

Journal of the SURGICAL HUMANITIES



Journal of the
SURGICAL HUMANITIES

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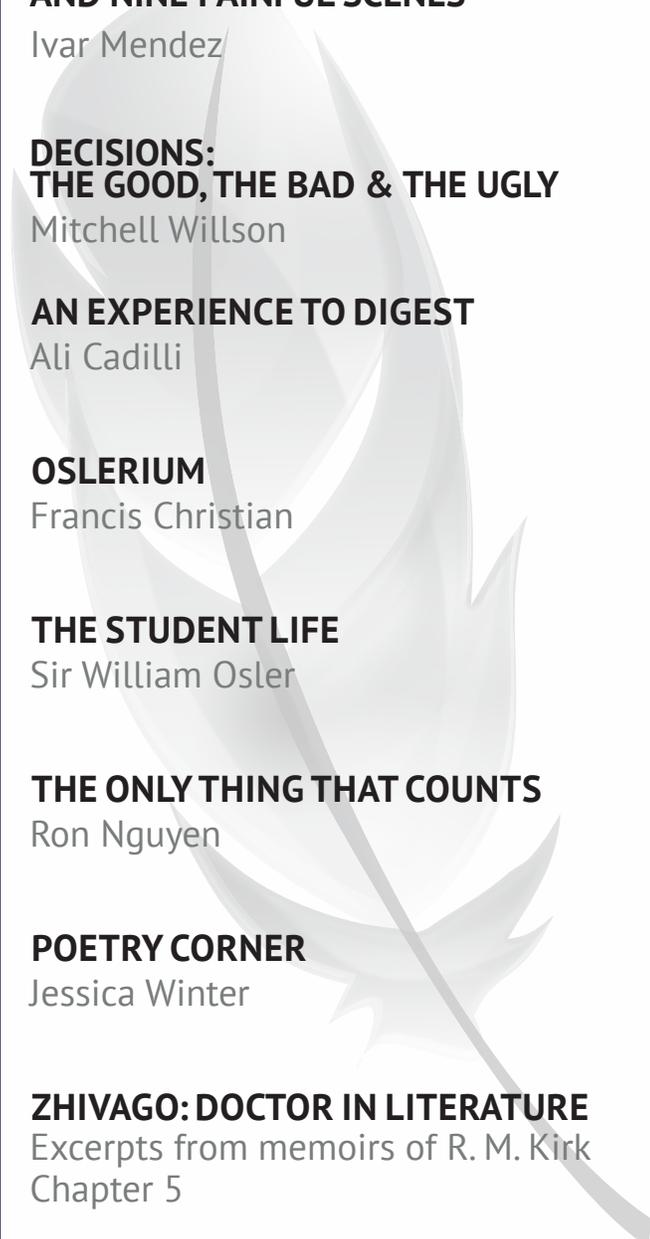
COVER PAGE
"Journey in Thick Wood: Childhood"
Mural by Dr. Norman Bethune

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■ CONTENTS

- 
- 02** EDITORIAL
Ivar Mendez
- 03** A DRAMA IN ONE ACT
AND NINE PAINFUL SCENES
Ivar Mendez
- 08** DECISIONS:
THE GOOD, THE BAD & THE UGLY
Mitchell Willson
- 10** AN EXPERIENCE TO DIGEST
Ali Cadilli
- 12** OSLERIUM
Francis Christian
- 14** THE STUDENT LIFE
Sir William Osler
- 20** THE ONLY THING THAT COUNTS
Ron Nguyen
- 26** POETRY CORNER
Jessica Winter
- 28** ZHIVAGO: DOCTOR IN LITERATURE
Excerpts from memoirs of R. M. Kirk
Chapter 5
- 38** SUBMISSION GUIDELINES

■ EDITORIAL

Ivar Mendez, MD, PhD, FRCSC, FACS, FCAHS
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As I reflect on the 3rd year anniversary of the Journal of the Surgical Humanities, it becomes clear that its role and impact on our Surgical Humanities Program has surpassed the most optimistic expectations. The Journal has become a conduit to its contributors not only to communicate their humanistic accomplishments but to enrich, with their articles, our lives both within and outside the operating room.

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

The quality and wide variety of topics published in the Journal under the able stewardship of Dr. Francis Christian and its hard working editorial board has helped propel the journal to an increased readership that has transcended our national borders and now reaches the United States, Europe and South America. International contributions are regularly published in the Journal and particular emphasis is given to humanitarian reports that illustrate the activities and importance of surgical outreach programs. The sobering statistics of increasing inequalities in

surgical access as estimated by the Lancet Commission of Global Surgery indicate that 67% of the world's population does not have access to safe, affordable and timely surgical care. Our role in narrowing this gap of inequality must become a priority at our academic and health care institutions. Our aim is that the Journal and the Surgical Humanities Program become effective tools to accomplish this goal.

As the Journal continues to develop and mature, we want to open its pages to new areas such as surgeon wellness. It is well known that throughout the continuum of our education and careers as surgeons we are exposed to high rates of burnout, depression, substance abuse, suicide and suicidal ideation. Talking about these issues and championing surgeon wellness is fundamental for our trainees and surgeon colleagues. It is our hope that the Journal becomes a platform of leadership and advocacy in this important area.

I am convinced that the Journal will have a long life, and that it will inform, enrich and inspire us for years to come.

Ivar Mendez
Guest Editor

■ A DRAMA IN ONE ACT AND NINE PAINFUL SCENES

The murals of Dr. Norman Bethune and their mysterious disappearance

Ivar Mendez, MD, PhD, FRCSC, FACS, FCAHS
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By the fall of 1926, the pioneer Canadian surgeon Norman Bethune was suffering from fatigue, weight loss and a persistent cough that progressed to frank hemoptysis. He was eventually diagnosed with pulmonary tuberculosis (TB) and his chest x-ray showed the ominous shadow of a left upper lobe tuberculous pneumonia. By mid December of 1926, Bethune admitted himself to the Trudeau Tuberculosis Sanatorium in Saranac Lake, New York (Fig 1). The sanatorium consisted of several cottages where patients observed bed rest for long periods of time, the preferred treatment for TB at that time.



*Dr. Norman Bethune
Trudeau Tuberculosis Sanatorium, Saranac Lake, NY*

Bethune was assigned to the Lea Cottage where he remained for his entire stay at the Trudeau Sanatorium. The cottage was shared by several roommates some of them physicians, among them John Barnwell who later became the Head of the Tuberculous Unit at Ann Arbor. Barnwell was a friend and a confidante of Bethune who entrusted Barnwell with the safekeeping of the murals when Bethune left the Sanatorium in 1932.

Bethune became interested in a new surgical approach to treat pulmonary TB called “collapse therapy” or artificially induced pneumothorax and a pneumothorax machine had been invented by an Italian physician with early indications of promising results. Bethune convinced his reluctant physicians at Trudeau to try the new procedure on him. They relented and Bethune had several treatments leading eventually to a cure of his TB.

The Murals

During his long stay at the Sanatorium, Bethune had times of great pessimism about his condition and also had the time for introspection and reflection. His creative mind channeled his energies and feelings into art and writing. He embarked on the creation of a nine panel mural that covered the entire wall of the cottage. The mural was called “Tuberculosis in progress: a drama in one act and nine painful scenes”.

The mural was painted on laundry

wrapping paper with oil pastels and chalk crayons, it measured 5 feet in height by 60 feet in length with cut-outs for windows and doors.

His prediction was not realized as Bethune died of septicemia in 1939 after cutting his finger while performing surgery on a



Scene III: "Journey in Thick Wood: Childhood"

As the title implies, the mural was divided into nine scenes or panels that consisted of an allegoric depiction of his life from the prenatal stage to his death that he predicted to occur in 1932.

Chinese soldier. At that time, he had volunteered to provide medical services to Mao Zedong's army fighting the Japanese in Northeast China.

A drama in one act and nine painful scenes... by Ivar Mendez

Scene III depicted in the cover of this Journal is entitled "Journey in Thick Wood: Childhood" and has the following legend at the bottom: "From Dragon Diphth, Sir Shick defends from other foes he cannot save. The wounds and scars of their attacks, he'll carry to his grave" This is probably a reference to the English poet Tennyson's King Arthur, with Sir Shick clad in heavy medieval armor valiantly defending young Bethune with a hypodermic syringe as a weapon from the assault of childhood diseases such as measles, mumps, whooping cough, diphtheria, scarlet fever, etc. Tuberculosis is shown as an ominous bat, this symbol for TB appears in several panels of the mural.

Scene IV entitled "Early Manhood" shows a ship sailing in stormy waters and has the following poem underneath: "On adolescence's trouble seas, The sails of argosy are set, Alas, he hears the Sirens's song, His course is changed, his bark a wreck" It seems to be an interpretation of Ulysses's temptation by mythical sirens - in the case of Bethune, the temptations are love, wealth and fame.

The last scene shows the angel of death carrying Bethune in his arms and the following poem was inscribed at the bottom of the panel: "Sweet Death, thou kindest Angel of them all, In thy soft arms, at last, O, let me fall; Bright stars are out, long gone the burning sun; My little act is over and the tiresome play is done" Bethune painted in this panel seven tombstones of

