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COVER PAGE

Photograph of Mildred Coddington (1902-1991), brilliant, pioneer surgical illustrator in full surgical clothing. For a fascinating account of the life, times and work of Mildred Coddington turn to the biographical essay by Christy Di Frances, Director of Narrative Writing at the Boston University School of Medicine (pp 6-14).

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Mildred Coddington

■ A LIFE WITHOUT ART

Henry Woolf

The word “Art” makes many people feel uncomfortable. When the word comes up, they feel a cultural carpet has been laid before them in order to trip them up.

The very group that one would expect to hold coherent opinions on “Art,” the artists themselves have no need to talk about it because their lives are already crammed with Art - it is the very air they breathe whether they are musicians, singers, poets, playwrights or painters, whatever they are. But let us not be dazzled by the mention of so many fields of artistic expression. The sad truth is that however much we pay lip service to its splendours, Art is held in very low esteem in our society.

“Sport” for example, is immeasurably more highly regarded. Thank goodness a certain amount of deference to “culture” is expected of anyone earning a decent income!

Heaven forbid that one should be labelled “non-cultural,” “uncultured,” because one was never seen at the ballet or swooning with delight at some heartfelt aria at the opera.

The funding bodies that keep “Art” going are well aware of all this and keep highly expensive “Art” like Opera and Ballet funded not only to maintain societal prestige for the financially deserving, but as a proof of our national and provincial sophistication! Incidentally, the affluent audience of today likes its “Art” to be not too disturbing. Which is why “safely dead” Art in symphonic ballet and operatic repertoires gets more funding than Art of any other sort. A few crumbs of funding are then left over for avant-garde, experimental Art - just enough to keep its half dead corpse still twitching but never enough to raise the daunting prospect that one day, really “living Art” might dominate the Art world.

How did all this come about? Modern man has become “top animal” on our globe not by caring a jot or a tittle about “Art,” but by simply learning how to count, how to do natural experiments and how to think abstractly about physical phenomena. From these humble beginnings, modern science and technology took the world by storm and shook it into its modern configurations. Some extremely clever chaps (the Freudians) estimated that only about 10% of our thoughts and feelings - our “psyche” if you like - are open to examination by our conscious, rational mind. That in fact is all that is apparently necessary to maintain modern man’s mastery of the known world. But what about the unknown world? That undiscovered country constituting the remaining 90% of our psyche - and which apparently only surfaces in dreams, in Art and in (what society regards) “unbalanced” behaviour?



Henry Woolf and his friend Harold Pinter

Photograph: Eamonn McCabe for the Guardian

Source: <https://www.theguardian.com/culture/2017/oct/15/harold-pinter-best-friend-reveals-painful-secrets#img-3>

What about it? Who really cares about the untidy froth of an uncharitable sea? How many bucks is it worth? It never seems to occur to more than a handful of people that cut off from our intuitive or unconscious selves ("useless baggage" some would say), most of us are leading deprived lives.

Becoming the wealthiest, healthiest animal that has ever lived is an empty triumph without the addition of Artistic expression to describe our lives in ways that illuminate what is happening to us. I do believe that a life without Art is like living in a house without windows - no light can come in nor can any of our hopes, joys, fears and questions about life itself ever reveal themselves.

Henry Woolf and his wife Susan live in Saskatoon, Canada. Henry was born in England and was a close friend and confidant of the playwright and winner of the Nobel prize in literature, Harold Pinter. Pinter's first play "The Room" was written at the behest of Henry Woolf who asked Mr. Pinter to go ahead and write out his idea for a play, so that he could put it on stage - Pinter wrote the play in three days and Henry staged it at the University of Bristol in 1957.

He is an accomplished stage and film actor himself and has acted in productions in the West End, London; in Broadway, New York and in numerous other venues around the world. Henry has been writing poetry from "within three weeks of becoming an actor" and examples of his searching, epigrammatic poetic style were featured in this Journal in a previous issue. Further examples will appear in a forthcoming issue.

From 1983 to 1997 he was Professor of Drama at the University of Saskatchewan and was a founding member of "Shakespeare on The Saskatchewan." Henry Woolf's memoir "Barcelona is in Trouble" was released in 2017.

Reference: Henry Woolf: "My 60 Years in Harold's Gang:" *The Guardian*: Thursday, 12 July, 2007.
<https://www.theguardian.com/stage/2007/jul/12/theatre.haroldpinter> (retrieved 29 Dec 2018).

■ Mildred Coddington's HUMANIZATION OF SURGICAL ART

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From ancient medical art created on papyrus to the varied iterations of Medieval Wound Man, Andreas Vesalius' *Renaissance De Humani Corporis Fabrica*, and today's digitized imaging, paratextual illustrations have long provided a natural—yet to some extent overlooked—modality for infusing the humanities into medical pedagogy.¹⁻³ Patel et al. define such art as “a study of medicine and surgery through the form of pictures, instead of words. Illustrations play a significant role in medical and surgical education. Medical illustrators use the universal language of visual imagery to facilitate the understanding of anatomy and operative approaches, especially in neurosurgery, allowing the communication of surgical ideas, techniques, and original research.”⁴ Even in an era defined by Artificial Intelligence and advanced imaging technologies, the data visualization facilitated by illustration is still fundamental to health sciences curricula.^{1,4} Close readings of paratextual surgical art provide a unique opportunity for contemplating the historical integration of the humanities into medical education.

This essay maintains that the work of Harvard Medical School (HMS) illustrator Mildred Coddington (1902-1991) can be viewed as an

example of twentieth-century illustration that endeavors to humanize surgical art by moving beyond merely technical portrayals of patients' biological frameworks. Traversing the boundaries of anatomical renditions, Coddington's illustrations comprise a thoughtful, and at times deeply moving, consideration of humanities within surgery. Indeed, based upon Coddington's training under renowned medical illustrator Max Brödel, some of her technical work can, and should, be considered through an aesthetic lens. To demonstrate the point, Coddington's original sketches for Matson and Shillito's *An Atlas of Pediatric Neurosurgical Operations*,⁵ published in 1982 but over twelve years in the making, will be considered from a primarily aesthetic rather than technical perspective to demonstrate that her training under Brödel, and subsequent development as a conscientious artist-educator, unite to infuse a humanistic motif into her work. Close examination of her sketches for the *Atlas* reveals a fascinating “humanizing aesthetic” encoded into the paratextual materials designed for the publication.

So, who was Mildred Coddington? Since her name and legacy have to a large extent vanished from the public eye, it will be useful to provide some background. Coddington worked as an illustrator in



Figure 1: Among her greatest achievements are the 1939 *Atlas of Surgical Operations*, written by Drs. Eliot Cutler and Robert Zollinger, which was used as a field guide for American military medical personnel during World War II, and the *Atlas of Pelvic Operations*, by Drs. Langdon Parsons and Howard Ulfelder of Massachusetts General Hospital (MGH), which was recognized for outstanding illustrations by the American Institute of Graphic Arts, appearing in the Institute's listing of the fifty best books of 1953.

the Department of Surgery at Harvard Medical School and at the Peter Bent Brigham Hospital (PBBH), which was later amalgamated with several other hospitals to form the present-day Brigham and Women's Hospital (BWH), a teaching affiliate of HMS. Coddington had earned a Master's Degree in Zoology and Genetics at Columbia University in 1926 before embarking upon a two-year course in medical art at Johns Hopkins University, studying under Max Brödel. She initially came to Boston by invitation in 1929, following her first year of art school, to work with Dr. Harvey Cushing, known as the father of modern neurosurgery, who was Moseley Professor of Surgery at HMS, Chairman of Surgery at the PBBH, and author of the Pulitzer Prize winning biography, *Life of Sir William Osler* (1925).⁶ Coddington returned to HMS

to work with Cushing on a full-time basis in 1930.⁷

In an era of rapidly progressing medical technology, when relatively few women were professionally active in medicine outside the field of nursing, Coddington exhibited an impressive combination of biomedical expertise and aesthetic sensibility to establish herself as an integral member of the medical community at HMS and its affiliated teaching hospitals. This fact is particularly impressive when grounded in the historical reality that HMS did not admit its first class of women until 1945—sixteen years after Coddington had begun working there. Indeed, a search through the PBBH surgical staff annual photographs in the BHW Archives at HMS's Francis A. Countway Library of Medicine reveals that although photos dating as far back as 1915 (Cushing is portrayed in that year) are present, women

do not begin to populate the scenes until 1953.¹ Staff photos depict Mildred Coddington in 1957, 1958, 1959, 1961, 1962 (in which she is unnamed but nevertheless recognizable), and 1966.⁸

Certainly, Coddington's professional achievements as a woman in early twentieth-century academic medicine are noteworthy, since over the course of a long and distinguished career in the field of medical illustration, she created paratextual material for many physician-authors with appointments at HMS. Her drawings featured in a variety of textbooks and academic journal articles, as well as in medical exhibits.⁸

¹ This is not meant to represent an exhaustive account of the BWH Archives; it is of course possible that official photos depicting women in the PBBH Department of Surgery exist elsewhere in the Archives.

Her willingness to don surgical clothing and enter predominantly male operating theaters resulted in innovative drawings that won regard from reviewers within academic medicine (Figure 1). Among her greatest achievements are the 1939 *Atlas of Surgical Operations*, written by Drs. Eliot Cutler and Robert Zollinger, which was used as a field guide for American military medical personnel during World War II, and the *Atlas of Pelvic Operations*, by Drs. Langdon Parsons and Howard Ulfelder of Massachusetts General Hospital (MGH), which was recognized for outstanding illustrations by the American Institute of Graphic Arts, appearing in the Institute's listing of the fifty best books of 1953.^{7,9}

Unfortunately, despite Coddling's significant achievements within the field of surgical illustration, her work has for the most part eluded critical attention. Indeed, a 2012 article published in the *Journal of Clinical Neuroscience* regarding medical artists who illustrated for Henry Cushing and his contemporaries fails to even mention Coddling.¹⁰ However, her contributions to the field of surgical humanities are significant, especially given the wide-reaching circulation of her work in textbooks and journal articles written by premier surgeon-educators of the twentieth century.

To some extent, Coddling's professional journey begins with the story of another

medical illustrator: Max Brödel (1870-1941), a German-born artist who came to the United States in 1894 to work at The Johns Hopkins University School of Medicine. "Brödel's skill was well received at The Johns Hopkins and, with the help of an endowment, he founded the 'Department of Art as Applied to Medicine' at The Johns Hopkins in 1911, the first department dedicated to the training of medical artists."¹⁰ Brödel's classical education—first in a rigorous German gymnasium and then at art school in Leipzig—meant that he was extremely well educated. In 1888, while still attending art school, he began working on medical drawings under Professor Carl Ludwig (1816-1895), the Director of the Institute of Physiology at the University of Leipzig. Although Brödel was a talented and proficient artist, his knowledge of anatomy was limited initially, so he undertook a self-directed course of anatomical studies.¹¹ He "felt that to be a good medical illustrator, one must first be an anatomist and one must subsequently learn how to project both a structural and functional image on paper in the form of an all-encompassing drawing."⁴ Brödel thus became a tireless student of human anatomy. Indeed, his perfectionism made him an artist who "set a precedent in his approach to medical illustration."⁴

Such was the environment in which Mildred Coddling received her formal training

in medical illustration, and it is worthwhile noting that she was essentially handpicked by Brödel to work with Cushing.⁷ The two men had met and formed a friendship at Johns Hopkins while Cushing was undertaking his residency under famed surgeon William Stewart Halsted.¹² Coddling's drawing style, initially based entirely on Brödel's training and techniques, evolved with time and new influences. Perhaps unsurprisingly, her independence of artistic vision could lend itself to ideological friction with Cushing, who had himself studied under Brödel.^{7,11} Cushing could be an exacting and difficult colleague for whom to render illustrations: Coddling recounted how he "felt the illustrator's role was to elaborate and clarify surgical illustrations for publication. He preferred this method versus relying solely upon the artist's view."⁷

Perhaps quite naturally given his primary field of study and training, Cushing seems to have maintained some bias towards the supremacy of technical exactitude over a philosophical aesthetic in surgical illustration. Coddling was keenly aware of both Cushing's surgical and artistic skill; nevertheless, even while working under him she maintained a unique method and style. In interviews, Coddling revealed her preference for "the 'half-tone' technique in which a brush was required to build the base from which an eraser removed

'highlights.' A sharp scratching tool could be used to show glistening droplets," resulting in a realistic style that differed significantly from Cushing's more coarsely shaded sketches.⁷ The aesthetic differences between Cushing and his illustrator indicate that Codding was developing a definitive aesthetic in her work.

