighting soldiers. He was thought to have clashed with the surgical hierarchy over prevention and treatment, being discharged, returning to take up his appointment as surgeon at Charing Cross Hospital. He was scientifically active and progressive. His personality was rather dry but I found him inspiring. Many years later he recounted to me a historically electrifying experience: The most distinguished Charing Cross alumnus was Thomas Henry Huxley (1825-1895), who became the foremost scientific supporter of Charles Darwins' 1859 theory of evolution by natural selection. In his honour a Huxley Lecture was inaugurated. The 1906 lecturer was the eminent Russian neurophysiologist and 1904 Nobel laureate, Ivan Pavlov. A galaxy of eminent scientists and physicians attending the lecture included Sir William Osler, Professor of Medicine at Oxford; the neurologist Sir Henry Head; Sir William Bayliss and Henry Starling who discovered the first internal secretion activator, named it secretin and introduced the generic name 'hormones,' (G hormaein = to stir up). The lecture venue



Thomas Henry Huxley (1825 - 1895)



Russian Nobel Prize winner Ivan Pavlov

was the badly lit and aired sub-basement outpatient hall, served by a small door at each end. After an effusive introduction, Pavlov began his lecture. The day was hot, the room was full to overflowing with many standing up, soon stifling. According to Lake the lecture lasted two and a half hours – in German (although Lake remembered it as Russian). It was incoherent to all but an elect few. When Pavlov sat down, the audience sighed with relief – but to general horror, the limp Chairman jumped to his feet, delivered another long, gushing tribute ending with, 'Now, are there any questions.'

The second surgeon was C Jennings Marshall (1890-1954), said to be frustrated by Lake seizing the role of senior surgeon. His large inguinal (groin) hernia played second fiddle to his ill-fitting full sets of

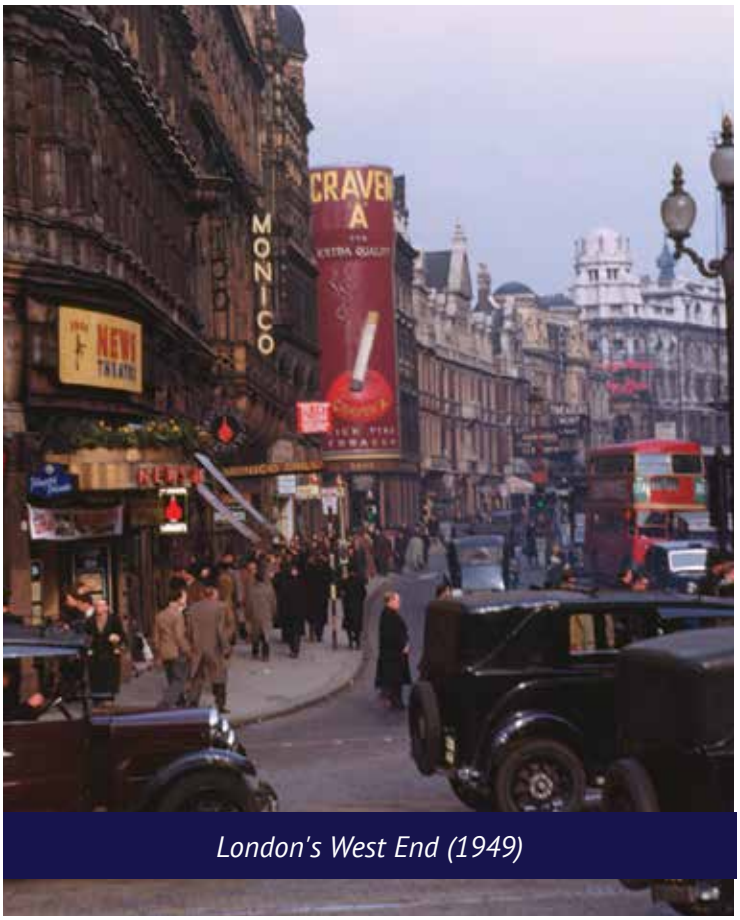
artificial teeth, which clattered with a high-pitched porcellanous-sound if he was annoyed. He was a superb technical surgeon but extremely taciturn. Quite uniquely, he employed his dentures as vicarious haemostats. I explain thus …when he inadvertently transacted a sizeable artery and it spurted, Jennings did not clip it with a haemostatic forceps. He glared at it and gnashed his teeth. The sound resembled the clatter of hooves created by a company of Cossacks galloping over cobblestones. He seemed to stare down the arrant vessels into constricting and shrinking back under control. A miracle of no-touch haemostatis? Jennings spoke only to ward and theatre sisters, senior registrars and once only in my memory, to a patient. He was hurting her and she screamed. He hissed, 'Shut up.' She did. Today he would be hauled before a tribunal. On one occasion a parent spoke directly to him. He glared, stood, and left.

When I later became his House Surgeon I was warned never to telephone him at home in the evenings. The registrar, who was petrified of him paled as I reported to him that a patient was suffering from post-operative bleeding and needed to be returned to the operating theatre, since he did not feel confident to deal with it but too terrified to telephone the chief. I volunteered to telephone and dialled the number. After an interval the telephone was lifted. Immediately I heard the clatter of the Cossack platoon. 'Yes?' 'Is this Mr Jennings Marshall?' 'Who is calling?' 'His House Surgeon.' Clatter, clatter. 'Yes this is Mr Jennings Marshall clatter clatter.' Click. Fortunately, I was able to recruit a more confident registrar who took over responsibility to re-operate successfully. Yes, I agree, urgent change was required.