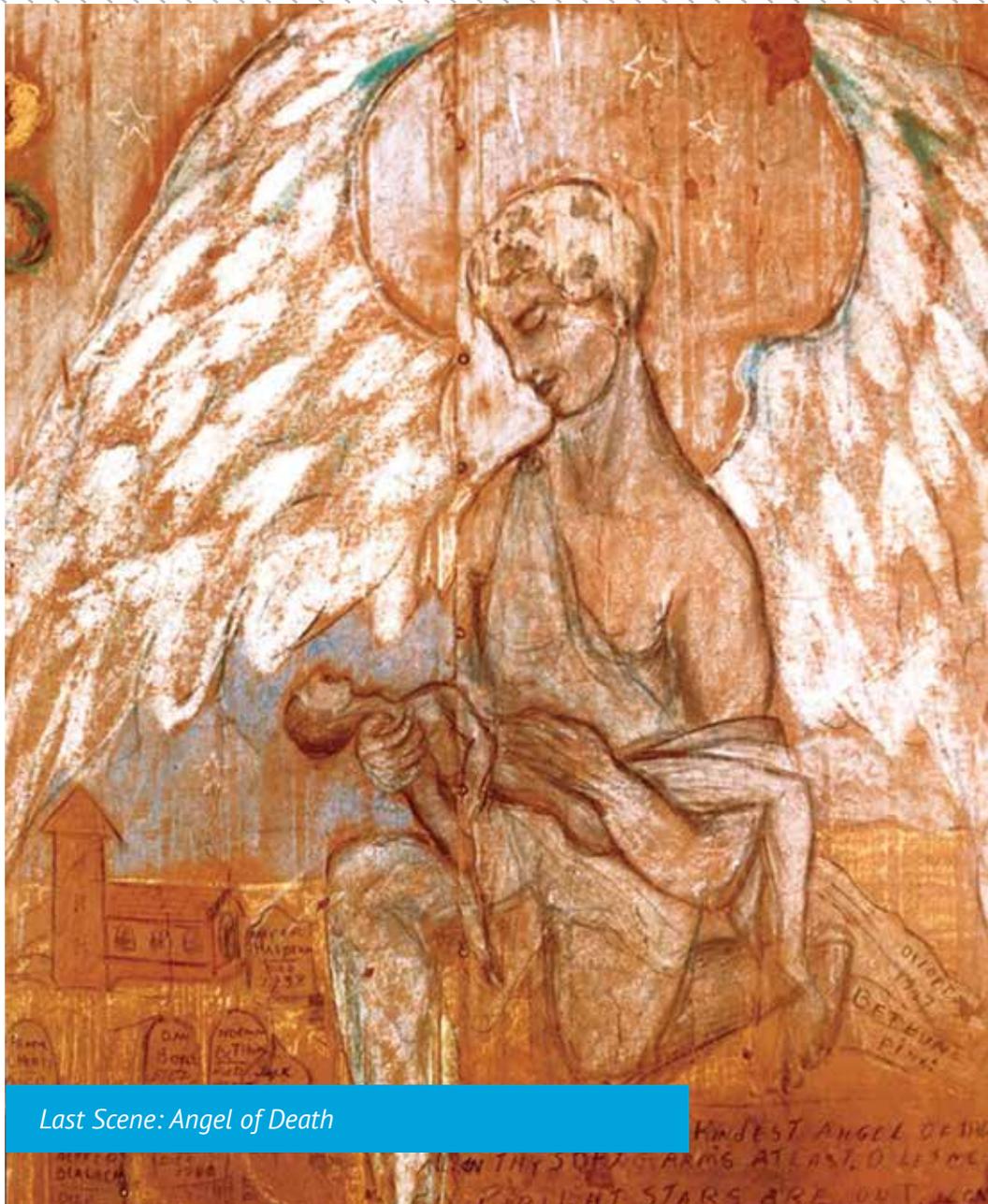


Scene IV: Early Manhood

Trudeau residents and friends of his, apparently two of the predictions became true.

The mystery of Bethune's Murals

When Bethune was discharged from the Trudeau Sanatorium in 1932, he apparently left the custody of his murals to his friend John Barnwell who removed the murals when the Lea Cottage was torn down. In 1960 Barnwell took the murals that were deteriorating back to Saranac. As the sanatorium had closed in 1954 the murals were given to the Saranac Free Library where they remained until 1967. They were then packed in crates and shipped to the John F. Kennedy Center for Special Warfare at Fort Bragg, North Carolina as a "loan to be studied for its psychological content" by the American army. Despite multiple attempts to locate the original murals by interested parties in Canada and the USA, they have never been found and are presumed irreversibly lost. The only permanent record of the murals came from class slides taken when the murals were at the Saranac Free Library.



Last Scene: Angel of Death



About Dr. Ivar Mendez

Dr. Mendez is a neurosurgeon, professor and head of the department of surgery at the University of Saskatchewan. His life is an eloquent testimonial of the importance of the humanities to the life and career of a surgeon. His work as a sculptor and photographer have been recognized in many exhibitions of art and his bust sculpture of the famous Canadian neurosurgeon Charles Drake is installed in front of the University Hospital, London, Ontario. The Ivar Mendez International Foundation works to provide nutritional and dental care and art programs to children in the Bolivian Andes.

■ DECISIONS: The Good, The Bad & The Ugly

Mitchell Wilson, MD
Radiology Resident
University of Alberta

The young man appeared about my age and looked like he'd be well-groomed on an average day. It was the first beautiful day the city had seen in some time, and I'm guessing he'd been enjoying it with friends on a patio. This would explain his choice to have "a couple" drinks earlier that afternoon.

At some point, these decisions were followed by a decision to leave. He told his friends he was safe to drive, fumbled through his pocket for his keys, and stumbled to his car. He climbed in, started the ignition, and drove off. This systematic process would be normative for him on any other day. However, there was something very different about today. Today, the skies were blue, the roads were clear, and he was very drunk.

From the moment the EMS rolled him into the trauma bay, the outlook was discouraging. Organized mayhem had broken loose as the trauma team diligently assessed his airway, breathing, and circulation in a calculated manner. I had already jumped to "disability" though, and noticed his bilateral non-reactive pupils had persisted since the EMS had found him ejected

from his vehicle several hours earlier. The aggressive hyperventilation and hyperosmolar therapy had been unsuccessful in staving off his uncal herniation. The true extent of his head injury was becoming apparent.

While I stared into his empty eyes, I noticed myself in their reflection. We had the same eye colour, the same goofy-looking nose too big for our faces, and the same patchy beard that said we hadn't shaved for a couple days, but that it hadn't been much longer since we became men. Then I noticed his father, standing ghost-like in the doorway.

By now, I had subconsciously established that this was myself lying flaccid on the table while the people surrounding me tried desperately to revive my limp body. The ghost-like figure had become my father. For so many years my father had been my hero, knowing exactly what to do and what to say. Today, however, he was standing speechless and helpless as he looked on. When I went to speak to this helpless hero, I too became tongue-tied. The only robotic words my mouth could regurgitate were: "I'm sorry, sir. We're doing all we can".

I remember reading a book titled *The Rational Manager: A Systematic Approach to Problem Solving and Decision-Making*. The thesis was focused on systematic decision-making. In the author's opinion, an underlying problem was a deviation from what was desired. Identifying the problem's causes was the first step to beginning the lengthy decision-making process of identifying objectives, considering options, choosing based on values, and re-evaluating while minimizing adverse consequences. I remember thinking how incredibly complicated this sounded. Now, as a Junior Physician, I think of this book often as I spend my days trying to become more efficient with the process of rational clinical decision-making. I work daily to avoid the same mistakes Dr. Groopman described of his learners when he penned *How Doctors Think*.

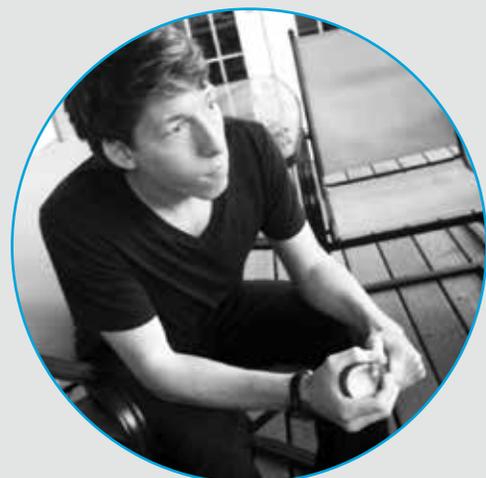
This metaphysical reflection is made only more complicated when I consider the number of decisions I

make in a day. One study published in the *Journal of Environment and Behavior* suggests that humans make an average of almost 230 daily decisions regarding food alone. If this is true, I would guess our total daily decisions would number somewhere in the thousands. Of course, not all of these can be conscious. Even the conscious decisions cannot all be rational. I try to remind myself of this when I make errors in my clinical decision-making, though this is often easier said than done.

As I reflect back on that afternoon, I am satisfied with the clinical decisions made by our team. It was a well-run trauma, and we were efficient in optimizing therapy. I am grateful that although his brainstem reflexes were absent even before he left the emergency room, we kept him supported before a formal diagnosis of brain death was made, and gave the family time to overcome the disbelief of the circumstance. Finally, I was

thankful to hear of his family's decision to request organ donation a few days later. While there were many rational decisions made that day, unfortunately one decision has left me unsatisfied with the ordeal.

I wish the words I chose to offer to his father during the overwhelming experience of his son's death had been more personal. I wish I could have expressed real and matched emotion that articulated the situation in a sensitive but clear manner. All I could produce was the same rote sentence I had used over and over again. I delivered it without a hint of the agony that seared my mind as I saw my father speechless in his most vulnerable moment. I'm sure he's thought about this moment for different reasons countless times since. I wish I could tell him that I have too, and that I truly empathize with his pain.



About Dr. Mitchell Wilson

Mitch is a third year radiology resident at the University of Alberta in Edmonton, Alberta. His undergraduate work was in Neuroscience, and he maintains a persistent interest in the structure and function of the brain and spinal cord. He is interested in pursuing Diagnostic and/or Interventional Neuroradiology. Mitch's inspiration for this work arose from a combination of experiences on several off-service rotations in his first year of residency including Emergency Medicine, General Surgery, and Orthopedic Surgery.



About Dr. Ali Cadilli

Dr Ali Cadili attended medical school at the University of Saskatchewan and completed his JURSI rotations in Regina. He then moved to Edmonton to undergo General Surgery residency at the University of Alberta. He took time off during his residency training to complete a Master of Science in Experimental Surgery degree under the supervision of Dr Norman Kneteman at the University of Alberta. Having always eyed a return to his home province, Dr Cadili has been in full time clinical practice in Moose Jaw, Saskatchewan since 2012.

■ AN EXPERIENCE TO DIGEST

Ali Cadilli, MD

I recently required an emergency procedure for the first time. After dinner with friends, I had a piece of meat stuck in my esophagus, requiring a gastroscopy to remove it. I have been a General Surgeon at the Five Hills Health Region for the last three years; for the first time, I found myself on the receiving end of one of the procedures I commonly perform on others.

I have heard several stories from physicians who have suddenly found themselves as patients. I have seen books written by physicians of how transformative an experience it was to view things from a patient's perspective. Reflections on these encounters, in many instances, describe overwhelming feelings of vulnerability and newfound humility. Often these feelings lead to states of worry and fear, partly because of loss of control (which physicians are not typically accustomed to) and partly because of the concerns generated by the disease process. My experience definitely left me with significant, new insights.

The interesting thing to me was not only that it was a procedure that I perform myself but also that it was done in the same physical setting as my everyday practice and by the colleagues I routinely work with. I can honestly say that rather than fear or worry, I was overtaken by absolute trust in the people with whom my health was now entrusted.

Through the work of the emergency room staff, operating room nurses, anesthesiologist, surgeon, and recovery and day surgery nurses, I felt completely relaxed and secure. I knew precisely the level of care I was going to receive since I had seen it in action with my patients many times before. After all, I work with these colleagues day in and out and I know their level of expertise and professionalism.

I took this as an opportunity to evaluate my own patients' experience as they would come in for this same procedure. For instance, I requested from the anesthesiologist and surgeon to administer to me the anesthetic regimen I prefer to

give my own patients; they kindly obliged. I was completely satisfied with my intra and perioperative sedation regimen. This reassured me that I was on the right track in terms of the choice and level of anesthesia provided to my patients as well. This particular regimen was revised over and over again since starting my practice; I may now truly say that my patients undergo the experience that I would rather have for myself when going through this.