On multiple levels—theoretical and thematic as well as practical—Codding's illustrations demonstrate the importance of interdisciplinary collaboration in training world-class surgeons. Her work played a critical role in elevating the status of aesthetics and paving the way for the contribution of the arts and humanities to be viewed as a meaningful element of surgical education with the potential of philosophical and technical significance. Indeed, the scope and importance of her art is exemplified by comments made in the PBBH annual report of 1962-1963: "Miss Mildred Codding was presented with a gift from the Surgical Service and the Surgical Alumni, in gratitude to her for excellent work, now known internationally, in surgical illustration. [...] Miss Codding's ability in rendition of the operative techniques

and findings, striking a perfect balance between photographic reality and representational simplification, is unique."¹³ Codding was also a proficient operative photographer but preferred drawing as a medium for her art.^{7,9} Codding's physical boundary-crossing from her studio in HMS, an embodiment of the traditional artist's generative space, to the operating theaters of the surrounding hospitals is

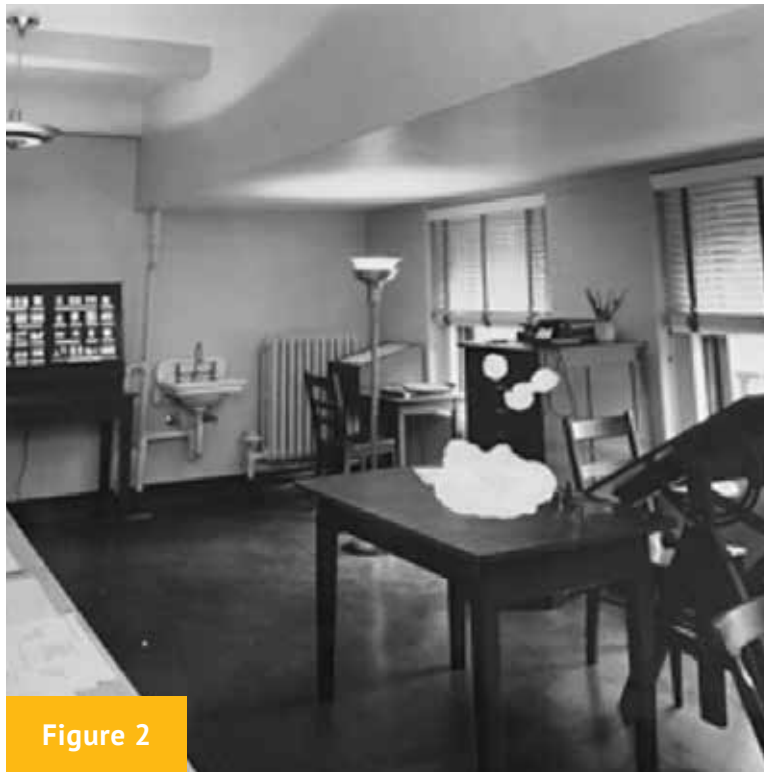


Figure 2

indicative of the ways in which her art seeks can be viewed as infusing a humanizing aesthetic into the surgical curricula of her era (Figure 2).

Codding's final medical illustration project, the landmark *Atlas*, provides a fascinating case study for exploring her integration of science, aesthetics, and humanism into paratextual

material in a textbook "created especially for the neurosurgeon in training."⁵ Following her formal retirement, she "agreed to work with Dr. Donald Matson, neurosurgery, to produce with him an atlas of neurosurgical operations. After his untimely death in 1969, Miss Codding continued to work with Dr. John Shillito, Dr. Matson's associate" to produce the *Atlas*.¹⁴ It is plausible to assume that the project must have exerted

a significant intellectual draw for her, as it represented a time-consuming and exhaustive undertaking for someone on the brink of retirement.

In an interview, Codding explained her artistic process in regards to the formulation of artwork for the *Atlas*, doubtless perfected over her many years of successful illustrating: "First, she would observe the operation, making very rapid and rough

sketches on page after page of her pad. This usually required around 12 pages of step-by-step sketches. Next, she would review all of these drawings with the surgeon and chose just the necessary steps. After finishing the important pencil sketches on tissue paper, they were transferred twice to the final page by rubbing the back of the original. The final shading and toning to produce

the published plate was done using her brush technique.”⁷

Codding’s experience in the operating theater, and keen attention to detail, resulted in an impressive publication. Indeed, in his review of the volume, renowned neurosurgeon Dr. Paul C. Bucy elaborates on the magnitude of the work, calling it: “a book that every prospective and novice neurological surgeon should read from cover to cover while studying each of the many, many illustrations (232 plates) carefully. [...] The numerous illustrations are largely the work of Mildred Codding, who was an associate of both Harvey Cushing and Donald Matson. Mr. Lashbrook filled out those illustrations that Miss Codding was unable to complete. The illustrations are line and wash drawings that provide pictographic augmentation of the text in every detail.”¹⁵

While the finished illustrations in *Atlas* are certainly impressive, this essay focuses on Codding’s preliminary sketches for the book, which are held in the library archives of the Boston Children’s Hospital. The rationale for focusing on her unpublished sketches is two-fold: first, some of the finalized illustrations in the published work received a degree of input from Grant Lashbrook and are thus not purely attributable to Codding, and, second, examining the sketches provides the benefit of investigating a thematic subtext to the art which

generally appears more raw—and less altered by current conventions—in earlier versions of the work. In comparing the sketches with the published illustrations, it seems that the former present a purer representation of Codding’s aesthetic vision.

Although Codding’s reputation as a surgical artist rests primarily on the technical skill of her finalized “products,” it can be argued that the sense of humanity portrayed in *Atlas* is simultaneously striking and unexplored. In the following sections, several sketches created by Codding for this publication will be considered through a primarily aesthetic lens to consider the humanizing inferences which may be located within her paratextual work.

The first image to be considered is Codding’s profile-view sketch of an infant prepared for surgery regarding a dermoid cyst (Figure 3). The published version of this sketch is less detailed.⁵ What strikes the viewer immediately in this piece is the sheer sensitivity of the artistic rendering—in particular, the profile view and softened facial details. Far from being a work of mere technical exactitude, this piece is reminiscent of the emotional complexity of fine art: what the sketch lacks in lifelike detail is more than compensated in

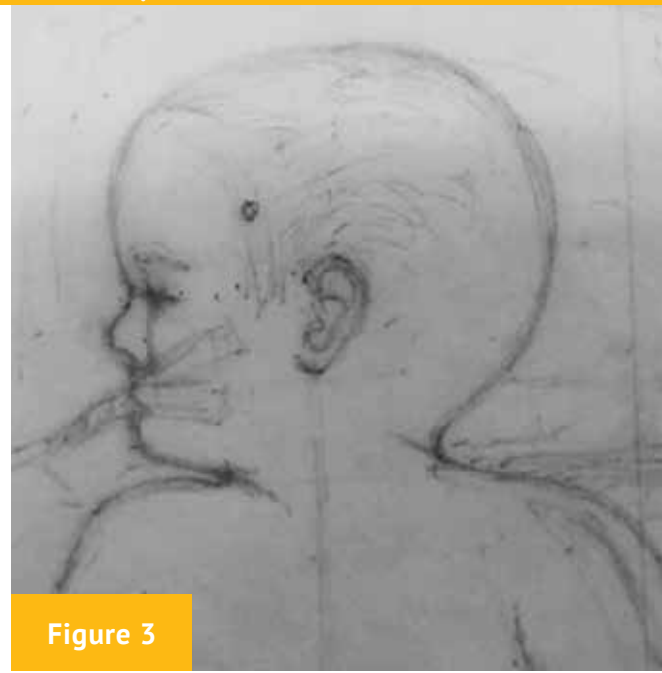


Figure 3

a tour de force in emotional realism.

From a thematic as well as aesthetic perspective, Codding’s sketch recalls early Renaissance art, such as Giotto di Bondone’s iconic fresco cycle in Padua’s *Capella degli Scrovegni* (1304-1306), wherein the artist interpolates joyful scenes of new life into a sequence of somber reminders of human mortality, with the latter reaching an emotional and aesthetic climax in *Lamentation*, where a bereaved Madonna weeps over her dead (adult) son while child-like cherubim mourn his impending entombment. In considering these pieces, viewers are guided towards reflecting upon that strange juxtaposition which T. S. Eliot so thoughtfully articulates in his poetry:

[...] There was a Birth,
certainly,
We had evidence and no
doubt. I had seen birth and
death,
But had thought they were

different; this Birth was Hard and bitter agony for us, like Death, our death.¹⁶

Birth and death—no matter how oppositional the two states may seem on a superficial level, in reality they occupy a space of inevitable duality. Just as Giotto's sequence of frescoes captures the anomalous juxtaposition of a new life and imminent peril, so Coddington's sketch captivates viewers with its mixture of wonder and ambiguity: the ventilator is our constant reminder that this child's life hangs by a thread, contingent on a delicate combination of surgical skill and biomedical innovation. Her sketch invites surgeons-in-training to consider the gravity of their interactions with the infant, not merely as a patient but, far more importantly, as a fellow mortal. In so doing, these drawings awaken an empathic sensibility as viewers are encouraged to create



Figure 4

emotional alignment with the patient.

Another of Coddington's sketches, this one for surgical procedures concerning depressed fractures in newborns, presents a sleeping infant who has been swaddled tightly, held fast by two straps that may be read as symbolizing the bonds of earthly affliction. Once again, simplification of the aesthetic is evident in the published version.⁵ Here, the presence of a mechanical device—perhaps a temperature gauge or blood pressure monitor—disturbs the moment's tranquility, solidifying imagery of “the unnatural” in our minds. The perspective in Coddington's artistic rendering draws the viewer's gaze downwards towards the infant, who seems curiously inaccessible, an invitation to remember the limitations of (even modern) medicine. The tightly-wound wrapping of the child is reminiscent of both an infant's “swaddling clothes” and grave cloths, both of which foreshadow the common resurrection motif of Medieval and Renaissance art, though Coddington's child appears tethered to earth by some physical malady which necessitates the corporeal bonds (Figure 4). Yet the latent symbolism here reminds us that a temporary “resurrection” is possible in the hands of a skilled surgeon.