One of the most eminent surgeons Theodor Billroth (1821-1894), Professor of Surgery in Vienna turned philosopher, stated, 'Do not judge the mores of yesterday by the mores of today.' The pre-war class-ridden British tolerated behaviour that is now viewed with horror.

Fortunately, there were also many inspiring jewels, remembered and cherished thereafter for a lifetime. The orthopaedic surgeon taught, demonstrated and imprinted simple attitudes which became lifelong talismans. Reflecting his speciality interest, whenever he saw a patient with a limb defect, he would drolly and humorously intone the question, 'Why did God give us two arms and two legs?' to which we were expected to respond, 'So we have a normal one to compare with the abnormal one.' On one occasion a smart young city junior clerk attended, dressed in the appropriate black jacket, pinstripe black trousers and highly polished shoes. He complained of a painful foot. 'Take off your shoes and socks,' ordered the surgeon. The young man duly exposed his clean but painful foot. The consultant turned expectantly to us for the customary mantra, then ordered the young man to bare the other foot. The young man flushed, muttered that it was not troubling him, but recognizing the surgeon's inexorable look, he un-socked his foot. It was filthy. This charade would now be condemned. But it deeply imprinted the vital rule in us and the cruelly shamed young man doubtless never forgot the lesson.

The hard-working registrars taught, demonstrated, assisted, delegated, monitored and encouraged us, earning our appreciation and often inspiring our



London's West End (1949)

choice of careers. They waited for years in the hope of achieving consultant appointments. Some of them were exploited by lazy, greedy, dishonest and

Women's Orthopaedic Ward, London (1950s)

unsupportive consultants. We were predominantly taught within the 'teaching' hospital environment, so the scope of our experience was restricted. Although the six physicians and six surgeons on the staff were nominally generalists, some of them had developed special interests, so their students had limited access to a wide range of conditions. What is now termed 'in course assessment,' was almost completely absent throughout the three clinical years. Although we were keen to learn, our knowledge was unstructured.

'Finals,' the qualifying undergraduate examinations beckoned ahead, generating rapidly mounting anxiety to complete, organize and revise our knowledge and skills. There was a gaping chasm of knowledge since the curriculum was not defined. The only means of estimating the limits was to study previous examination papers and ask our predecessors about the viva voce questions they had faced. These were sometimes exaggerated and dramatized.

One member of our year could not take his examination. He had been involved in a serious accident while driving a motor-bicycle and suffered multiple injuries, one of which was a wrist fracture. The sheath of an overlying tendon became inflamed. When he flexed and extended his wrist the tendon produced a groaning sound as it moved within the dry, rough sheath. Since there was a shortage of suitable patients he was recruited as a examinations patient. To my (very short-lived) glee, I was sent to examine and diagnose his disability. I put his wrist through a full range of movements, provoked the toad-croak, he smiled at me and half winked, I opened my mouth, 'Sir, he has had an injury to his wrist, involving the tendons resulting in .....' My friend flexed his wrist which croaked furiously as I stood inarticulate. Then the recalcitrant word returned and I proudly declaimed finished my sentence, 'tenovaginitis' (L tendere = to stretch, tendon + vagina = sheath + -itis = inflammation of).

One future eminent member of our year, a connoisseur of rare diagnoses, was led to a patient who had been acceptably labelled by his predecessors to be gout. He offered, 'Probably gout, but it could just be benign diffuse calcified epitheliosis (G epi = upon + thele = nipple; skin +). Silence. The examiner then suddenly exploded, grabbed him, danced him round the room exclaiming, 'Yes it is. It is the first case I have seen!' How to earn 'honours' by reading the small print? Sadly, I write this a few days after attending his funeral.

Ushers at St. Mary-le-Bow, Cockney London

I believed that if I failed, my ex-service grant would stop. As a precaution I backed up the University examination with one organized in cooperation between the Royal Colleges of Medicine and Surgery, hence named 'The Conjoint qualification.' The oral and clinical examinations were organized at an Examination Hall in Queen's Square. Since this was not a hospital and so had no available supply of patients, the examiners sent in their own patients. There was a core of regulars who came up regularly as models. Later, as an examiner, I learned to realise that they formed an informal club and their attendance was an interesting interlude. Among them were some traditional Cockneys – Londoners, strictly born within sound of Bow bells. They would offer some astute opinions on the candidates, often in rhyming slang. These 'regulars' did not mince their words about the students who examined them - 'That last one didn't know his arse from his elbow but the one before him, he was sharp.' The chirpy Cockneys (the origin is uncertain but is traditionally defined by those born within the sound of Bow church bells)seem to have disappeared like the sparrows with which they were often linked.

Their reward was usually a half a crown (an eighth of a pound), a cup of tea and a slab of 'canary' cake. Endless anecdotes were exchanged, some may even have been true. Disabled patients were often delivered to the examination rooms by taxi. One man limped out of his taxi. A student, assuming him to be a patient, rushed to him, pressed a coin in his hand, muttering, 'Tell me what is wrong with you.' The man smiled, put the half crown in his pocket but said nothing as he entered the entrance hall. The student duly attended the clinical examination to be greeted by the smiling examiner – who had a limp.

Peggy and I duly qualified in 1952. She won prizes in orthopaedics and obstetrics and gynaecology. I won the surgery prize. We were doctors. Some disenchanted seniors sourly labelled it a 'seven day wonder.' It has been a long seven days!

To be continued...

Queen's Square today

Submission Guidelines...

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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