One realization that came from this experience was how infrequently I have expressed gratitude and appreciation for the people I work with during the last three years. My colleagues are truly remarkable people; I would not be exaggerating a tiny bit by saying that I would not be able to do my work without them.

I am learning to ensure that the intensity of my work does not mean that I forget to smile and give a nod of appreciation to those making sure that I in turn do the best I can for our patients.

Oslerium

*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:

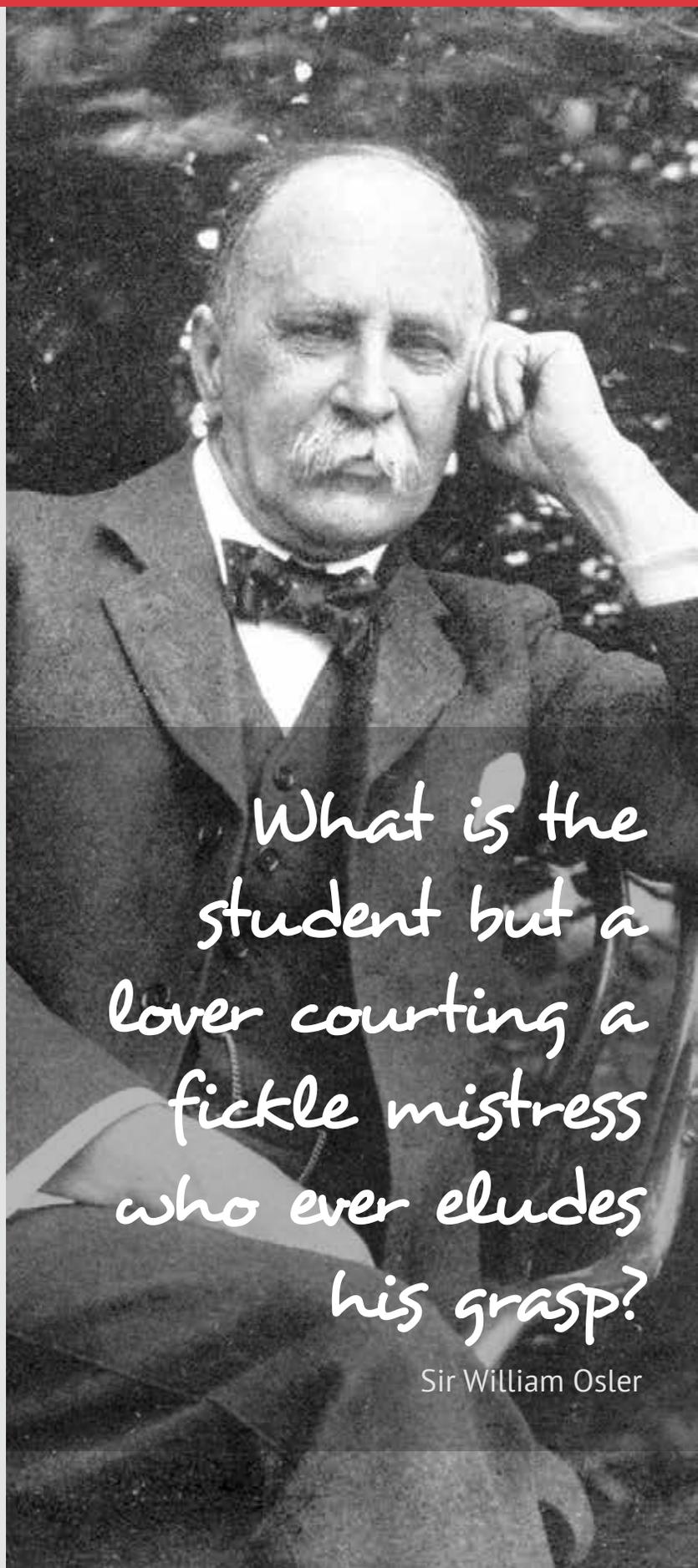
Sir William's brother, Edmund Osler (who was a railway baron) has a living connection with Saskatchewan - the town of Osler (about 20 min North of Saskatoon) is named for him; and there is an "Osler Street" close to the Royal University Hospital.

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 the concluding part of Osler’s address.

F.C.



What is the student but a lover courting a fickle mistress who ever eludes his grasp?

Sir William Osler

THE STUDENT LIFE

Sir William Osler

The student-specialist has to walk warily, as with two advantages there are two great dangers against which he has constantly to be on guard. In the bewildering complexity of modern medicine it is a relief to limit the work of a life to a comparatively narrow field which can be thoroughly tilled. To many men there is a feeling of great satisfaction in the mastery of a small department, particularly one in which technical skill is required. How much we have benefited from this concentration of effort in dermatology, laryngology, ophthalmology, and in gynecology! Then, as a rule, the specialist is a free man, with leisure or, at any rate, with some leisure; not the slave of the public, with the incessant demands upon him of the general practitioner. He may live a more rational life, and has time to cultivate his mind, and he is able to devote himself to public interests and to the welfare of his professional brethren, on whose suffrages he so largely depends. How much we are indebted in the larger cities to the disinterested

labours of this favoured class the records of our libraries and medical societies bear witness. The dangers do not come to the strong man in a speciality, but to the weak brother who seeks in it an easier field in which specious garrulity and mechanical dexterity may take the place of solid knowledge. All goes well when the man is larger than his speciality and controls it, but when the speciality runs away with the man there is disaster, and a topsy-turvy condition which, in every branch, has done incalculable injury. Next to the danger from small men is the serious risk of the loss of perspective in prolonged and concentrated effort in a narrow field. Against this there is but one safeguard – the cultivation of the sciences upon which the speciality is based. The student-specialist may have a wide vision – no student wider – if he gets away from the mechanical side of the art, and keeps in touch with the physiology and pathology upon which his art depends. More than any other of us, he needs the lessons of the laboratory, and wide contact with men in other departments may

serve to correct the inevitable tendency to a narrow and perverted vision, in which the life of the anthill is mistaken for the world at large.

Of the student-teacher every faculty affords examples in varying degrees. It goes without saying that no man can teach successfully who is not at the same time a student. Routine, killing routine, saps the vitality of many who start with high aims, and who, for years, strive with all their energies against the degeneration which it is so prone to entail. In the smaller schools isolation the absence of congenial spirits working at the same subject, favours stagnation, and after a few years the fires of early enthusiasm no longer glow in the perfunctory lectures. In many teachers the ever-increasing demands of practice leave less and less time for study, and a first-class man may lose touch with his subject through no fault of his own, but through an entanglement in outside affairs which he deeply regrets yet cannot control. To his five natural senses the student-teacher must add two

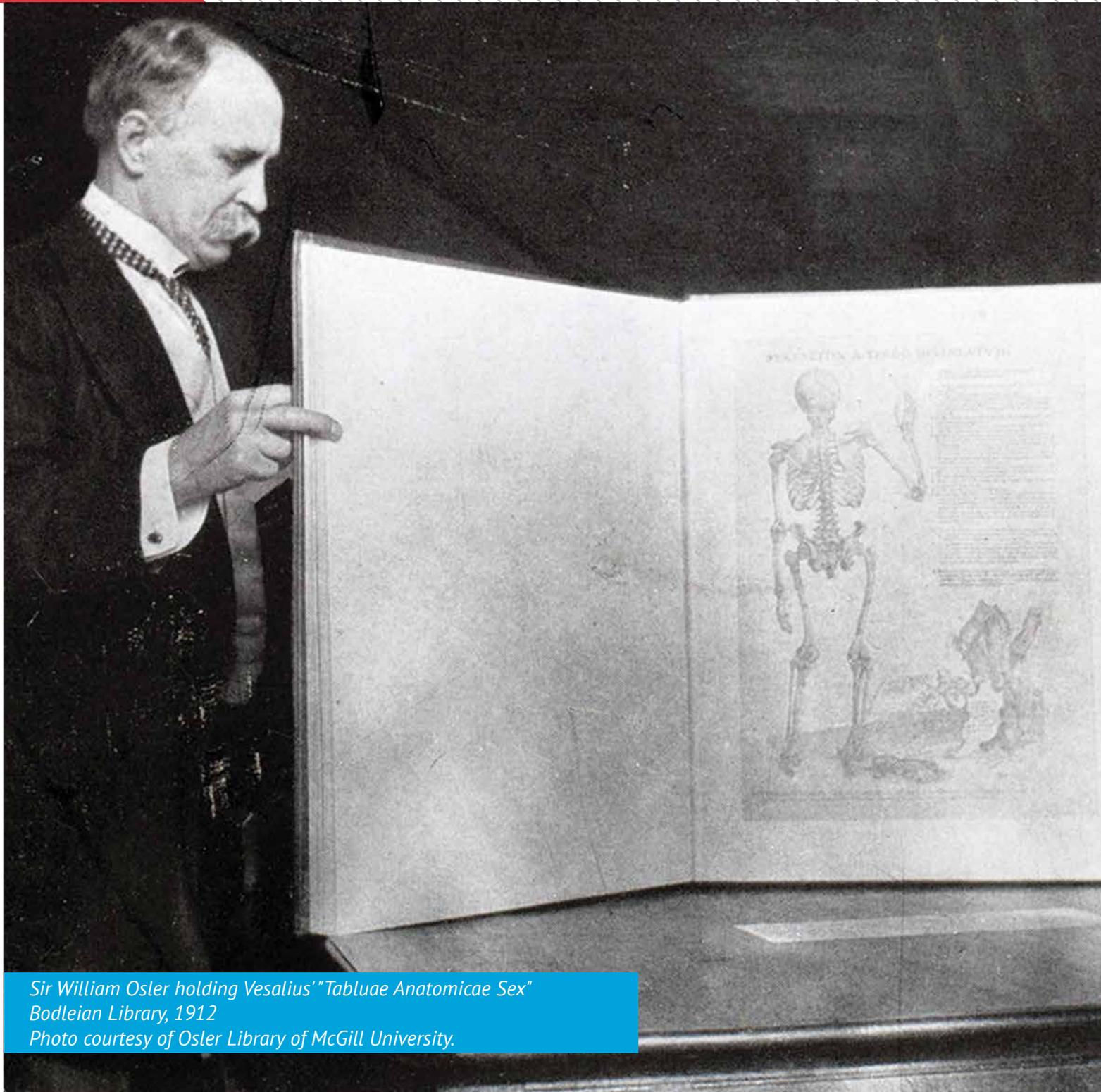
more – the sense of responsibility and the sense of proportion. Most of us start with a highly developed sense of the importance of the work, and with a desire to live up to the responsibilities entrusted to us. Punctuality, the class first, always and at all times; the best that a man has in him, nothing less; the best the profession has on the subject, nothing less; fresh energies and enthusiasm in dealing with dry details; animated, unselfish devotion to all alike; tender consideration for his assistants – these are some of the fruits of a keen sense of responsibility

in a good teacher. The sense of proportion is not so easy to acquire, and much depends on the training and on the natural disposition. There are men who never possess it; to others it seems to come naturally. In the most careful ones it needs constant cultivation – nothing over-much should be the motto of every teacher. In my early days I came under the influence of an ideal student-teacher, the late Palmer Howard, of Montreal. If you ask what manner of man he was, read Matthew Arnold's noble tribute to his father in his well-known poem, Rugby Chapel. When young,