The gaze of the youthful subject in one of Coddington's instructional sketches for cranioplasty is uncannily direct, even jarring, inviting viewers to recognize the personhood of this individual

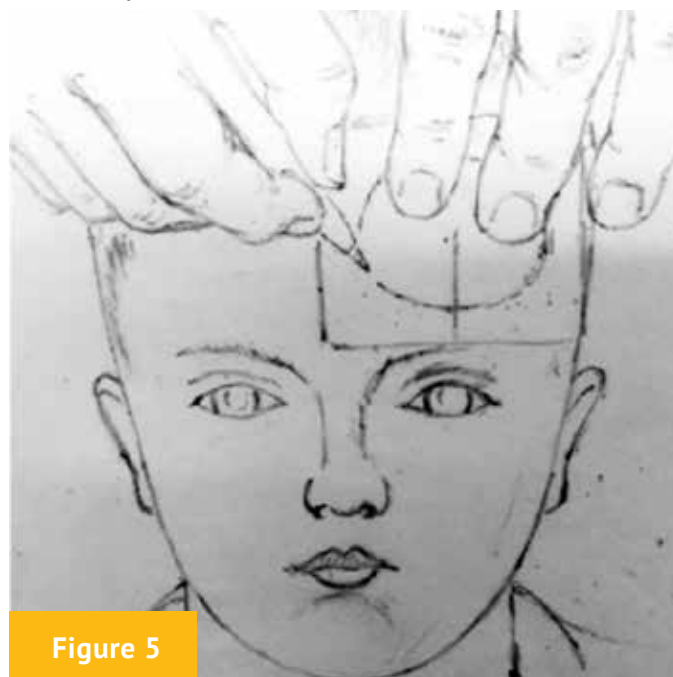


Figure 5

(Figure 5). Once again, Coddington's rendition invites a realization that the unique humanity of the child cannot be avoided or lost in his or her temporary identity as a patient. This child's personhood confronts the viewer unapologetically, presenting no mere “stock image,” as we might otherwise be tempted to imagine from the superimposed surgical diagram, a technical interpolation for educational purposes. Quite noticeably, Coddington has chosen to depict the child with open eyes, although she omits details of the irises and pupils.ⁱⁱ The implications of this rendering might be read as pedagogical as well as thematic, yet another

ii Details of the child's eyes have been completed in the published version. (5. Shillito J, Matson DD, Coddington MB, Lashbrook GS. An Atlas of Pediatric Neurosurgical Operations. Philadelphia, PA: W.B. Saunders Co.; 1982.)

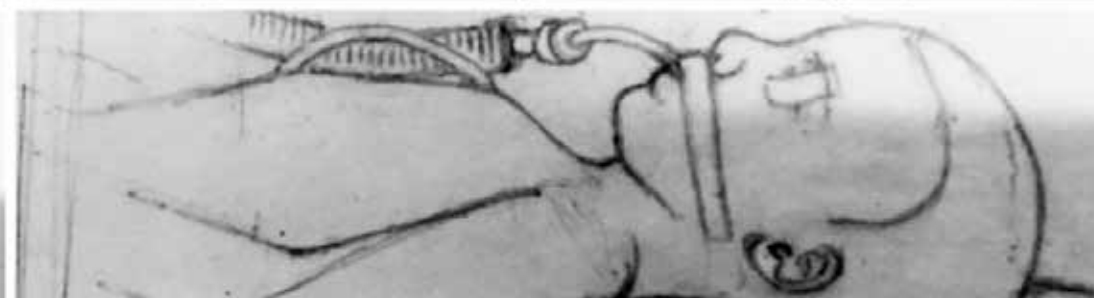
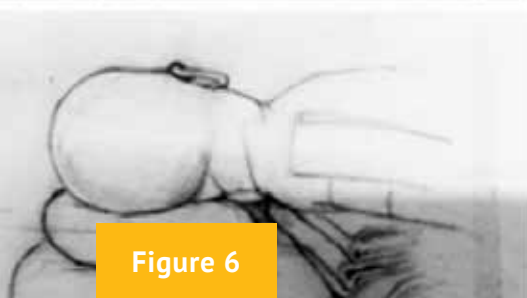
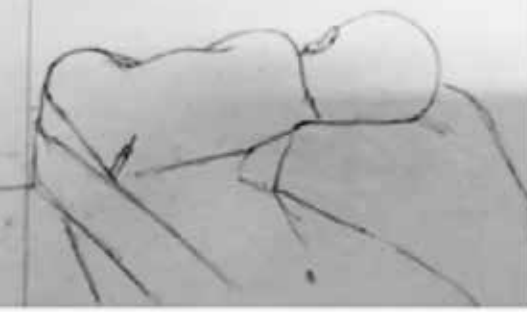


Figure 6

admonition for surgeons to view prospective patients as individuals rather than “cases.”

Codding’s sketches of unconscious and sleeping children prepared for various craniotomy procedures vacillate in nature from seemingly peaceful to obviously alarming (Figure 6).ⁱⁱⁱ Despite being unconscious, the young patients often project an appearance of being tired and worn down. In some sketches, the child’s attitude is one of wholly unnatural slumber: human-made tubes enter and exit the small body at its most fragile touchpoints. In one sketch, a line is attached to the back of the head, where a ventricular shunt appears, presumably to relieve pressure on the brain.

Another of Codding’s sketches depicts a child with his back turned towards the viewer, seemingly asleep, his body curled restfully into a semi-

fetal position. At first glance he strikes the viewer as a typical infant—only closer observation reveals the line protruding from his back, perhaps a lumbar puncture for the purpose of retrieving a sample of cerebrospinal fluid, an alarming detail that gestures towards the reality of suffering in the otherwise placid world of childhood dreams. Ventilators often take center stage in these compositions, presenting immediate focal points—both aesthetically and thematically. The resulting sense is one of abject vulnerability, stark visual reminder that surgeon and child occupy a shared space of fragility—in which compassion, as much as professional acumen, is a critical component of the healing process.

A similar motif can be read in Codding’s sketch depicting an infant immediately prior to preparation for a ventricular drainage procedure—the newborn held, literally and figuratively, in the surgeon’s hands (Figure 7). Her

depiction of a pacifier in the baby’s mouth reinforces the humanizing associations, again foregrounding the patient’s identity. We can easily envision the entire surgical team that will soon surround the child, once the administration of anesthesia has achieved its work in rendering death-like sleep.

Significantly, the tropic maternal figure is absent in Codding’s operating theater, replaced by a surgeon who functions as a proxy to protect and preserve the child’s life. This binary is less blurred in the published version of the illustration, where gloves are more obvious on the hands, thus providing a clearer distinguishing marker of the holder’s primary role as surgeon.⁵ The notion of such temporary code-switching between the roles of objective surgeon and maternal/paternal proxy is certainly contentious (even downright uncomfortable) by the standards of modern medicine—yet it succeeds

ⁱⁱⁱ For several examples of published versions, see Schillito and Matson 148; Plate 69; 268, Plate 126; 288, Plate 135; 324, Plate 151; 332, Plate 155; 362, Plate 169.

in awakening empathy, not to mention interrogating the nuanced philosophical ramifications of the Hippocratic Oath.

The surgeon's task, when properly conceived of, is surely a daunting one. Yet, when read within a historical-aesthetic context, Coddington's imagery imbues a sense of hope in the midst of dire circumstances. Despite the inherent uncertainty of surgical procedures, her sleeping child evokes an aura of peacefulness and hope. The unconscious patient presented in this and other Coddington sketches is indelibly marked by universal blights of being human. As W. H. Auden wrote:^{iv}

Time and fevers burn away
Individual beauty from
Thoughtful children, and the
grave
Proves the child ephemeral:
But in my arms till break of
day
Let the living creature lie,
Mortal, guilty, but to me
The entirely beautiful.¹⁷

The dual threat of "time" and "fevers" are aspects of our shared "ephemeral" existence, a constant reminder that the "grave" is always within our "mortal" view. Yet amidst such difficulties, the child emerges "entirely beautiful"—worthy of every lifesaving effort by the surgical team.

Coddington's surgical sketches can certainly be contextualized as generative boundary crossings on multiple levels: they are the unique contributions of a woman in a male-dominated field, of an artist-scientist operating within an overwhelmingly quantitative environment, and of a professional championing drawing in an age when photography and film held powerful sway. Her work spans decades and transgresses social, as well as academic, norms of the era. It melds scientific clarity with humanistic qualities—all the while offering a fascinating subtext of a philosophical inquiry that is so eloquently conveyed through the vehicle of art.

Far from simply speaking to the need for technical education,

Coddington's illustrations impress upon a rising generation of surgeons the fragile humanity of their patients. The bodies on which they operate possess spirit and personality: they are intricately unique, profoundly human. Coddington's surgical illustrations present trainees with a different—and profoundly humanized—viewpoint. Perhaps after considering her work, they might approach their own from a new perspective, echoing Eliot's enlightened narrator:

[...] I had seen birth and death,
But had thought they were
different; this Birth was
Hard and bitter agony for us,
like Death, our death.
We returned to our places,
these Kingdoms,
But no longer at ease here, in
the old dispensation.¹⁶

Certainly such philosophical realizations—uncomfortable though they may be—are as necessary as technological innovation for achieving real improvement in patient care, which, after all, is the *summum bonum* of all medicine.

iv This excerpt from Auden's 'Lullaby' (1937) presents a literal approach to these specific lines in relation to the poem's title and is not intended to provide commentary on the broader thematic implications of the poem.



Figure 7

Figures

Figures 1-2: Brigham and Women's Hospital Archives, Peter Bent Brigham Hospital Records:1830–(inclusive), 1911–1980 (bulk). Box 26. Folder 19, Mildred Coddington, circa 1930s, 1950s. (Photographer: Russell B. Harding, 32 Princess Rd. West Newton, MA.)
Figures 3-7: Coddington, Mildred. Sketches. Boston Children's Hospital Archives. Department of Neurosurgery Records: 1929-1999. AC 13. Archival Collection. Box 28.

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■ TIMELESS SEABEE

Garry Linassi

Editor's note:

As doctors, time management is one of our greatest challenges. In this true account of Angelo, a medical student who in a previous career worked as a geologist, that lesson would come early in his career...

When Robert Service wrote “There are strange things done in the midnight sun by the men who moil for gold” in his timeless work *The Cremation of Sam McGee*, little did he know that almost 90 years later, his words would continue to ring true in a little gold mine in Northern Saskatchewan.

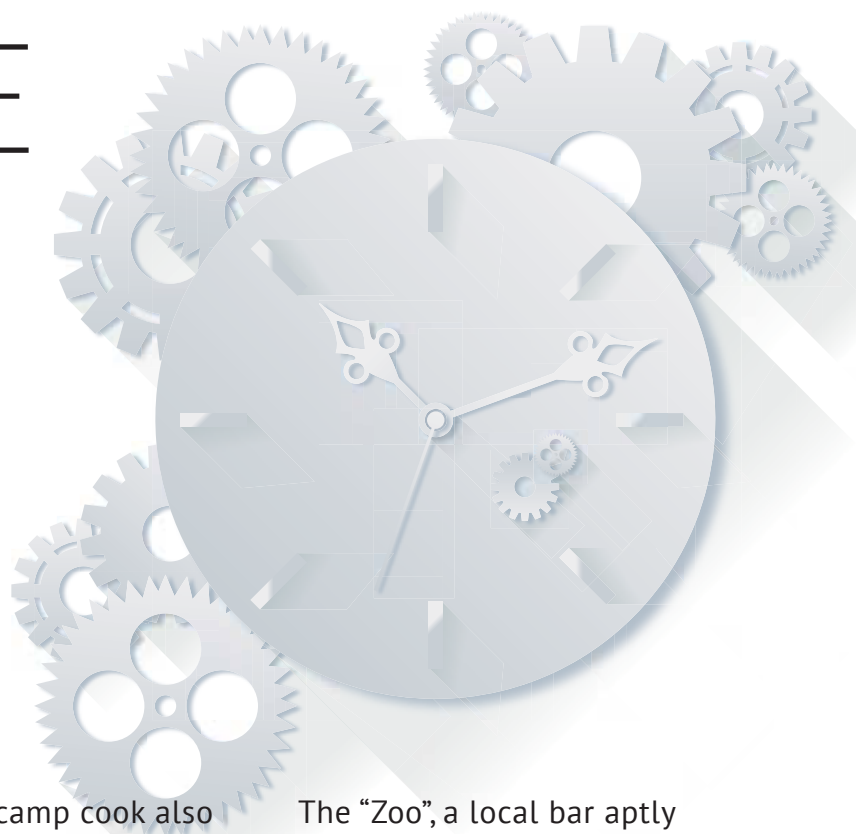
Angelo had taken the year off medical school to work at the Seabee gold mine as an underground truck driver. He was nicknamed “doc” by his crew who often consulted him for a variety of ailments ranging from the regular assortment of cuts and bruises, to identifying spots that moved during the night, to questions about

whether the camp cook also had spots that moved during the night. Angelo was hired by the mining contractor whose crews consisted of very tough, hardened miners, blasters, truck drivers and timbermen. Club soda was not in their vocabulary and previous incarceration was a rite of passage recounted often while successively trying to outdo each other. Angelo didn’t fit in, but it paid well.

They rotated in and out of the mine every six weeks with a two-week break between. At the beginning of every six week rotation, they would meet at the float plane base in La Ronge, Saskatchewan to fly in to the isolated Seabee gold mine.

The “Zoo”, a local bar aptly named for reasons that aren’t usually discussed publicly, was their gathering place of choice. While officially “dry”, the Seabee camp was in reality a bit damp, though apparently not damp enough for his crew to miss “last call” at the famous northern watering-hole.

While waiting at the Zoo for the call to board the *Twin Otter*, Angelo realized to his horror that he had left his watch in Saskatoon. Back then, no one owned a cell phone, and working 400 meters below the surface in the pitch black darkness of a mine required accurate time keeping; there was the need to not be on the ramp at blast times and



more importantly the desire to avoid the ever present scorn of the shift boss who being from Newfoundland, expected everything to be done a half-hour earlier than was possible. He rushed through the morning mist rolling off Lac La Ronge to Robertson's Trading to buy a replacement watch. Robertson's Trading was a meeting place of sorts, where trappers from all across Northern Saskatchewan gathered to sell their furs, replenish their supplies and get updates on market trends. He was relieved to find a small cabinet buried deeply beneath piles of muskrat, beaver and rabbit pelts that contained an assortment of watches. On a budget, he bought the cheapest watch he could find. Needless to say, by the time he got back to the Zoo, his new six dollar purchase had already stopped working.

Angelo hurried back to the heady smells of smoked moccasins and industrial strength mosquito repellent to buy another watch. Clutching his prize tightly in hand, he returned to the Zoo and raised a few eyebrows by celebrating with a club soda. As he sipped his "sissy" drink, he noticed again in horror that the second hand on his new watch had already stopped working.

Angelo felt cursed and ran back to Robinsons in a frantic daze while the crew lumbered towards the dock as the call to board the otter had come in. The startled store clerk sold him the most expensive watch

he had in stock. It was a twenty two dollar Timex complete with a genuine leather strap and a calendar feature. As the float plane lifted off the water, the keening of the propellers lulled everyone into a deep restful sleep - everyone except Angelo, who stayed awake the entire flight, willing his watch to cooperate.

The rule was that everyone worked the first shift when they got back to the mine. The first shift was uneventful, and his trusty new Timex kept perfect time. He started to settle into a routine, if not monotonous 6 week contract, which in itself was comforting given the long days ahead in a challenging, sometimes dangerous and often unpredictable work environment.

He awoke the following day to discover to his dismay that like the other watches, the Timex had stopped working too. Incandescent, he acrimoniously proclaimed that \$22 dollars just didn't buy what it used to. Fearing an encounter with live explosives on the ramp and more terrifying, one with his highly explosive shift boss, he leapt out of bed to find the camp electrician.

Dave was a personable fellow, known around the mine as "Sparky". Angelo swallowed his pride and found Dave at his workbench in the powerhouse. After quickly explaining that this was the third watch that had stopped working, Dave agreed to try to

fix it. He instructed Angelo to leave it with him and to come back before heading to the mine. About an hour later and to his delight, Dave handed over a fully functioning watch set to the proper time (and date). When he asked what the problem was, Dave mumbled something about the battery. Not wanting to take up anymore of his time, he profusely thanked him and left to start his shift.

He woke up the next day feeling anxious; it was the kind of anxiety that can only be felt when situations get completely out of control, the kind of anxiety experienced by someone who depends on something that was completely unreliable. He was convinced this had to be how the pilots of the Hindenburg felt. Sure enough, the Timex had stopped working again. It read 11:00am July 16, but according to his clock radio, it was 6:00 am, July 17. Sheepishly, he went back to Dave. He didn't need to say anything as the look on his face said it all. "still having trouble with that watch of yours?" Dave asked.

As before, Dave sent him away while he fixed the Timex. When he returned, Angelo was puzzled to see that Dave had attached an "AA" battery on the watchband with black electrical tape. Two tiny wires were soldered to each pole of the battery and inserted into the back plate of the watch. "That ought to do it," Dave said confidently. His puzzlement

led to concern then to relief. The watch was ugly and would garner a lot of unwanted attention in the camp, but at this stage, he didn't care; he was happy that it was working again. Inevitably, there were a few snickers from other camp employees as they saw the contraption on his wrist.

He continued to have problems with the watch, but Dave was always willing to get it going at the beginning of every shift by replacing the battery, re-adjusting the wires or re-soldering the leads. This went on for several days, and the situation was attracting a lot of unwanted attention. Suddenly, it seemed that everyone at the camp needed to know what time it was.

After a few days of repeated time checks, Angelo, embarrassed from constantly asking Dave to fix his watch, took matters into his own hands and asked the mechanical shop foreman for a replacement "AA" battery. Obviously annoyed,

the foreman extended his hand and demanded to see the Timex. Greatly intimidated, Angelo complied and to his horror watched as the foreman threw it against the shop floor and stomped on it. "Why the heck did you do that for?" he demanded in protest as he bent over to salvage the pieces. "To save what's left of this company's reputation," replied the exasperated foreman. From the corner of the shop, his crew giggled like a bunch of pre-pubescent schoolgirls.

With the remains of the destroyed watch in his hand and in a state of complete disbelief, Angelo noticed something amongst the pieces that had eluded his attention up until then. It was a small dial. A small, corrugated dial designed for grasping and turning. The type of small, corrugated dial used to wind a watch. The type of small, corrugated dial used to wind a watch that didn't require a battery because it only needed to be wound once a day to

keep it going. Suddenly, it all became painfully clear. Dave hadn't been replacing the watch battery at all and the lead wires led nowhere; he'd simply been winding the watch and resetting the time and date every day. With indescribable embarrassment, Angelo also realized that the entire camp knew what Dave had been doing as well.

He decided to keep to himself for the rest of the summer, enjoying the anonymity and solitude that can only be found at the bottom of a mine shaft. He went on to complete medical school and specialty training in Rehabilitation Medicine. Angelo is of course me. Now, when I look at a watch and the challenges that accompany time management in my current profession, I think of myself at the mine, walking around with a battery taped to my wristband and chuckle about that timeless summer spent at Seabee.



Dr. Garry Linassi practices Physiatry in Saskatoon and occasionally yearns for the peace and quiet of the mine. He writes stories for his two young daughters who think he has too much time on his hands. Gary is the provincial head (Saskatchewan), Physical Medicine and Rehabilitation.

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



About

SIR WILLIAM OSLER

time, and Osler was sent for his schooling to Trinity College School, an independent school for boys in Port Hope, Ontario. In the fall of 1868, Osler enrolled in the Toronto School of Medicine, but soon transferred to McGill, because it had better clinical opportunities. He graduated from the McGill University School of Medicine in 1872 and taking advantage of an older brother's generosity, Osler spent the next two years studying in Europe and visiting the great clinics and hospitals of Berlin, Vienna and London.

Upon his return to Canada, he was appointed to the faculty of McGill University and spent the next five years teaching physiology and pathology in the winter term and clinical medicine in the summer. In 1884, Osler was appointed to the staff of the University of Pennsylvania as Professor of clinical medicine and this was the start of a 21 year period of work and achievement in the United States. His appointment to the founding professorship and staff of the new John Hopkins Medical School in Baltimore in 1888 marked the

beginning of a very fruitful association with the "Big Four" - the pathologist William Welch, surgeon William Halstead, gynecologist Howard Kelly (and Osler himself).

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

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

In 1905, Osler was offered the prestigious Regius professorship of Medicine in Oxford, England, and the

Oslers made the last move of their eventful lives, across the Atlantic, once more, to England. Another distinguished period of William's career followed - he was knighted and continued to write and deliver memorable addresses to distinguished audiences and societies.

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

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

Sources:

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Note:

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

Throughout his illustrious career, Osler distinguished himself from most of his peers by the universal, broad and truly international approach he had to medicine and its practice around the world.

Chauvinism, as Osler defines it, is the very opposite of the essential humility and receptiveness that made this universal approach possible – an approach that recognized our common humanity and the close fraternity of physicians, no matter their nationality.

“Chauvinism in Medicine” was addressed to the participants of the 1902 meeting of the Canadian Medical Association in Toronto.

Of course in Osler’s time, when travel and its means were much more limited, it was mostly of Europe and its many different medical traditions that North American physicians possessed any degree of familiarity. This is reflected in Osler address, where he invokes the great contributors to medical science that Western Europe made in the 19th century.

But in spite of having lived in the age of colonialism, where students were taught that all knowledge and all science began with Greece, Osler acknowledges the great advances made by Islamic (“Arabian”) medicine in the middle ages as well as the “Alexandrian and Byzantine” schools. Readers will remember

Observe, record, tabulate, communicate.

Use your five senses. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone you can become expert.

Sir William Osler

that the histories of Chinese and Indian systems of medicine were only systematically documented in the West during the 20th century and especially during its latter half.

In an age that revelled in and celebrated various degrees of anti-Semitism, Osler’s recognition of our common humanity and appreciation for the achievements of other nationalities and races, extended to his Jewish colleagues as well. Surrounded as he was by prejudice and bigotry, he wrote two very appreciative essays – “Letter from Berlin” and “Israel and Medicine” – that celebrated the achievements of the Jewish people and physicians and condemned all forms of anti-Semitism.

It is generally regarded as something of a mystery as to how Osler from rural, small-town, Bondhead, Ontario, the son of missionary parents from England, grew up with such a generous view of other people and the world in defiance of the age in which he lived. If we believe with Wordsworth that the “child is father of the man,” perhaps these were attitudes he learned, together with his siblings, from his parents.

Previous issues of this Journal carried the first two parts of Osler’s address. In this concluding portion, Osler turns the attention of the profession to itself and to each individual physician’s duty to resist the temptations of chauvinism in his or her own life.

F.C.