Dr. Howard had chosen a path – "path to a clear-purposed goal," and he pursued it with unswerving devotion. With him the study and the teaching of medicine were an absorbing passion, the ardour of which neither the incessant and ever-increasing demands upon his time nor the growing years could quench. When I first, as a senior student, came into intimate contact with him in the summer of 1871, the problem of tuberculosis was under discussion, stirred up by the epoch-making work of Villemin and the radical views of Niemeyer. Every lung lesion at the Montreal General Hospital had to be shown to him, and I got my first-hand introduction to Laennec, to Graves, and to Stokes, and became familiar with their works. No matter what the hour, and it usually was after 10 p.m., I was welcome with my bag, and if Wilks and Moxon, Virchow, or Rokitanski gave us no help, there were the Transactions of the Pathological Society and the big Dictionnaire of Dechambre. An ideal teacher because a student, ever alert to the new problems, an indomitable energy enabled him in the midst of an exacting practice to maintain an ardent enthusiasm, still to keep bright the fires which he had lighted in his youth. Since those days I have seen many teachers, and I have had many colleagues, but I have never known one in whom was more happily combined a stern sense of duty with the mental freshness of youth. But as I speak, from out the memory of the past there rises before me a shadowy group, a long line of students whom I have taught



*Sir William Osler with Canadian Doctors
at 13 Norham Gardens, May 1914
Photo courtesy of Osler Library of McGill University.*



Sir William Osler holding Vesalius' "Tabulae Anatomicae Sex"
Bodleian Library, 1912
Photo courtesy of Osler Library of McGill University.

and loved, and who have died prematurely – mentally, morally, or bodily. To the successful we are willing and anxious to bring the tribute of praise, but none so poor to give recognition to the failures.

From one cause or another, perhaps because when not absorbed in the present, my thoughts are chiefly in the past, I have cherished the memory of many young men whom I have loved and lost. Io victis: let us

sometimes sing of the vanquished. Let us sometimes think of those who have fallen in the battle of life, who have striven and failed, who have failed even without the strife. How many have I lost from the student

band by mental death, and from so many causes – some stillborn from college, others dead within the first year of infantile marasmus, while mental rickets, teething, tabes, and fits have carried off many of the most promising minds! Due to improper feeding within the first five fateful years, scurvy and rickets head the mental mortality bills of students. To the teacher-nurse it is a sore disappointment to find at the end of ten years so few minds with the full stature, of which the early days gave promise. Still, so widespread is mental death that we scarcely comment upon it in our friends. The real tragedy is the moral death which, in different forms, overtakes so many good fellows who fall away from the pure, honourable, and righteous service of Minerva into the idolatry of Bacchus, of Venus, or of Circe. Against the background of the past these tragedies stand out, lurid and dark, and as the names and faces of my old boys recur (some of them my special pride), I shudder to think of the blighted hopes and wrecked lives, and I force my memory back to those happy days when they were as you are now, joyous and free from care, and I think of them on the benches, in the laboratories, and in the wards – and there I leave them. Less painful to dwell upon, though associated with a more poignant grief, is the fate of those whom physical death has snatched away in the bud or blossom of the student life. These are among the tender memories of the teacher's life, of which he does not often care to speak, feeling with Longfellow that the surest pledge of their



*Osler Family at 7 Norham Gardens, Oxford, circa June 1905
Photo courtesy of Osler Library of McGill University*



remembrance is "the silent homage of thoughts unspoken." As I look back it seems now as if the best of us had died, that the brightest and the keenest had been taken and the more commonplace among us had been spared. An old mother, a devoted sister, a loving brother, in some cases a brokenhearted wife, still pay the tribute of tears for the untimely ending of their high hopes, and in loving remembrance I would mingle mine with theirs. What a loss to our profession have been the deaths of such true disciples as Zimmerman, of Toronto; of Jack Cline and of R. L. MacDonnell, of Montreal; of Fred Packard and of Kirkbride, of Philadelphia; of Livingood, of Lazear, of Oppenheimer, and of Oechsner, in Baltimore – cut off with their leaves still in the green, to the inconsolable grief of their friends!

To each one of you the practice of medicine will be very much as you make it – to one a worry, a care, a perpetual annoyance; to another, a daily joy and a life of as much happiness and usefulness as can well fall to the lot of man. In the student spirit you can best fulfil the high mission of our noble calling – in his humility, conscious of weakness, while seeking strength; in his confidence, knowing the power, while recognizing the limitations of his art; in his pride in the glorious heritage from which the greatest gifts to man have been derived; and in his sure and certain hope that the future holds for us richer blessings than the past.

Ron's Column

■ THE ONLY THING THAT COUNTS

*A Commentary on the
'Heart to Heart' Writing Project*

Ronald Haisen Nguyen
Medical Student
University of Saskatchewan

After someone has read one of these stories, I'm often asked, "So, what is the meaning of the story?"

It's a question I've often asked myself with the stories that I've read in the past. I would think about the story and its relation to philosophy, the commentary on human behaviour, or the story's reflection on a time in history. The lessons of the story, I had always believed, were the most important part of reading any story.

That notion has changed for me in the last few years, a time period that was particularly difficult and transformative for my life, and now, there are fewer things that I am certain of. Many of the passions and causes that I had believed to be true turned out to not be as true as I had thought, or the things that I had condemned and thought of as false sometimes found redemption for their shortcomings. Almost everything that I knew, including the lessons of the stories that I read, veered somewhere towards the middle, somewhere unknown.

But from those stories that I had read, what remained true to me were the emotions and experiences of the characters. I could always relate to Leo Tolstoy's description of Prince Andrey's rejuvenated hope and elation that stretched as far out as the young Natasha's arm did towards the silver moonlight while sitting on a window ledge, or Ernest Hemingway's recollection of his own younger self as he walked along the Seine river in Paris, his head buried in the shadows of the bronze tree branches, swaying with resentment towards lazy labels like, 'Lost Generation'. With the writer's description of the emotions and the experiences that had led to producing those emotions, I could relate to that feeling and encompass it within my own experiences. I could be certain that what I had felt for myself was at least as true as what the writer had described. Knowing that my feelings were not solitary incidents, that they had happened back then in the writer's time and now in my own time, I would feel intertwined with time and history and humanity, and not only because of the relation to the writer, but also to all of the readers that I believe have also connected with that same passage...

That is what I am trying to do with these stories, reproduce the emotions and the experiences of the people that I interview. What I hope is that you will be able to recognize the emotion that is told from the story, but more importantly, that you will be able to relate to the emotion. Despite you being separated by time and space and familiarity with this person in the story, at that moment of relation, you are there with them. As their experience ultimately becomes a part of your experience, your individual self reconciles with a piece of the world around you, and for at least a moment, there is a moment of true faith in an uncertain world. The world, with its many conflicting differences, becomes a little smaller.

The emotion, the experience, the relation. That's all I want from any reader to garner from reading these stories. It's that simple. It's the only thing that counts.

Now, as a young medical student, I am displaced in another arena of uncertainty. Each day, I am learning the lessons of medicine, trying to understand and put to memory the many diagnostic criteria sets and treatment algorithms. All of these lessons will be essential for this time period in my training, although not all of them are with absolute certainty. Some of this information will remain true throughout my practice, but others will change with more research and the progress of medical knowledge.

That being said, there is an aspect of medicine that I believe will always remain true, having seen it from the physicians I hope to emulate in the future, and it is also

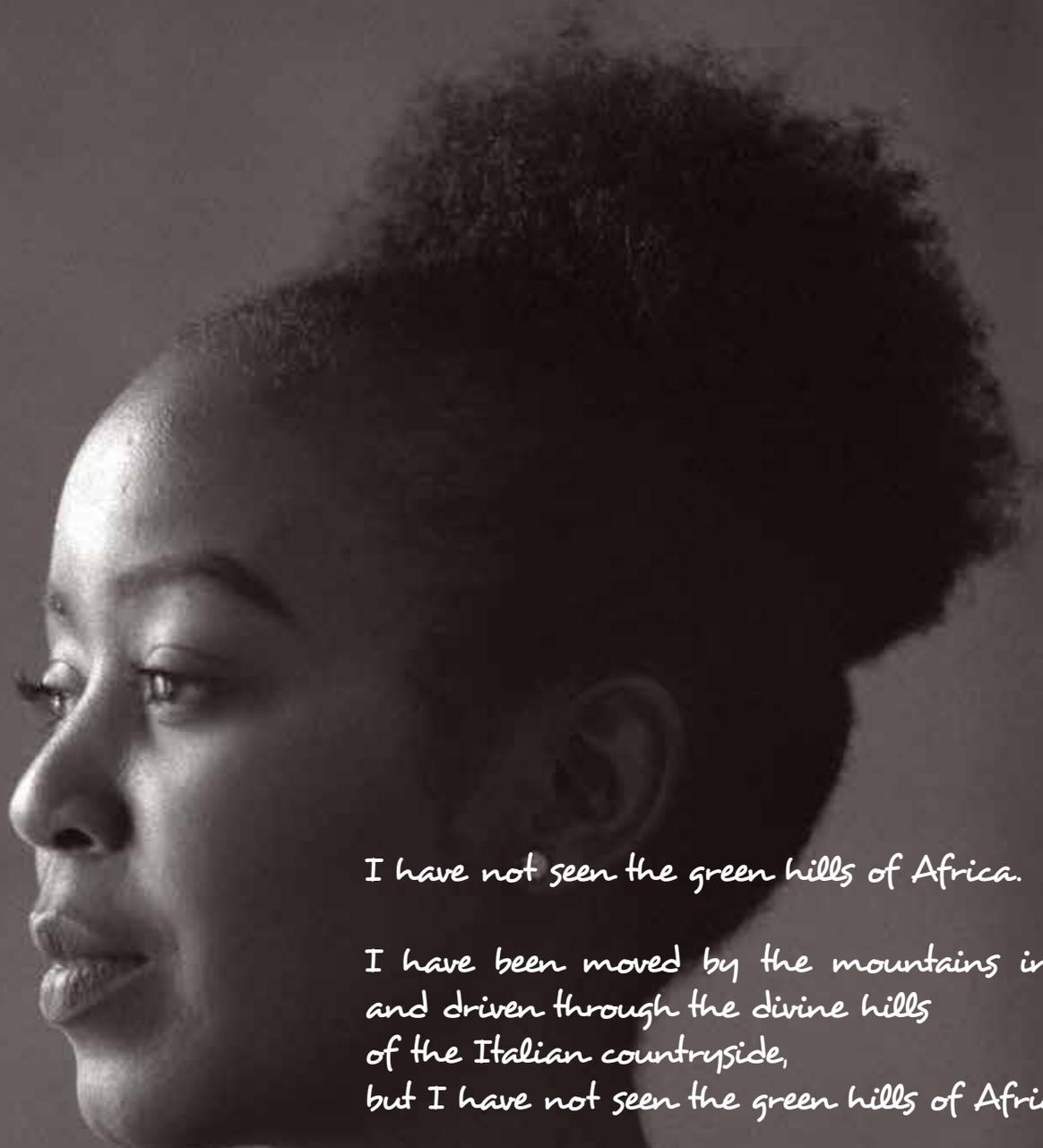
a moment of relation. That moment of relation itself is difficult to describe, but that moment is essential to gaining the trust of the patient. It is not a quantifiable or determinable moment, but it can certainly be felt. At this point, the best way that I can describe it is as a moment that is made true while the physician truly listens and is concerned about the patient's feelings and their fears, when the physician has considered what the patient has been through and what they will go through as they walk through the charcoal corners of their medical complaints. Ultimately, that the patient sees that the person in front of them is simply another human being caring for another human being. When that moment of relation is realized, and the physician reconciles with the emotions and experiences of the patient, that is when the physician's words and expertise are bounded by trust and faith, and have the capacity to transcend beyond the walls of the clinic and be reflected in the lives of the patients and the world that we live in.

The concern, the consideration, the care. At that particular moment when a patient is gauging their trust for a physician, that's all any patient wants from their physician. It's that simple. It's the only thing that counts.

If you would like to read more stories from this series, 'Heart to Heart', visit www.hthstories.com



Ronald Haisen Nguyen is a medical student. He was born and raised in Calgary, Alberta, but has called Saskatoon his home for the last number of years.



I have not seen the green hills of Africa.

*I have been moved by the mountains in Alberta
and driven through the divine hills
of the Italian countryside,
but I have not seen the green hills of Africa.*

*From where I've been and what I know,
I can imagine that the cradle of the world
caresses the land with the wind
as it sweeps through the tops of the thick trees
and across the gorging rivers,
rocking and cooing the rich, restless land.*

■ VK

Nursing Student

But on the bottom of those green hills, there was once a little girl who lost both her parents at a young age, coming home from school, with one hand holding her bag with the sugar and soap and toilet paper she had to supply for herself at school, and the other hand carrying a suitcase. She would arrive to a place, not that of solid stucco walls and sturdy red roofs like her earlier years of childhood, but of the shoddiest of bricks and rusted sheet metal roofs. By the evening, she would lie in a narrow bed, her unpacked suitcase beside it, with the kick of another foot or two upon her leg, and she would look out of the window and towards the moonlight that corralled around the tips of the green hills, and she wondered how far that light could travel beyond that range.

I have never been to Bangladesh, but I've been told that there are not many high hills, but there is the ocean that colours the land like light streaming through a prism, with rare and hidden hues flourishing from nature's spectrum. But in the city, all the colours convert to a greyscale, and the smoky clouds cloak the streets, with roads that are lined with the flat tones of the ticking motors that are inches away from each other, their cranking blares spilling endlessly from them.

At an intersection on any one of those streets, there was perhaps one woman waiting, crowded by hundreds of people, with the sweat of the running river washing down beneath her cotton shirt. As she would wait, she would grip the handle of her bag tightly with her

heavily callused hands, pressing it firmly against her body as street children dangled past her. When it would be time to walk along with the horde of people on the ruddy, uneven roads, she would look beyond the crowd and to the port of the city, where the row boats paddled away on the temporarily tranquil waters and she wondered how far they could row beyond this port. In a postpartum unit in a hospital far away from the green hills of Africa or the busy streets of Bangladesh, a nursing student picked up a clipboard with the patient assessment forms for discharge.

She walked up towards a Bangladeshi couple, shook their hands, pulled up a chair, and sat eye level with the new mother. She smiled at the couple, introduced herself, and then skimmed through the forms, noticing that all the boxes had been ticked of.

"So I'm just going to go through these forms again and make sure that you have everything that you need for when you leave," she said with a smile.

"Okay, so first thing on the list, you're okay with using the car seat?" She saw the new mother turn her head and look up to her husband, with the husband trying to translate for her.

She spoke slower and outlined the shape of the car seat, also using the motion of her hands upon a steering wheel, and she could then see the patient slowly nod her head towards her.

The nursing student went down to the next item on the list. The same sequence happened, with the student listing the item, the patient turning her head to her husband, and the student breaking it down for her. After that, the nursing student noticed the patient's nurse conversing near the doorway.

"Did you understand what she was saying to you?" she said to the couple. They both shook their heads.

She smiled at them and then went through each one, going through the same sequence, explaining each one, speaking more slowly, using her hands.

When she came to the breastfeeding section, she noticed a bottle of formula on the table beside the patient, but that the boxes were checked off for a recommendation for breastfeeding. Even though the patient had two children previously, the way she explained how she had breastfed in the past, it was clear that she did not understand.

The student went to find her instructor, and together, they helped explain the process to the new mother. Together, they positioned the new mother's arms, with the baby's head and shoulders to be scooped in the crook of her forearm, the baby's nose aligned to the breast and its chin drawn in towards it. The other arm was to be nestled underneath the baby's legs, with the mother's chin to be tucked in and the baby brought towards the mother, and the smile that was to emerge on the mother's face as baby and mother were together again.

When it was time for the patient to leave, with the patient's husband holding a car seat in his hand, the nursing student walked with the new mother to the door and into the hallway. The patient stopped and said something to her husband, and he went on.

The patient suddenly turned around and hugged her. At that moment, between those two people, rivers did not seem to stretch so far and hills did not seem to tower so high, and the whole of the world seemed as small as the space between them.

In an operating room, his hands working with the tools of his trade, gently pushing aside organs, tissues so he could see the cancer better that riddled the patient's lower abdomen.

At a certain point during the operation, he started to think about the cancer that was swallowing whole this patient's body. Cancer starts as a single cell that loses its purpose and place in the body. It proceeds to clone itself, over and over again, growing and invading the surrounding tissue and beyond, ignoring the regulations and signals from the body to stop. Yet, in a sense, cancer was a part of nature itself, and it had been here on this earth since human history could be thought of.

The longer he looked at the trench that he had opened up, the more the sight seemed to draw him into a space as dark and cold as a black hole.

In this space, he was suddenly aware of the pressure of the steel instruments along the crease of his palm, the smooth rubbery coating of the latex gloves touching the skin of his palms, the thin sterile paper scrubs robed around his body. He was suddenly aware of the patient in front of him, in the sense of who he truly was and just how young he was in this era of medical care, middle-aged with a wife and small children, and that this was almost the end for him, the operation being palliative.

As he looked around the room, from the scrub nurses to the anesthesiologist, he thought of the days of before, without all of the benefits of modern

■ ANON. The Surgeon

medicine, with all the people that died very young and they knew that they could die very young too. Each single person, with families and hopes and dreams, with faces and tears and laughter and bodies, all to fade into the whole.

It was a few weeks later and he checked up on the patient, with the thoughts of the operating room still trailing him. They met in a quiet part of the hospital, with the patient's wife by his side.

The wisps of his patient's thin white hair were on their last wave. The lustre of his blue pigmented eyes was overshadowed by the heavy dark pads that hung underneath them, with the paper skin on his cheeks and chin smoothed away to the layer just beyond bone. The breaths were slow and crumpled with grain. The only remaining feature from the past was the cross and chain that hung around the nape of his neck and ran down along his bony chest.

He updated the patient on his condition.

Like many times before, the patient choked out hard, stifled breaths, his temples sharply pulling downwards, his mouth trembling. Tears surfaced along the crest of the patient's lower eyelid and softly streamed down his cheeks.

But unlike before, something else stirred within him. That sight took him back to when he was a boy and he saw someone else cry, and he knew that feeling and felt that feeling all at once. A force, one that was as sudden and strong and natural as gravity, seized and swallowed him whole, his own head slipping into the sharp, downward pull of the temples, his lips toppling under the weight of the trembling mouth, and the resistance of his soul dissolved in the stream of tears.

With his feet planted on the floor and his shoulders hunkered down, he lowered his head...

Then, there it was.

A catching of a breath.

He looked up towards the patient's face and saw a smile emerge amidst the tears. At that moment, that pocket of air seemed to be a reservoir of hope, and it closed the existing chasm within his heart and soul and released forth a feeling of cosmic awareness. And how can one describe this feeling, this feeling of infinity and wholeness? That a flashing feeling of awe passes before your eyes like the tail of a transiting comet, and when suddenly, you feel weightless, as if floating on a sheet made of fine specks of stardust, rotating and grazing past gas giants and fragments of faraway nebulae. An understanding that separation and singularity and the closure of time and the force of nature are only moments, like the moments between breaths, and that the human spirit, that of love and grace, can transcend beyond all of that and become apart of eternity.

As they parted ways, the patient soon to cross over into one world, he felt like he had crossed into another world, and beside him, walked the Truth of the World.

Poetry Corner



This issue's poet is
JESSICA WINTER

Dr. Jessica Winter graduated from the University of Saskatchewan's College of Medicine in 2017. She will soon be starting a residency training program in Plastic and Reconstructive Surgery at the University of Manitoba.

Author's Note

I started to write poems 3 summers ago while I was traveling through Switzerland by train and at a particularly difficult time in my life. I can remember very vividly passing in and out of tunnels through the Swiss Alps with every corner revealing waterfalls and green mountains, each more beautifully than the last. I believe this was the moment I fell in love with train rides; solo train rides are especially powerful at provoking thought and contemplation. I had a lot of feelings and a lot of words that I wanted to put together, so I picked up a pen, turned to a blank page in my travel journal and let the thoughts pour out on to the lined sheet. I finished my first poem just as we had 5 minutes to spare before we reached our destination. Remarkably I discovered I felt much lighter, like a heaviness that I had been carrying around that disappeared.

Writing quickly became a therapy for me, a way to deal with feelings of anger, sadness, curiosity and of course, matters of the heart. I would write to solve problems, and even if I did not solve the problem I was facing, I at least felt a little bit closer and I had a new poem!

Traveling through Portugal with a good friend we met a man who told us that during our stay we must listen to Fado music. He explained that Fado is a Portuguese genre of music characterized by Jazz ballads that sing songs about Saudad. Saudad, he expanded, is a Portuguese word that has no English translation. Very simply it is like missing someone, but not just missing a person, it is missing an era or a period of time you spent with a person. Although no sadness is felt, more so you reflect on your memories with great fondness. My mind was fixated on this word - it was complex, I could not describe it but I knew exactly what it felt like. I had to write about it.