■ CHAUVINISM IN MEDICINE

Part 3

Sir William Osler

Of the parochial and more personal aspects of Chauvinism I hesitate to speak; all of us, unwittingly as a rule, illustrate its varieties. The conditions of life which round us and bound us, whether in town or country, in college or institution, give to the most liberal a smack of parochialism, just as surely as we catch the tic of tongue of the land in which we live. The dictum put into the mouth of Ulysses, "I am a part of all that I have met," expresses the truth of the influence upon us of the social environment, but it is not the whole truth, since the size of the parish, representing the number of points of contact, is of less moment than the mental fibre of the man.

Who has not known lives of the greatest freshness and nobility hampered at every

turn and bound in chains the most commonplace and sordid, lives which illustrate the liberty and freedom enjoyed by minds innocent and quiet, in spite of stone walls and iron bars. On the other hand, scan the history of progress in the profession, and men the most illiberal and narrow, reeking of the most pernicious type of Chauvinism, have been among the teachers and practitioners in the large cities and great medical centres; so true is it, that the mind is its own place and in itself can make a man independent of his environment.

There are shades and varieties which are by no means offensive. Many excellent features in a man's character may partake of its nature. What, for example, is more proper than the pride which

we feel in our teachers, in the university from which we have graduated, in the hospital at which we have been trained? He is a "poor sort" who is free from such feelings, which only manifest a proper loyalty. But it easily degenerates into a base intolerance which looks with disdain on men of other schools and other ways. The pride, too, may be in inverse proportion to the justness of the claims. There is plenty of room for honest and friendly rivalry between schools and hospitals, only a blind Chauvinism puts a man into a hostile and intolerant attitude of mind at the mention of a name. Alumni and friends should remember that indiscriminate praise of institutions or men is apt to rouse the frame of mind illustrated by the ignorant Athenian who, so weary of hearing Aristides always called

the Just, very gladly took up the oyster shell for his ostracism, and even asked Aristides himself, whom he did not know, to mark it.

A common type of collegiate Chauvinism is manifest in the narrow spirit too often displayed in filling appointments. The professoriate of the profession, the most mobile column of its great army, should be recruited with the most zealous regard to fitness, irrespective of local conditions that are apt to influence the selection. Inbreeding is as hurtful to colleges as to cattle. The interchange of men, particularly of young men, is most stimulating, and the complete emancipation of the chairs which has taken place in most of our universities should extend to the medical schools.

Nothing, perhaps, has done more to place German medicine in the forefront to-day than a peripatetic professoriate, owing allegiance only to the profession at large, regardless of civic, sometimes, indeed, of national limitations and restrictions. We acknowledge the principle in the case of the scientific chairs, and with increasing frequency act upon it, but an attempt to expand it to other chairs may be the signal for the display of rank parochialism.

Another unpleasant manifestation of collegiate Chauvinism is the outcome, perhaps, of the very keen competition which at present exists in scientific circles. Instead of a generous appreciation of the work done in other places, there

is a settled hostility and a narrowness of judgment but little in keeping with the true spirit of science. Worse still is the "lock and key" laboratory in which suspicion and distrust reign, and everyone is jealous and fearful lest the other should know of or find out about his work. Thank God! this base and bastard spirit is not much seen, but it is about, and I would earnestly entreat any young man who unwittingly finds himself in a laboratory pervaded with this atmosphere, to get out ere the contagion sinks into his soul.

Chauvinism in the unit, in the general practitioner, is of much more interest and importance. It is amusing to read and hear of the passing of the family physician. There never was a time in our history

in which he was so much in evidence, in which he was so prosperous, in which his prospects were so good or his power in the community so potent. The public has even begun to get sentimental over him! He still does the work; the consultants and the specialists do the talking and the writing; and take the fees! By the work, I mean that great mass of routine practice which brings the doctor into every household in the land and makes him, not alone the adviser, but the valued friend. He



William Osler, William Francis, H.A. Lafleur, and W.S. Thayer at Johns Hopkins Hospital, 1891

is the standard by which we are measured. What he is, we are; and the estimate of the profession in the eyes of the public is their estimate of him. A well-trained, sensible doctor is one of the most valuable assets of a community, worth to-day, as in Homer's time, many another man. To make him efficient is our highest ambition as teachers, to save him from evil should be our constant care as a guild. I can only refer here to certain aspects in which he is apt to show a narrow Chauvinism hurtful to himself and to us.

In no single relation of life does the general practitioner show a more illiberal spirit than in the treatment of himself. I do not refer so much to careless habits of living, to lack of routine in work, or to failure to pay due attention to the business side of the profession – sins which so easily beset him – but I would speak of his failure to realize first, the need of a lifelong progressive personal training, and secondly, the danger lest in the stress of practice he sacrifice that most precious of all possessions, his mental independence. Medicine is a most difficult art to acquire. All the college can do is to teach the student principles, based on facts in science, and give him good methods of work. These simply start him in the right direction, they do not make him a good practitioner – that is his own affair. To master the art requires sustained effort, like the bird's flight which depends on the incessant action of the

wings, but this sustained effort is so hard that many give up the struggle in despair. And yet it is only by persistent intelligent study of disease upon a methodical plan of examination that a man gradually learns to correlate his daily lessons with the facts of his previous experience and of that of his fellows, and so acquires clinical wisdom.

William Osler with Doctors, Nurses and Patients at the University of Pennsylvania Orthopedic Hospital and Infirmary for Nervous Diseases (Summer of 1887)



Nowadays it is really not a hard matter for a well-trained man to keep abreast of the best work of the day. He need not be very scientific so long as he has a true appreciation of the dependence of his art on science, for, in a way, it is true that a good doctor may have practice and no theory, art and no science. To keep up a familiarity with the use of instruments of precision is an all-important help in his art, and I am profoundly convinced that as much space should be given to the

clinical laboratory as to the dispensary. One great difficulty is that while waiting for the years to bring the inevitable yoke, a young fellow gets stale and loses that practised familiarity with technique which gives confidence. I wish the older practitioners would remember how important it is to encourage and utilize the young men who settle near

them. In every large practice there are a dozen or more cases requiring skilled aid in the diagnosis, and this the general practitioner can have at hand. It is his duty to avail himself of it, and failing to do so he acts in a most illiberal and unjust way to himself and to the profession at large. Not only may the older man, if he has soft arteries in his grey cortex, pick up many points from the young fellow, but there is much clinical wisdom afloat in each parish which is now wasted or dies with the old doctor, because he

and the young men have never been on friendly terms.

In the fight which we have to wage incessantly against ignorance and quackery among the masses and follies of all sorts among the classes, diagnosis, not drugging, is our chief weapon of offence. Lack of systematic personal training in the methods of the recognition of disease leads to the misapplication of remedies, to long courses of treatment when treatment is useless, and so directly to that lack of confidence in our methods which is apt to place us in the eyes of the public on a level with empirics and quacks.

Few men live lives of more devoted self-sacrifice than the family physician, but he may become so completely absorbed in work that leisure is unknown; he has scarce time to eat or to sleep, and, as Dr. Drummond remarks in one of his poems, "He's the only man, I know me, don't get no holiday." There is danger in this treadmill life lest he lose more than health and time and rest – his intellectual independence. More than most men he feels the tragedy of isolation – that inner isolation so well expressed in Matthew

Arnold's line "We mortal millions live alone." Even in populous districts the practice of medicine is a lonely road which winds up-hill all the way and a man may easily go astray



William Osler performing an autopsy in the Blockley Mortuary in Philadelphia (1886 or 1889)

and never reach the Delectable Mountains unless he early finds those shepherd guides of whom Bunyan tells, Knowledge, Experience, Watchful, and Sincere. The circumstances of life mould him into a masterful,

self-confident, self-centered man, whose worst faults often partake of his best qualities. The peril is that should he cease to think for himself he becomes a mere automaton, doing a penny-in-the-slot business which places him on a level with the chemist's clerk who can hand out specifics for every ill, from the "pip" to the pox. The salt of life for him is a judicious scepticism, not the coarse, crude form, but the sober sense of honest doubt expressed in the maxim of the sly old Sicilian Epicharmus, "Be sober and distrustful; these are the sinews of the understanding." A great advantage, too, of a sceptical attitude of mind is, as Green the historian remarks, "One is never very surprised or angry to find that one's opponents are in the right." It may keep him from self-deception and from falling into that medical slumber into which so many drop, deep as the theological slumber so lashed by Erasmus, in which a man may write letters, debauch himself, get drunk, and even make money – a slumber so deep at times that no torpedo-touch can waken him.

It may keep the practitioner out of the clutches of the arch enemy of his professional

independence – the pernicious literature of our camp-followers, a literature increasing in bulk, in meretricious attractiveness, and in impudent audacity. To modern pharmacy we owe much, and to pharmaceutical methods we shall owe much more in the future, but the profession has no more insidious foe than the large borderland pharmaceutical houses. No longer an honoured messmate, pharmacy in this form threatens to become a huge parasite, eating the vitals of the body medical. We all know only too well the bastard literature which floods the mail, every page of which illustrates the truth of the axiom, the

gullible public. Even the most respectable houses are not free from this sin of arrogance and of ignorant dogmatism in their literature.

A still more dangerous enemy to the mental virility of the general practitioner, is the "drummer" of the drug house. While many of them are good, sensible fellows, there are others, voluble as Cassio, impudent as Autolycus, and senseless as Caliban, who will tell you glibly of the virtues of extract of the coccygeal gland in promoting pineal metabolism, and are ready to express the most emphatic opinions on questions about

of the practitioner by the manufacturing chemist and the revival of a pseudoscientific polypharmacy are too large questions to be dealt with at the end of an address.

But there is a still greater sacrifice which many of us make, heedlessly and thoughtlessly forgetting that "Man does not live by bread alone." One cannot practise medicine alone and practise it early and late, as so many of us have to do, and hope to escape the malign influences of a routine life. The incessant concentration of thought upon one subject, however interesting, tethers a man's

mind in a narrow field. The practitioner needs culture as well as learning. The earliest picture we have in literature of a scientific physician, in our sense of the term, is as a cultured Greek gentleman; and I care not whether the young man labours among the beautiful homes on Sherbrooke Street, or in the slums of Caughnawauga, or in some sparsely settled country district, he cannot afford to have learning only. In no



*Osler family out for a drive
(circa 1908)*

greater the ignorance the greater the dogmatism. Much of it is advertisements of nostrums foisted on the profession by men who trade on the innocent credulity of the regular physician, quite as much as any quack preys on the

which the greatest masters of our art are doubtful. No class of men with which we have to deal illustrates more fully that greatest of ignorance – the ignorance which is the conceit that a man knows what he does not know; but the enthrallment

profession does culture count for so much as in medicine, and no man needs it more than the general practitioner, working among all sorts and conditions of men, many of whom are influenced quite as much by his general ability, which they can

appreciate, as by his learning of which they have no measure. The day has passed for the "practiser of physic" to be like Mr. Robert Levet, Dr. Johnson's friend, "Obscurely wise and coarsely kind." The wider and freer a man's general education

potions. But what of the men of the type of Mr. Robert Levet, or "Ole Docteur Fiset," whose virtues walk a narrow round, the men who do the hard general practices in the poorer districts of the large cities, in the factory towns and in the widely

of training. If we had only to deal with one another the difficulties would be slight, but it must be confessed that the practice of medicine among our fellow creatures is often a testy and choleric business. When one has done his best or when a mistake has arisen through lack of special knowledge, but more particularly when, as so often happens, our heart's best sympathies have been engaged, to be misunderstood by the patient and his friends, to have evil motives imputed and to be maligned, is too much for human endurance and justifies a righteous indignation.