3 years later, a few more train rides, countless adventures, a little bit of heartbreak and some of the most meaningful experiences of my life, I have now graduated from medical school and I continue to write. Remarkably, I've begun to piece together a small paper trail of my young adulthood. It brings me complete enjoyment to reflect on the experiences that inspired me to write my poems. Saudad is the poem I have chosen as my debut piece. I wish to share a word that most beautifully aims to describe a feeling that I believe most of us have lived.

SAUDAD

- by Jessica Winter

Sort of like

longing, but not a missing.

It is much more than that, more than a feeling or a thought.

Similar to fire, but unlike reminiscing,

This burn is not easily forgot.

More than a story and not well explained.

an Intense, aching, radiating passion,

Captured by song and released In the refrain.

Worn on the hearts of those who know, saudad.

Not just a person, but everything shared,

It is the weeks not the hours we miss...

Not a trace of sadness, or dispare,

Only euphoria at the thought of that kiss...

Insomnia haunts the minds of the invoked,

Restless as the ocean, but with the warmth of the sun...

These dreams are fading faster then I had hoped.

But tonight souls take flight; off into the darkness they run.

It is very purposeful granite taken to slate,

Carve our names so that generations to come will see,

No thought is required; do not let the hand hesitate,

Unfold my secrets, and expose every part of me, Saudad.

Please, Do not fleet as I begin to sleep,

Delicate memory of this tamponade...

Come with, where the ocean and the moonlight meet,

And here you will live, sweet Saudad.

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

In 2015, 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 5, in his own words ...

F. C.

LIFE STORY

Excerpts from the memoirs of R. M. Kirk

Chapter 5



House appointments

We both succeeded in gaining house appointments at Charing Cross Hospital, which were resident. My initial appointment was house surgeon to a charming, kind man who had lost his nerve during his war service because he was rapidly promoted to a high rank in charge of others but losing his skills and his self confidence. The other, was a brilliant operator but who was embittered and taciturn. This man had a full set of loose dentures and responded to irritation by gnashing his teeth.

Peggy worked as a house surgeon to a delightful orthopaedic surgeon who had taught us the rudiments of careful clinical examination as students. Although he was Welsh born, he had been raised in London and spoke with a slightly Cockney accent which he proudly displayed against anyone behaving arrogantly. Some years later I was in the operating theatre surgeons' room while the surgeon proudly informed us that he had been called to see a member of a foreign royal family. Our Cockney orthopaedic surgeon chirped up with, 'You're not the only one. I've seen royalty too. I was called out by a toff of a doctor. I asked for the address so I could go in my Rover. The doctor said he would pick me up in his chauffeur-driven Rolls Royce. On the way, he told me I was seeing the teen-aged king of (a middle eastern country). He said I should

walk into the room and wait to be introduced to the king, and then bow low and say, "May it so please your Majesty." I wasn't 'aving anything of this. I walked in and said, "Hello, sonny."

The relationship between Peggy and I had continued and deepened. I have always puzzled how one chooses a desirable life partner. It certainly is not rational but is intuitive – with the factors undefined, even indefinable. When we join a group of new acquaintances, we are unpredictably drawn to some, not attracted to others, even antagonistic to one or two. My initial attraction towards Peggy had strengthened. The possibility of marriage at that time presented a contentious problem. Peggy is Jewish. It would not now be considered a problem in today's much more cosmopolitan society. We discussed it interminably during the five years of studentship and internship. In retrospect that interregnum gave us time to know our cultural backgrounds and appreciate each other beneath the personalities most of us try to project on first meeting, which are unsustainable over a lengthy, stressful period. My impression is that following marriage that proved incompatible at that time, it was generally expected that the couple would make the best of it. 'Divorce' had a Bohemian connotation, respectable people did not indulge in it, especially if

they had produced a family. Today's people are much more likely to take a lead from King Henry VIII – though without the necessity for heads to accompany the separation.

At the end of our first 6 months of post-registration experience we decided to marry if we both acquired second resident appointments at Charing Cross Hospital. We succeeded. Peggy acquired an

surgien). Peggy had acquired the surgical title of Miss in recognition of her previous appointment with the orthopaedic surgeon. Her delightful ex-chief, tongue in cheek, asked her if he should now call her, "Sir."

By coincidence the restaurant manager at the nearby Savoy Hotel had been a patient on my ward. When he left hospital he invited me to let him know if I had anything to celebrate. I mentioned our intended



Caxton Hall, London, UK

appointment with a paediatrician and a dermatologist. I became a casualty officer – now called accident and emergency (A&E). We married. The civil wedding was at Caxton Hall, on the day following the second marriage of Sir Anthony Eden, the then Foreign Secretary. The hall remained highly decorated with flowers in his honour. We enjoyed our brief celebrity because press photographers were awaiting us and we were headline news. Our photographs appeared in the London newspapers with the caption, 'Doctor's bride a surgeon.' This was in recognition of the fact that as an emergency doctor I was addressed as 'Dr.' In Britain surgeons are still addressed as 'Mr (or Miss)' since they are manual workers (G cheirourgos: cheir = hand + ergon = work > chirurgion > AngloFrench

marriage and he promised to arrange a wedding lunch. At that time the post-war rule of standard meal charges was still in force. We were rewarded with a central table in the riverside dining room, a printed menu signed by the waiters, bottles of champagne and a specially prepared desert – all for about five shillings each. We have recently celebrated our Diamond (60 year) anniversary and returned to celebrate it at the Savoy. Our children booked and paid for to spend the night there. It was a little more expensive than five shillings each – but well worth every penny.

Bankrupt postwar Britain limited us to £25 each for a 10 day honeymoon and we nearly starved in the bitter cold of Paris in December. As we looked at our few

surviving francs before our return flight, we found a restaurant that served a single meal each, just within our budget. It was grilled steak. We ordered it. The waiter asked, 'Bien cuit?' I did not comprehend and feared there was an extra charge. 'Non.' I remember it well. Perhaps it had been briefly passed over a lighted match. It passed through my digestive tract without touching the sides.

On our return from honeymoon in Paris we claimed adjacent rooms, moving both beds into one room, freeing the other as a sitting room. We received a message to see the Dean. This was not for the congratulations we anticipated but for a reprimand. It was then considered reprehensible to have a married couple as residents (in the hospital accommodation) as it would set a precedent. The Dean informed us that Lord Inman, the Chairman of the Board of Governors, had ordered us to be dismissed for failing to report our intentions beforehand. We were told that he relented only when assured that we should be ordered to lead bachelor lives while occupying the Residency. Having served for four wartime years you may imagine my response. He then weakly stated that we should at least occupy separate beds when the maid brought in the morning tea. The war had not erased the arrogance of the 'establishment.' The older generation obviously assumed that everything would return to the 'Good old days.' Sadly, because they were back in charge, in many ways this was true. That complacent 'We won the War,' assumption deprived us of the drive to recover the vision and optimism that had driven us during the Industrial Revolution. Looking back, the dreary days of, 'I'm alright Jack' bad management and consequent strikes brought us to near paralysis. The losers, in an even worse state than us, picked themselves up and rebuilt. Japan learned modern methods from their American occupiers; Chancellor Adenauer concentrated on rebuilding the infra-structure that had been almost totally destroyed in Germany.

Peggy took up her new appointment as Paediatric and Dermatological house physician, reverting to the title of 'Dr.' During my next post as a Casualty Officer, we were unsupervised. Fortunately, the department was managed by one of the dedicated spinster

nursing sisters. Sister Audrey Record, always dressed impeccably in smart, un-creased uniform, knew all the 'lags' who attended, hoping to gain a meal, a bath, a bed, fresh dressings, clean clothes, a dose of medicine or an injection. She wandered into the rooms and we could hear her monotone voice, stating, 'I see you have registered yourself as Mr Smith. I've seen you before.' She would go to her office, consult her 'black book' containing descriptions and names, then return to say, 'Yes you told us then that you were Mr Brown.'

A frequent ruse was to reproduce the excruciatingly painful symptoms of an obstructed kidney stone passing into the ureter. This was in the hope of getting a bed for the night or an injection of a powerful painkilling drug such as pethidine (Demerol), which was the forerunner of drug abuse. If they were sent to produce a urine specimen, they first pricked their finger. A few drops of blood dripped into the urine specimen allowed for the microscopic detection of red blood cells in the urine, a screening test for ureteric colic. On first encounter I admitted the patient and took him to



Rationing of bread - post 2nd World War Britain

the ward. As I was writing the x-ray form the consultant arrived and I described the classical features reported by the patient. The consultant curtly ordered the man to leave, which he obeyed without protest. I enquired how he had been sure of his diagnosis and he told me that it was intuitive – what we would now describe as ‘pattern recognition.’ The consultant then left to visit another hospital in South London. A few minutes later he telephoned me. He had entered the ward to see a man undressing, ready to get into bed – the same man he had ordered out of my ward. He laughingly said that when the man saw him, he leaped out of bed, pulled on his trousers and rushed for the door, muttering to the consultant as he passed, ‘Are you on at every bloody hospital in London?’

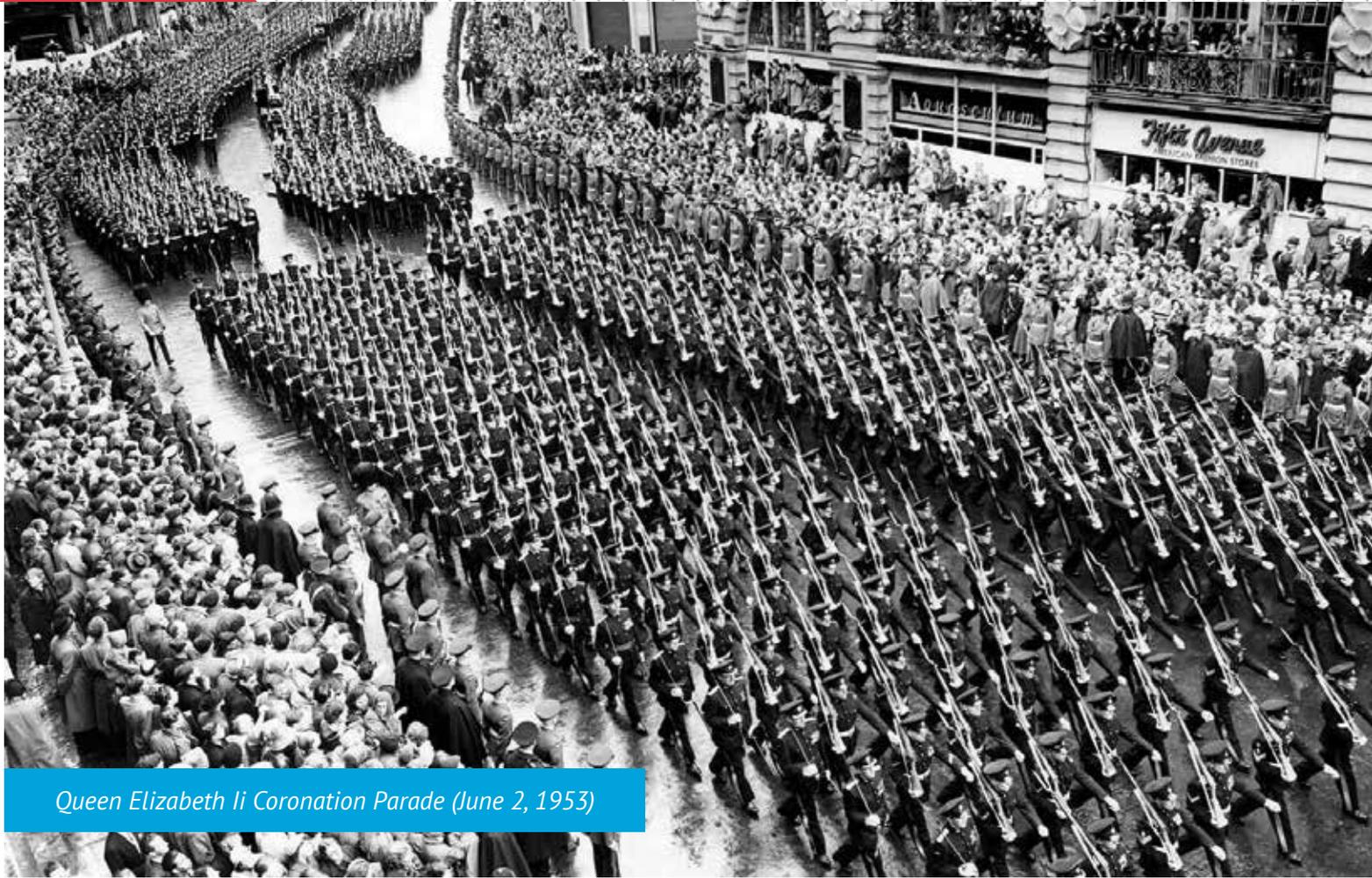
Beneath her formal stiffness Audrey Record quietly displayed her humanity, especially to the local homeless ‘tramps,’ surreptitiously dispensing their requirements without registering them. At Christmas she used the ‘Casualty ward beds’ to provide warmth, baths, changes of clothes and a share of Christmas fare. Moreover, she quietly guided the doctors, warned us from long experience, admonished us – and treated us like a hen with her chicks.

When we were in difficulty we turned to the medical and surgical registrars for advice. Many of them were overworked, unsupported, time expired and blocked from promotion to consultant status. Those who had no hope of advancement often sought appointments elsewhere, such as within the Commonwealth countries. They were mature and clinically sound and confident. One of the seniors, Dennis Dooley, had been a classics student and enjoyed displaying his knowledge of Latin. On a particularly busy day he joined me, offering to help reduce the large queue of revisiting patients. After a half hour a distraught nurse sought me out and showed me a treatment card on which the senior doctor had written only ‘RUSDD.’ She told me that she had a room full of his patients, all with this as the sole instruction. I could not decipher it and in despair I approached the doctor. ‘What does this mean?’ ‘These are instructions for treatment specifically authorized by me. Obviously your education is inadequate.’ ‘rep ut supra Denis Dooley’ (repeat the above).’

I was on duty for 48 hours without a break during the Coronation of Queen Elizabeth. Charing Cross Hospital on 2nd June 1953, was one of the few hospitals accessible along the route of the parades. The atmosphere was wonderfully patriotic and good-hearted. I did not see a single assault or any evidence of misbehaviour. We did encounter a condition that appeared to be unique and which we jokingly referred



to as ‘Coronation belly.’ Many people sat on the cold pavement edge overnight in order to secure good views along the parade. We had a stream of attenders complaining of pain and mild localized tenderness in the right side of the abdomen, raising the possibility of appendicitis. We lay them on mattresses and as they warmed up, their symptoms subsided. A few spectators sustained chest bruises by being pressed against the railings during the evening firework displays taking place on the South Bank of the river Thames. There was



Queen Elizabeth II Coronation Parade (June 2, 1953)

no drunkenness but a man was admitted after taking a drink while he was under treatment with antabuse (disulfiram) and he had suffered the resultant effects. The day brought an added pride with the news that Edmond Hillary from New Zealand and the Nepalese Tensing Torgay had succeeded in climbing Mount Everest for the first time.

Anatomy

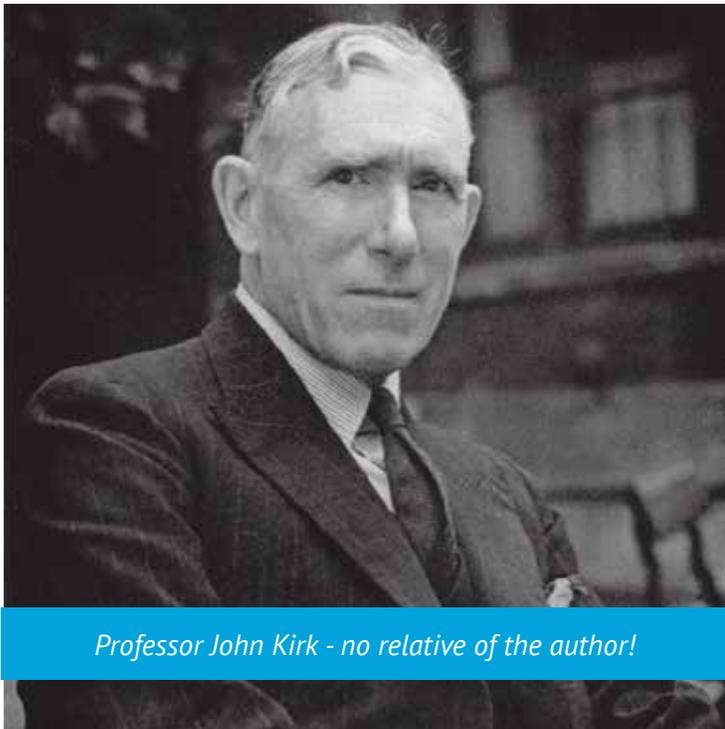
In order to apply for a post as a trainee surgeon I needed to pass an examination (called the Primary FRCS – Fellow of the Royal College of Surgeons) in Anatomy, Physiology (function) and Pathology (disease). I failed. I was fortunate to gain the post of Anatomy Lecturer at King's College London to prepare for a second attempt. The Professor was Tom Nicol, a Glaswegian, was writing 'The Finite Textbook of Anatomy', and from time to time called me to help him with proof reading, though the book was never published. On one occasion, quite out of context he asked, 'Kirk, who is your 'uncle?' Who is pushing for you?' My interpretation was that I may

have ingratiated myself with some powerful senior supporter. I curtly replied, 'No one!' Tom responded with, 'Well, you are a bloody fool. If you had any sense you would be sycophantically saying to me, "Oh what a brilliant anatomist you are, Professor Nichol" – not that you know enough to make a judgement of anatomy. But if you did, do you know what I would do? I'd simper.' Benjamin Disraeli (1804-81), British Prime Minister in the late 19th century had recognized, 'Everyone likes flattery and when it comes to Royalty you should lay it on with a trowel.' I was outraged. By coincidence, a senior lecturer, Richard Snell, treated me unctuously, using a trowel. I discovered that he had the mistaken belief that I was the son of Professor John Kirk, Head of Anatomy at the Middlesex Hospital. He once placed a hand on my shoulder and enquired, 'How is your father?' When I jocularly stated that he was still emptying dustbins, Snell turned aggressive but I sharply rebutted him. I later met John Kirk when he visited Professor Nichol. He was amused but not surprised when I recounted my conversations. Snell's

ambitions were well known and indeed, he later became a very successful author of anatomy texts in the USA.

One of my contemporaries stupidly but maliciously locked himself in the lecture room before he was due to teach, in order to draw on the blackboard complicated anatomical relations in purple chalk. He mistakenly thought them too indistinct for the students to see but they well knew his intentions. He then questioned the students and sarcastically demeaned them if they could not answer the detailed questions he posed. They waited for an opportunity when the lecturer briefly left to empty his bladder, to wipe the board clean. The lecturer re-entered, started the session with an arcane question which could not be answered. He sarcastically turned to refer to his drawing to discover that it was no more. Moreover it was patently obvious that he did not know the answer. The students began to chuckle, laugh, chortle, howl and shriek. The lecturer screamed in rage and we were forced to rush in to drag him out. I did not then know that wonderful German word Schadenfreude (pity happiness) but I certainly knew the emotion that it signified.

Peggy meanwhile had a desire to practise paediatrics and obtained a post at the Children's Branch of St



Professor John Kirk - no relative of the author!

George's Hospital in Tite Street, Chelsea. She found it a fulfilling career and a wonderful challenge. Her parents welcomed me into their home since I was not resident. Her father, Emmanuel ((Mark) Schafran, a school teacher at the London School for Jews was also a teacher of Hebrew. We thoroughly enjoyed discussion on a variety of topics. His great enjoyment was to attempt each week the fiercely difficult cryptic crosswords set by someone who entitled himself Ximines – successor



Kirsten Flagstad - Great Norwegian Soprano

of Torquemada the Grand Inquisitor of Spain. He was Derrick Somerset Macnutt, a schoolmaster. As an added challenge, Mark eschewed a Chambers Twentieth Dictionary, on which the answers were based – but frequently managed to complete the puzzles. For one of his birthdays we bought him, in our penurious final state, a 1909 edition. In the Addenda appeared Aëroplane – a form of flying machine.

Peggy's mother, Caroline was an immensely handsome woman, proud to be of Sephardic (Portuguese) Jewish origin with the maiden name of Mendoza. This wonderfully characterful lady, with smooth black hair, tied in a bun at the neck, looking like a splendid, proud Spanish senora. Peggy's elder sister Betty had a beautiful singing voice and a love for opera. We helped to queue at the Covent Garden House for tickets in the amphitheatre slips. They cost a half crown (eighth of a pound), and allowed a view of half the stage, together with a complimentary stiff neck from twisting to vainly extend one's view. I benefitted, with Peggy to be enraptured with the 'Liebestod' (Love death), the end of Richard Wagner's Tristan und Isolde. We had the good fortune to hear it sung ineffably by Kirsten Flagstad in one of her final appearances. Another joy was The Lover and the Nightingale by Enrique Granados sung with wistful beauty by Victoria de los Angeles.