It is hard to say whether as a whole we do not suffer just as much from the indiscriminate praise. But against this evil we are helpless. Far otherwise, when we do not let the heard word die; not to listen is best, though that is not always possible, but silence is always possible, than which we have no better weapon in our armoury against evil-speaking, lying, and slandering. The bitterness is when the tale is believed and a brother's good name is involved. Then begins the worst form of ill-treatment that the practitioner receives – and at his own hands! He allows the demon of resentment to take possession of his soul, when five minutes' frank conversation might have gained a brother. In a small or a large community what more joyful than to see the brethren dwelling together in unity. The bitterness, the rancour, the personal hostility which many of us remember in our younger

scattered rough agricultural regions – what, I hear you say, has culture to do with them? Everything! It is the bichloride which may prevent the infection and may keep a man sweet and whole amid the most debasing surroundings. Of very little direct value to him in his practice – though the poor have a pretty keen appreciation of a gentleman – it may serve to prevent the degeneration so apt to overtake the overworked practitioner, whose nature is only too prone to be subdued like the dyer's

hand to what it works in.

Whether a man will treat his professional brethren in a gentlemanly way or in a narrow illiberal spirit is partly a matter of temperament, partly a matter

the better practitioner is he likely to be, particularly among the higher classes to whom the reassurance and sympathy of a cultivated gentleman of the type of Eryximachus, may mean much more than pills and

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Back of an advertisement for Sal-Codeia Bell featuring a portrait of William Osler (1905-1919)

days has been largely replaced by a better feeling and while the golden rule is not always, as it should be, our code of ethics, we have certainly become more charitable the one towards the other.

To the senior man in our ranks we look for an example, and in the smaller towns and country districts if he would remember that it is his duty to receive and welcome the young fellow who settles near him, that he should be willing to act as his adviser and refuse to regard him as a rival, he may make a good friend and perhaps gain a brother. In speaking of professional harmony, it is hard to avoid the trite and commonplace, but neglecting the stale old chaps whose ways are set and addressing the young, to whom sympathy and encouragement are so dear, and whose way of life means so much to the profession we love, upon them I would urge the practice of St. Augustine, of whom it is told in the Golden Legend that "he had these verses written at his table:

Quisquis amat dietis
absentum rodere vitam,
Hanc mensam indignam
noverit esse sibi:

That is to say: Whosoever loves to missay any creature, that is absent, it may be said that this table is denied to him at all." With our History, Traditions, Achievements, and Hopes, there is little room for Chauvinism in medicine. The open mind, the free spirit of science, the ready acceptance of the best

from any and every source, the attitude of rational receptiveness rather than of antagonism to new ideas, the liberal and friendly relationship between different nations and different sections of the same nation, the brotherly feeling which should characterize members of the oldest, most beneficent and universal guild that the race has evolved in its upward progress – these should neutralize the tendencies upon which I have so lightly touched.

I began by speaking of the art of detachment as that rare and precious quality demanded of one who wished to take a philosophical view of the profession as a whole. In another way and in another sense this art may be still more precious. There is possible to each one of us a higher type of intellectual detachment, a sort of separation from the vegetative life of the work-a-day world – always too much with us – which may enable a man to gain a true knowledge of himself and of his relations to his fellows. Once attained, self-deception is impossible, and he may see himself even as he is seen – not always as he would like to be seen – and his own deeds and the deeds of others stand out in

Advertisement for Sal-Codeia Bell featuring a portrait of William Osler (1905-1919)



their true light. In such an atmosphere pity for himself is so commingled with sympathy and love for others that there is no place left for criticism or for a harsh judgment of his brother. But as Sir Thomas Browne – most liberal of men and most distinguished of general practitioners – so beautifully remarks: "These are Thoughts of things which Thoughts but tenderly touch," and it may be sufficient to remind this audience, made up of practical men, that the word of action is stronger than the word of speech.

Poetry Corner

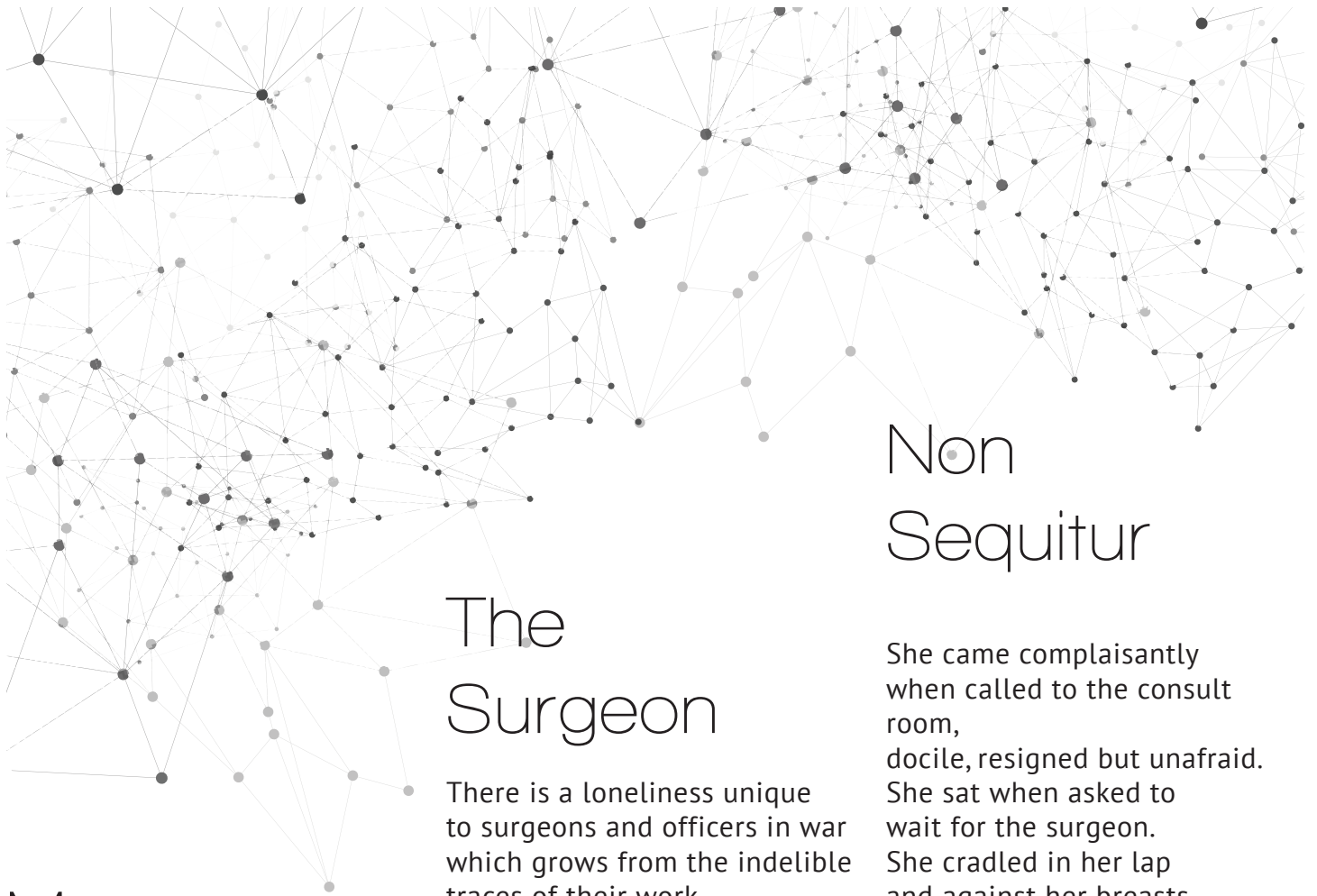
■ THE SURGEON SPEAKS

This issue's poet is Lloyd Jacobs - Professor Emeritus of General and Vascular Surgery of the University of Toledo, Ohio.

Professor Jacobs is a surgeon, a poet and writer and was the 16th President of the University of Toledo from 2006 to 2014. Since becoming President Emeritus, he has embarked on a career of actively writing and speaking on medical ethics. He is the author of two books, several book chapters and more than 50 articles in peer-reviewed medical and scientific publications. His book, "Practical Ethics for the Surgeon" (Wolters Kluwer, Philadelphia) is due to be released in 2019.

Prior to coming to Toledo, he was Chief Operating Officer of the University of Michigan Hospitals and Health Centers and Senior Associate Dean for Clinical Affairs at the University of Michigan Medical School. He also held a faculty appointment as professor of surgery and maintained an active vascular surgical practice.





Mastery

The apprentice surgeon
lives in the dream
that there really is something
out there maybe in there

Dissection is discovery
in an amorphous ghee
in which is hidden some
culprit to be separated

The master surgeon
knows the creative act erases
the subject object distinction
the ghee gives up its secrets

His dissection is sculpture
planes are created not found
the medium of blood and flesh
becomes one with him

The Surgeon

There is a loneliness unique
to surgeons and officers in war
which grows from the indelible
traces of their work
and threatens the soul
the fates are constrained to
alter course

A loneliness not unlike
that of a priest who standing
alone before God, creates him
he gathers the consecrated
instruments
his devotees surpliced alike
the supine sacrifice awaits
the miraculous elevation

Their ardour may fail
confidence may become pride
exactitude become
perfectionism
perseverance a stubborn
obsession
these like the amputated leg
or excised kidney are
irretrievable

Non Sequitur

She came complaisantly
when called to the consult
room,
docile, resigned but unafraid.
She sat when asked to
wait for the surgeon.
She cradled in her lap
and against her breasts
the fractured, pavement scored
motorcycle helmet she had
brought.

Her holding it reminded me
of the protective gesture
an astronaut used
of looking back upon the earth.
How she came to have the
helmet
in the short interval
since the crash
she didn't volunteer
and no one asked.

She stood when I entered
and sat again at my gesture,
helmet clutched now not
cuddled.
I uttered the platitudes.
"Autopsy?", she said, "My son's in
Denver".



Amputation

A third year trainee should know
its best to bevel the shin bone
half an inch perhaps, so that no
sharp edge impinges on the
skin.
The resultant stump should
taper
slightly, but with a rounded end,
an effect facilitated by cutting
the
fibula an inch or two
shorter than the shin.
And, of most importance
the severed limb should be
handed off
discreetly, as if it were slightly
shameful,
covered quickly, as one covers
the
pudenda, and never joked about.
This may be difficult due
to the awkward angle of the
ankle
and the protruding heel and
toes.



The Surgeons Knowledge

Lived forward understood
backward
the philosopher said.
But the thrust of the notion
here
is how we are forced
to begin in the middle of things,
to join the show already
underway
and to leave the theatre
before it is over. Upon reflection
most of what we understand
we enter from the middle
with inadequate preparatory
base.
The infinitesimal calculus for
example,
one embarks into its great
utility;
its foundations may be
vouchsafed
at some later time or never.

Most of what the surgeon
knows about
what it is to be a human
creature
begins with the imperative of
the middle:
a cancer well begun, an
appendicitis
far advanced. "Thrown" another
said
into an urgency for handiwork
of which experience forms the
base,
the theory of the work comes
only afterward.



Night Operation

It was late, well past midnight,
he was old, my training near its
end.
As was the custom then, I had
been assigned
to assist the frail declining
surgeon.

The dressing room, prepared for
morning,
conducted to recognition of son
and father.
He was pensive, regretful. There
had been
severe blood loss, sutures
tearing through,
the operation's purpose unmet.

He sat with knees akimbo.
I remember a case long ago
when
I thought the woman couldn't
survive.
My impulse in the morning was
avoidance,
but she was alive, radiant even,
eager to assure and comfort me.

Suddenly he became wary and
glanced about.
The funny thing: she stood up
and touched me.
Perhaps again tonight

Surgeon's Lament

Who interposed
devices with electronic circuitry
between us?

Who tied our hands
until the simulacrum
became the reality?

Who decried the unitive touch
binding us together?
Who destroyed our art?

Surgeon's Intention

It is an act of faith to think
the universe to be constrained
to react in a patterned way
to our setting of conditions.
All faith is hubris.

The naturalist would have
God subject to Pavlov's rules
or failing that posit a universe
fraught by accident and chance.
All faith is hubris.

The surgeon knows great rents
exist
in the fabric of the universe;
there is but a loose coupling
between an act and its
consequence.
Human certainty is hubris.

Unlike the alchemist or shaman
who may engage in sleight of
hand
the surgeon knowingly
confronts
the hole in human efficacy.
Certainty is hubris.

The stock in trade of the
surgeon
his identity and being
is his venturing into this space
where evil spirits may reside.
Certainty and faith are hubris.

The Inner Life of a Surgeon

Surgeons are never solipsists
as was joked by an American
philosopher
who conflated solipsism with
narcissism.

Operating rooms often in
former times
had galleries adjacent.
Operating
Theatre is a phrase still heard.

The surgeon is always
conscious
of a sea of presence about him.
The anesthetized patient
hovers.

The famous painting by Thomas
Eakins
of Samuel Gross declaiming
makes clear his perception of
other minds.

There are degrees of solipsism,
the notion is a slope, only
in the extreme do no other
minds exist.

A common stopping place on
the slope
is to perceive no other minds
but those
upon a substrate of diodes and
neurons.

Surgeons are never of this ilk.
Their experience of human
blood and flesh
unexpectedly reveals the spirit
also

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 - and the Spring 2015 issue of this Journal carried Chapter 1 of his life story.

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 has appeared in a previous issue 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 8, in his own words ...

LIFE STORY

*Excerpts from the memoirs
of R. M. Kirk*

Chapter 8



Like my revered trainer Norman Tanner, who called everyone 'Doc,' I have always had a poor memory for names, now even worse. At Willesden I was greeted by two anaesthetists, and two house surgeons called Margaret. Married to Peggy (Margaret) I thought I had found a solution by applying the same name to everyone in my team. It collapsed in face of the boot-faced response from my registrar when I tried it out on him!

The unfinished thesis nagged. As soon as I had settled into the work at Willesden I concentrated on writing up my thesis on the study of defective lymphatics in the legs. I had had no supervision. I learned nothing. Scientific logic never appeared. I had spent years acquiring two capital letters, MS (Master of Surgery), after my name. It was usual to engage one's secretary to undertake typing. There were two difficulties. My secretary was utterly incompetent and surly. She also announced that she could not start for a year – and her fee was much higher than that charged to my friends. I bought a portable typewriter and typed my own. It was at that time necessary, when adding or erasing any substantial part, to retype the whole of the subsequent thesis. I drowned in rejected typescript. Moreover, five

copies (I think), were needed to be submitted. This was achieved with the aid of carbon paper interleaved with the paper. The keys needed to be struck forcibly to ensure that the last sheets were legible. I was eventually able to share the secretary, Joyce Lindsell who worked with my delightful friend Ewart Jepson, the junior physician. Joyce was a superb typist and her command of English far exceeded mine. Indeed, when I eventually left, she quietly and without any malice, mentioned to me that she had been in the habit of correcting habitual errors in my spelling and grammar. She gave me a list of them. It was chastening.

The thesis was finally finished, bound and submitted. After an interval I was called to defend it. The chairman David Patey, was extremely kind and generous. The physiologist was fussy, picking up trivial points. The third was Bill Irvine, Professor of Surgery at St Mary's Hospital. He was notorious for his aggression at scientific meetings toward young researchers. He attacked me. When he had finished, Patey gently asked me, 'Kirk, who supervised you?' 'No one, sir. It was not obligatory, so I worked alone.' 'How much spare time was given to allow you to carry out your research?' None sir. I was fully

committed to a very busy surgical service.’ ‘How did you fund your research?’ ‘I had no funds. I made my own equipment or borrowed it.’ His obvious intention was to point out that I had worked in difficult, unsupported circumstances. To my delight Bill Irvine unexpectedly rang me later to tell me I had passed and I could have access to his department. I thought this was generous but his motive became clear, later. He wished to unload to me several patients suffering from lymphoedema since he had no interest in the condition. I recently encountered a wonderful quotation of the American financier, John Pierpoint Morgan – ‘A man has two reasons for doing anything: a good reason and the real reason.’ Apt? Sadly, Irvine became an alcoholic, surrendered his Professorial chair and eventually died, presumably from liver failure.

In the course of my career at Willesden I operated within all the specialities, either because it was expected of a ‘general’ surgeon, or because there was no sub-speciality expert available. My first

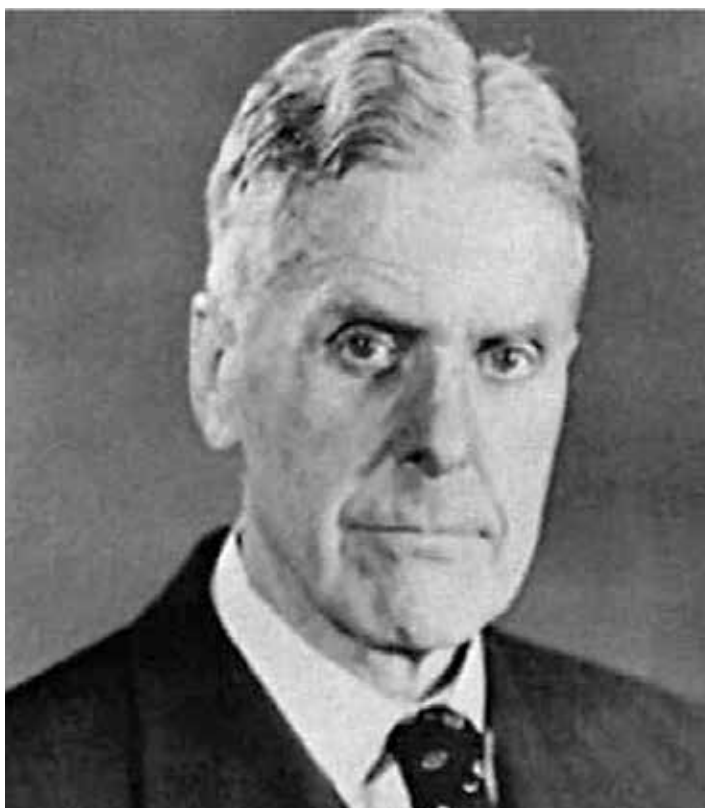
Smith-Peterson pinning of a fractured neck of femur was performed without having seen one previously. As new techniques became available, we were often faced with the need to perform them without any practical training. Whenever possible we tried to visit and watch a convenient expert. I invited an expert in parotidectomy (an apt name for a salivary gland sitting just beside the ear. G para– beside + otos = the ear), to teach myself and my registrar. This earned an admonishment from George Qvist for being disloyal to the hospital. His logic was that if

we did not offer a comprehensive service, local general practitioners and the public would lose confidence in the hospital and doctors. Within a few days of taking up my appointment a motor cyclist smashed into a brick wall. He was admitted wide awake but suddenly became unconscious. This was a classical sign of some increase in intracranial pressure, assumed to be from bleeding within the brain or remaining extra-cranial spaces. We did not then have any means of reducing his increased intracranial pressure except by draining blood or the cerebrospinal fluid.

Guided by a pre-war emergency operating textbook, I drilled four burr holes through the cranium. There was no evidence of extra-dural or extra-cerebral bleeding. I gently inserted needles through the brain, aimed at the reservoir of intracranial cerebrospinal fluid. At the fourth attempt a jet of cerebrospinal fluid nearly hitting the theatre light. Almost immediately the patient began to regain consciousness. I thought he might climb off the table and hurriedly recovered the needle. To my relief he

made an uneventful recovery. I never see or think of the famous Jet d’eau in Lake Geneva without recall my first, naive attempt at neurosurgery.

During my training most surgeons avoided operating for ruptured abdominal aortic aneurysm - weakened, dilated arterial trunk. When plastic stents became available, we acquired one and read the technical reports. On my first patient I struggled to apply an occlusive clamp across the aorta just below the renal arteries, to avoid prejudicing renal function. I



David Howard Patey, (1899-1977), British surgeon. Described the Patey (modified radical) mastectomy in 1948.

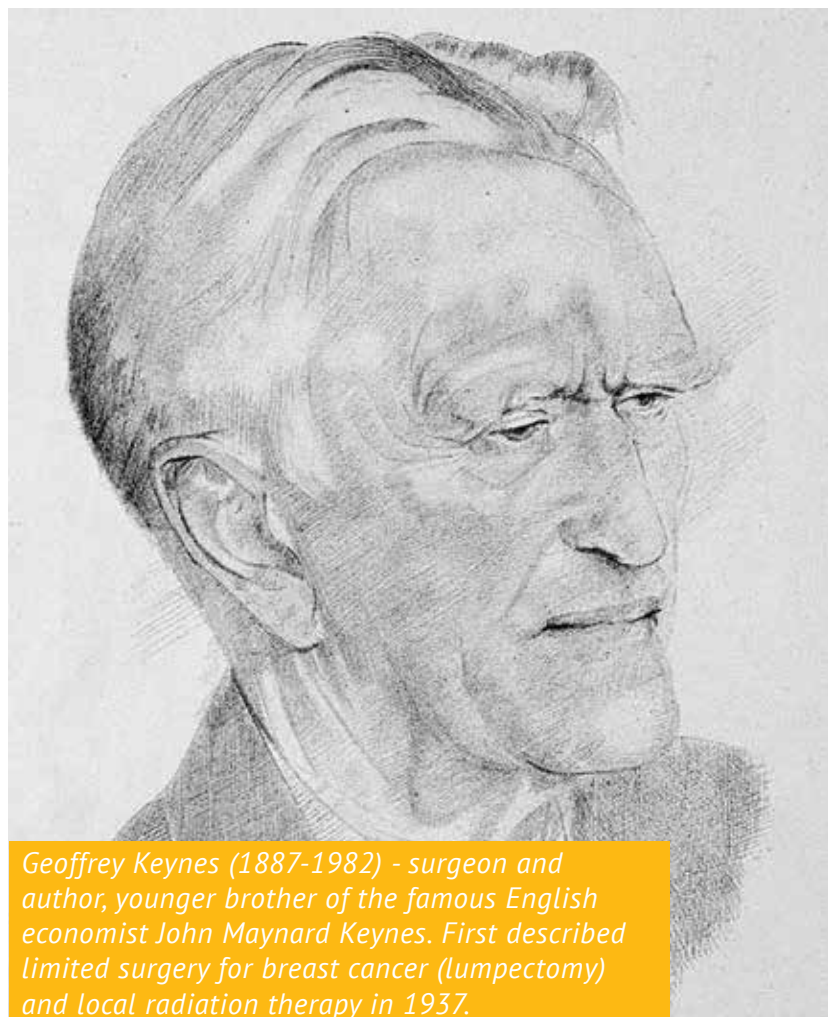
hesitated to take the risk without seeking help and telephoned a vascular surgeon friend. He arrived, dressed in a dinner jacket, hurriedly changed, scrubbed and joined me. After a struggle he succeeded in applying the clamp, confirmed that I was happy and rushed away. Next morning I learned that he had left his marriage engagement party to assist me.