The experience of living with a Jewish family confirmed what I should have already realised – that people are people. Beyond their tribal beliefs and customs they are much the same and the Schafrans welcomed me as though I was a son. They overlooked my inadvertent breaks with their way of life and I was rapidly able to feel thoroughly at home. Nonetheless, living with people with a different religious culture requires sensitiveness on both parties to avoid inadvertently causing offense. I have found this equally with Catholics and Presbyterians. We have all developed pre-conceptions, attitudes, beliefs, prejudices which have become part of our cultural background. Many become modified when we enter previously unfamiliar communities but some are so automatic that we do not always recognize them as potentially offensive. Equally, it is possible to take umbrage from the receiving end. I was anxious regarding my future attitude towards antisemitic expressions. It transpired that it was exactly the same as my response to anti-British remarks – I usually shrug them off, quietly expostulate – but never embark on a show of aggression.

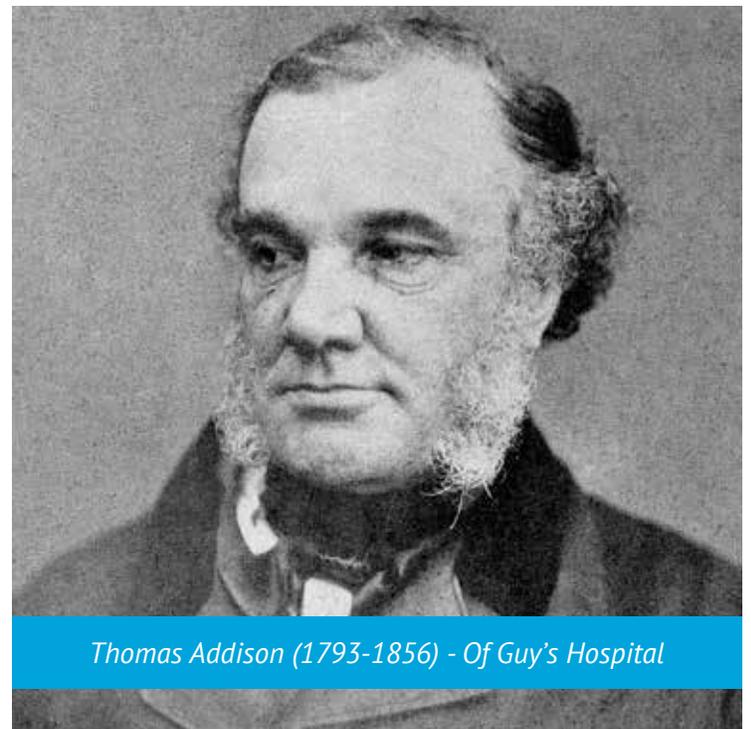
Surgical Trainee

With great relief I passed the Primary FRCS examination on the second attempt. Tom Nicol was a friend of Professor Ian Aird at the Royal Post-Graduate

Medical School (RPGMS) in Hammersmith, author of the famous textbook, Companion in Surgical Studies which had been my undergraduate prize book. I was now eligible to apply for surgical training. When I asked Tom Nicol for permission to resign in order to apply for a post at the RPGMS, he feigned outrage. He picked up the telephone, called Aird and tongue in cheek while I stood by his side, reported to his friend that he had a useless wastrel he wanted to get rid of – would his dear friend, as a favour, take me off his hands? Having never boot-licked to Tom (what my future Australian companions referred to as 'brown-nosing'), I had acquired an 'uncle.' I was appointed.

There was an interval before I took up my next post and I spent it as a locum in Ophthalmology at Guy's Hospital next to London Bridge. This hospital had produced the distinguished physicians Richard Bright (1789-1858) who described chronic nephritis and Thomas Addison (1793-1860) who named the disease from which President John F Kennedy suffered.

My first day was a revelation. I entered the ward and was immediately approached by a nurse, who politely asked who I was. She then excused the absence of my sister, who was accompanying Sir Charles Symonds, the



neurologist; staff-nurse was with the dermatologist. She assured me she would accompany me and report my instructions to sister. Such attention was new to me and I took it to be indicative of the pride in this prestigious hospital taken by members of the staff. I was later told that recently the gynaecologist had been ignored when he arrived. He took a vaginal examination tray to visit a new patient. When he was about to leave her the patient, who had never seen him before, asked, 'By the way, who are you?' He replied, 'The electrician, madam.' The ensuing furore resulted in an edict that no one should be allowed to enter a ward without first being identified and then accompanied. The story may have been made up but it fitted the behaviour I encountered.

While I was there, Peggy developed a small lump which worried us, since she was newly pregnant. I was recommended to take her to the Professor of Surgery, Sir Hedley Atkins. He was an impressive, almost regal, large, handsome, immaculately tailored personality, who had prompted a member of the audience at an American lecture he had just delivered to exclaim, 'Gee that guy's smooth. He must piss lavender water!' During the couple of days of anxiety, thankfully resolved, I was asked to clerk the ENT patients listed for operation. I did so, but forgot to inform the operating room staff. The next morning I met the surgeon and entered the operating suite to discover it was empty. I apologized to the already boot-faced surgeon and hurried to arrange the theatre staff. During the ensuing operation the charming theatre superintendent popped in her head to share the blame, expressing her remorse for not anticipating the surgeon's routine list. He swept it aside, excoriating me by stating 'Sister, Kirk here,' contemptuous at me, 'He's not a Guy's man.' That put it all in context.

Hedley was not, though the most impressive personality I met at Guy's. We admitted an elderly man, a nightwatchman, who suffered epileptic fits. He had a fit while sitting near a brazier and fell into. He suffered horrifying burns of his face, scalp and eyelids. In spite of attempts to cover the exposed corneas, one eye developed intra-ocular infection requiring evisceration of the contents of the globe

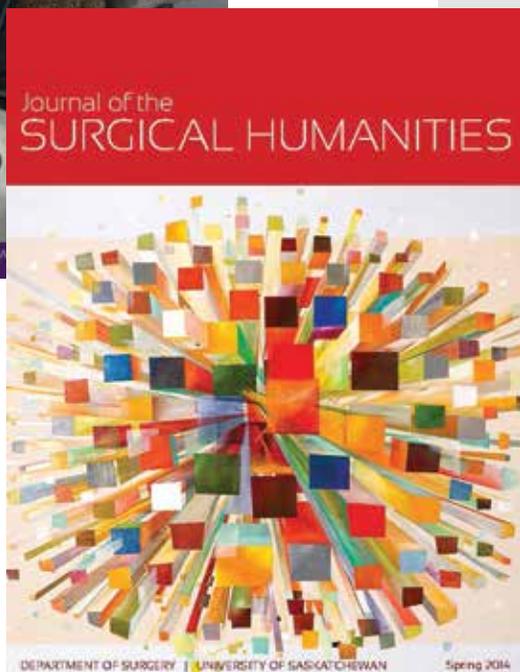
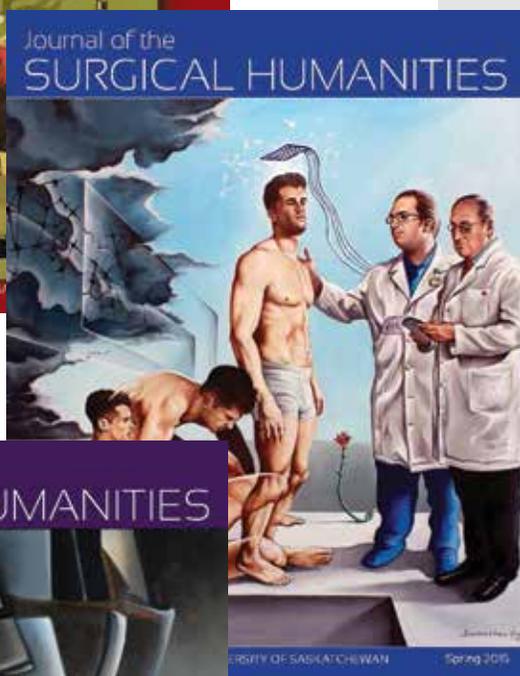
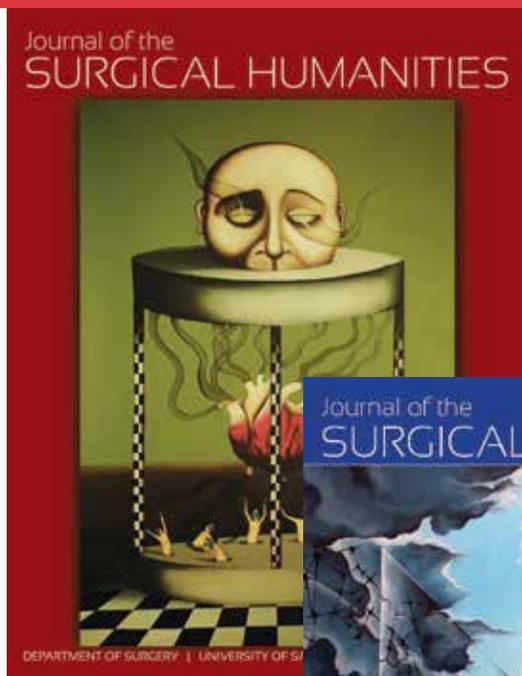
and a similar fate was threatening the other eye. My chief told me that he had telephoned Sir Benjamin Rycroft. I later discovered that he had worked with Sir Archibald McIndoe at East Grinstead and treated many servicemen during the Second World War with corneal injuries, setting up a corneal transplant unit there. My chief had a prior commitment and ordered me to greet him. I stood in the draughty entrance to Guy's hospital until a resplendent Rolls Royce limousine drew in. The chauffeur leaped out, opened the passenger door, automatically lighting the rear compartment, revealing an immaculately dressed silver headed man, aside a stunning blonde-headed lady in silver fox coat(?). The chauffeur whipped off the tartan sheet covering their knees as the man leaned over, kissed the lady and emerged, handing me a leather instrument case. I led him to the ward and such was his presence that everyone froze. He gestured. The nurses whipped off his dressing and without greeting the patient he stood at the foot, carefully looking at the situation. He quietly asked for a sheet of paper, drew out and uncovered a gold pen (surely engraved with 'In gratitude for saving my sight'). He wrote in effect, 'Eviscerated lidless left eye. Potential sympathetic loss of right lidless eye without conjunctival coverage. Only available source is on the sclera of left eye.' He closed and replaced his pen, nodded and walked away with me chasing him. As we approached the car, the chauffeur leaped out, opened the door, interior light on, Rycroft nodded to me, took the case, sat, kissed the lady, tartan replaced, door closed, exit Sir Benjamin. None of us remarked on Rycroft's total neglect of the patient as a person. Today there would be an outcry, media condemnation. Such is the transformation brought about by the revolution generated by the emergence of human rights recognition. Critics might point out that the only people who attract such reverence are the new elite, who are feted in 'Hello' magazine.

To be continued ...



Statue of John Keats at Guy's Hospital, London, UK

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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