A man discovered when blood emerged beneath a public lavatory door, was admitted having cut his neck. My registrar reported that the larynx was absent in the almost moribund, choking, suicidal who had cut his throat from ear to ear. The ear, nose and throat (ENT) senior registrar who had been called was leaving as I arrived, muttering that he refused to take any responsibility. At operation it was obvious that the patient had succeeded in completely transecting the pharynx just above the laryngeal cartilage, allowing the larynx to sink out of sight. Miraculously, he had spared the carotid arteries and the internal jugular veins. The bleeding was from the cut external jugular veins. It was remarkably easy to insert a simple continuous repair and he made a complete recovery. His vocal apologies attested to his intact peripheral nerves. I am reminded that one of my patients had had a partially paralysed vocal cord following excision of an upper oesophageal carcinoma by me. I had damaged the nerve which controls its movements – the recurrent laryngeal nerve. He courteously refused my offer to bulk up the affected cord with the plastic substance polytetrafluoroethylene and so appose it to the other active cord. He explained that he earned a successful livelihood as a salesman using the telephone. He believed that his slight breathy speech impediment was very much admired by his lady customers, who found it sexy.

My most enjoyable Christmas dinner was one that I was forced to abandon before I reached the post-prandial heartburn trigger point. A friend from another hospital telephoned to tell me that he had just admitted a patient with recurrent adhesive intestinal obstruction, in which the bowel loops stick to each other

and may obstruct the flow through the gut. He did not feel able to embark on yet another extensive and hazardous exploration and asked me to undertake it. I drove to his hospital and spent several hours dissecting out the totally solid abdominal contents. The current method of preventing recurrence was described by Noble in 1937. The freed bowel was laid back and forth like a jumping jack firework and the contiguous segments were sutured together. The resulting path resembled the track traditionally followed by an ox-drawn plough and was therefore called 'boustropic,' (G bous = ox + tropein = to turn). The bottle of antacid tablets remained unopened that evening.

Success was elusive. I seemed to attract minor surgical procedures alone. I did my best for them – and attracted further ones. One general practitioner sent me nothing but in-growing toenails. Why? He explained that he took great efforts to match his referrals to the available



Geoffrey Keynes (1887-1982) - surgeon and author, younger brother of the famous English economist John Maynard Keynes. First described limited surgery for breast cancer (lumpectomy) and local radiation therapy in 1937.

expertise. I was such an expert that he had labelled me 'Mr in-growing toenails' - not what I was seeking! I continued to do very little private practice, attributing it to lack of interest - but possibly it was ineptitude.

Having worked with some inspiring teachers I was fired with ambition to make my mark and attempt to climb the greasy pole of success - so defined by Benjamin Disraeli (1804-81). By making great efforts, publishing experimental and clinical papers, attending meetings and acting as one of the College of Surgeons' tutors, I gradually established a modest presence. This was augmented by gaining a post within the Royal Free Hospital group, in 1964. The success was achieved at the cost of being treated as a leper for about a year. The staff at Hampstead General Hospital had voted for another candidate and were resentful that I had usurped him. I shrugged my shoulders and was eventually accepted except for one lady surgeon; she ignored me for several years - but eventually became a strong supporter.

It was difficult to establish a name as a surgical upper gastroenterologist. In a nearby hospital was the international medical expert in the field, Sir Francis Avery Jones who had his own superb surgical team. In the hope of cooperating with

them I introduced a newly developed procedure for the management of peptic ulcers from Seattle, having watched it performed by David Johnston in Leeds, who had just returned from an attachment there. It consisted of a highly selective separation of a nerve, the vagus (L = wandering, describing its wide distribution), from the stomach, thus reducing the stimulus to secrete acid. Sir Francis heard of this and sent one of his surgical colleagues to watch me. He did so and adopted it - briefly. His first patient developed a fatal gangrenous perforation of the stomach, the first of several described. The originator of the procedure, Chuck (Charles) Griffith visited me, we became friends and I was able to demonstrate my own procedure for preventing or dealing with recurring and intractable ulcers.

The eminent and much loved Norman Tanner was preparing to retire from my prestigious teaching hospital, Charing Cross Hospital. I had hopes for succeeding him. One of the anaesthetists there also worked with me at Willesden. To my intense surprise, one day he conspiratorially sidled up to me with, 'Jerry, would you like to join the lodge?' In my innocence, 'lodge' signified hunting and I told him I had no knowledge of it. He corrected me by saying this was a Masonic lodge allied

to Charing Cross. 'What do you do?' 'We do a lot of good things.' 'But you are a secret society. I would not know what I was committing myself to.' He answered rather petulantly, 'We do not ordinarily invite people. They ask to be admitted. Do you wish to join or not?' Very flippantly, I told him I believed that initiation to secret societies involved arcane practices and if I came home in disarray, my wife, who respects me now, would lose it. More importantly, if I joined and subsequently achieved success, I would wonder if this resulted from my ability



Royal Free Hospital



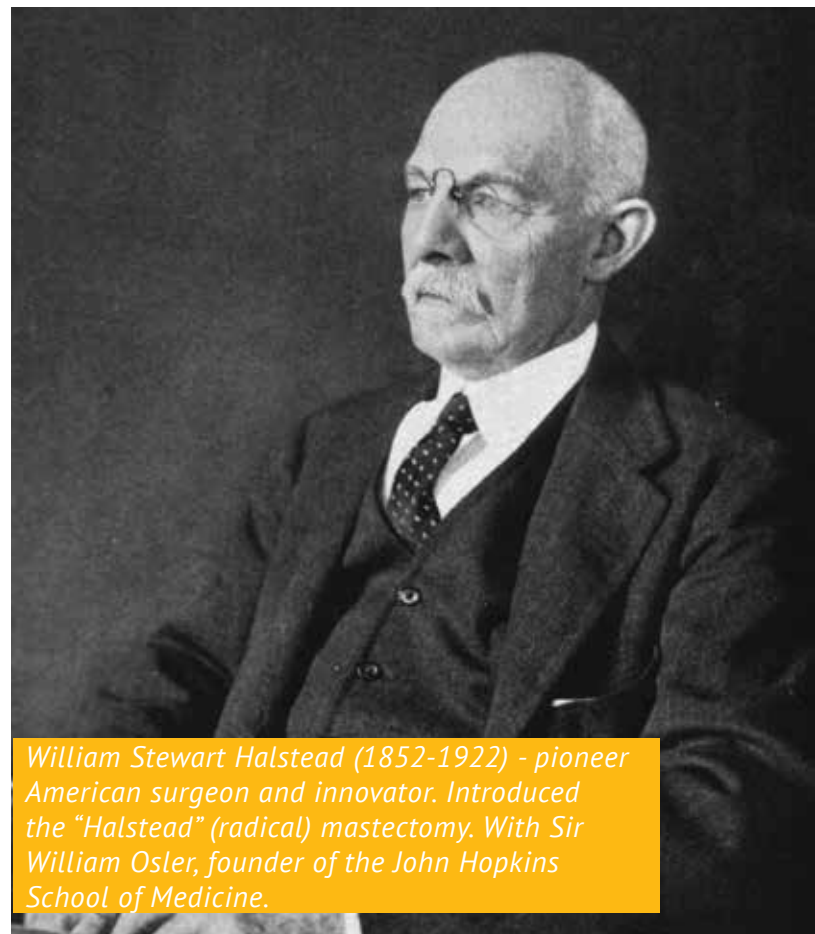
St. Bartholomew's Hospital

as a surgeon or because I had joined the lodge.' He was seething as he left and I heard nothing more of it. Tanner's post was advertised, I applied and was not short listed. I came to know that virtually all the London teaching hospitals had Masonic lodges and assume that my anaesthetist considered himself to be showing me a helping hand.

I succeeded in getting financial support and leave of absence to take up a Royal Free Hospital School of Medicine Travelling Professorship in America for 3 months. We preceded it with a wonderful national tour with the children, visiting New York, Denver, San Francisco, Los Angeles, Las Vegas, and Washington DC. I then visited colleagues in Baltimore, Tennessee, San Francisco, Seattle, Chicago, Minneapolis, New York and Boston. Baltimore was famous for its founding Professor of Surgery, William Halsted, considered the Father of American surgery. He had devised the standard operation for breast carcinoma, 'radical' (by the roots) mastectomy on which I was trained. Sir Geoffrey Keynes (1887-1982) of St Bartholomew's Hospital, London, had demonstrated the equally good survival rates

following simple mastectomy with adjunctively inserted radium needles or external radio-active beam therapy. Many years later the then President of the Royal College of Surgeons of England, Sir Reginald Murley, (Keynes assistant in his studies), kindly dropped me off at my home after a College meeting. He identified the house and to my astonishment informed me that the previous owner had been the St Bartholomew's Hospital statistician, who had statistically verified the benefit of Keynes' modified management. In my visit to Baltimore, I asked the academic surgeons if they still retained Halsted's radical operation. All of them had abandoned it – except for one elderly surgeon. Asked why he retained it, he tersely

responded in a gravelly Southern drawl – I hope with tongue in cheek, 'Ah git a bigger fee!'



William Stewart Halstead (1852-1922) - pioneer American surgeon and innovator. Introduced the "Halstead" (radical) mastectomy. With Sir William Osler, founder of the John Hopkins School of Medicine.

Submission Guidelines

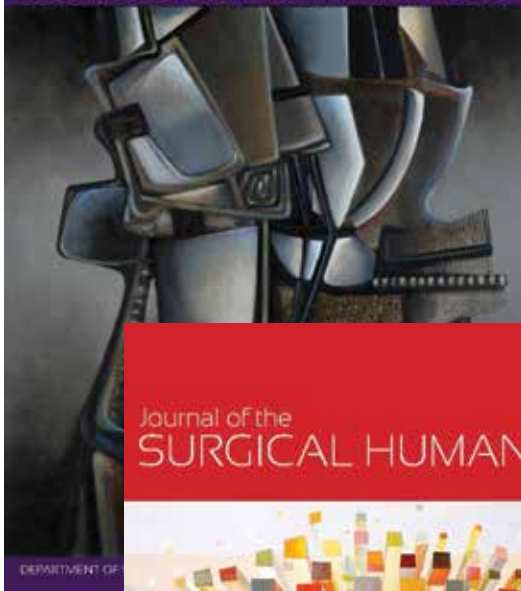
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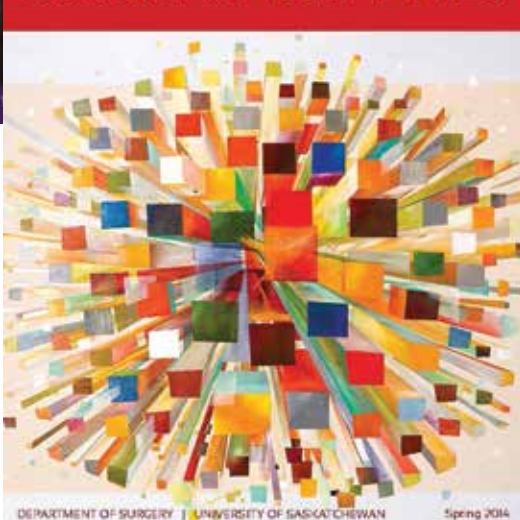
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Submissions to the Journal will be accepted in two categories:

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

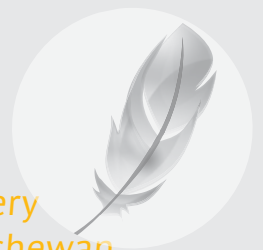
All submissions must be accompanied by a cover letter in Microsoft (MS) Word format, with a short (300 words) biography of the author, name, address and telephone number.

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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