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COVER PAGE
Medical teams at work on the beaches of Normandy -D-Day, June 1944. The 75th anniversary of D-Day was commemorated in June 2019. (pp 4-6).

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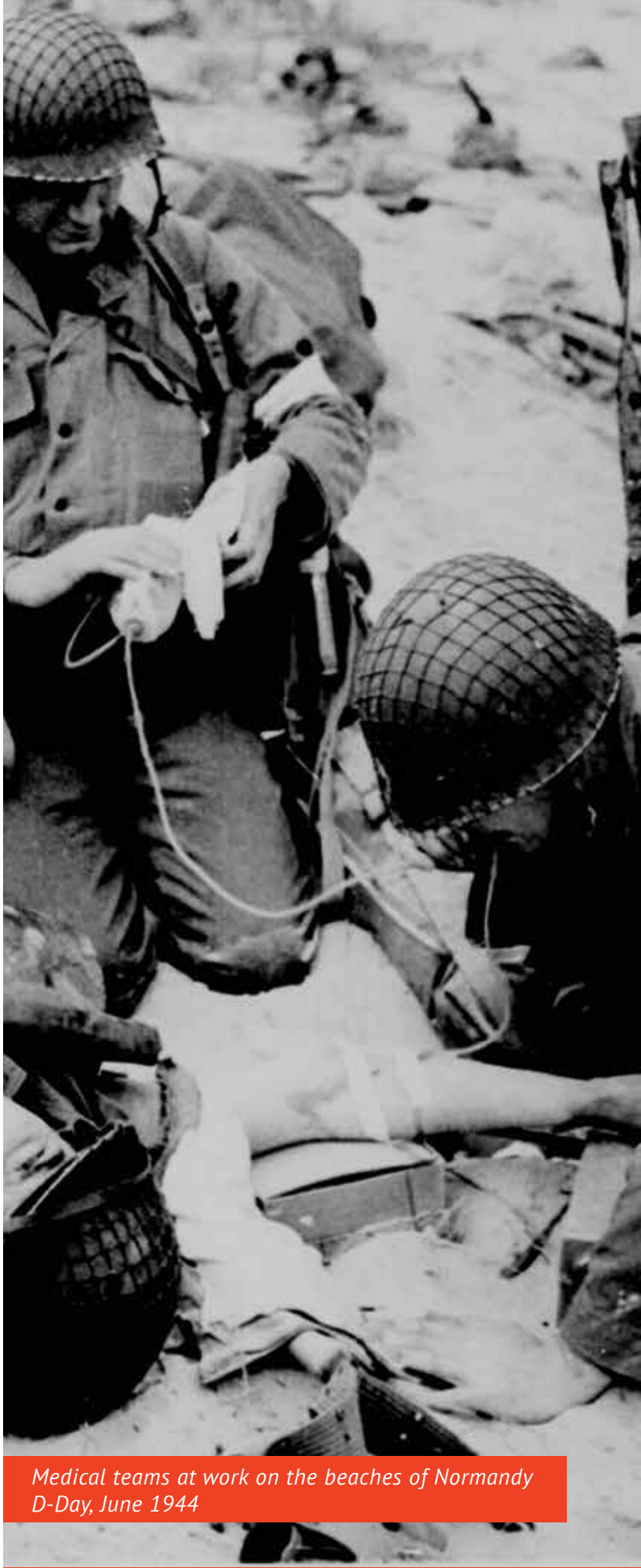

Medical teams at work on the beaches of Normandy D-Day, June 1944

WAR and the SURGEON

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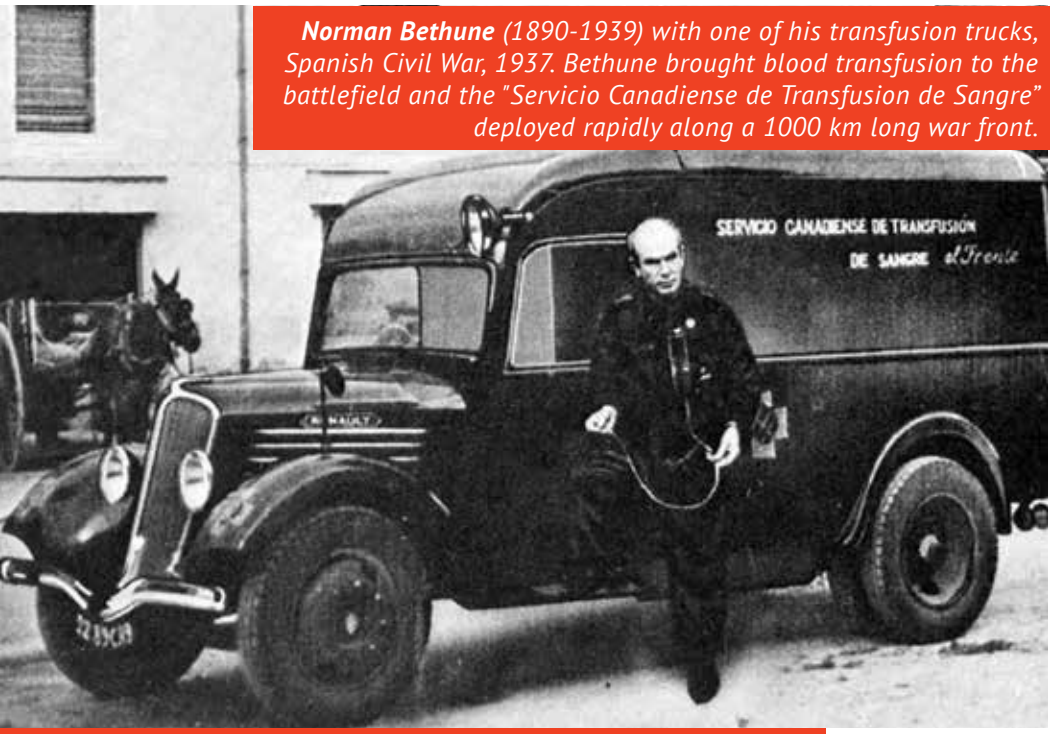
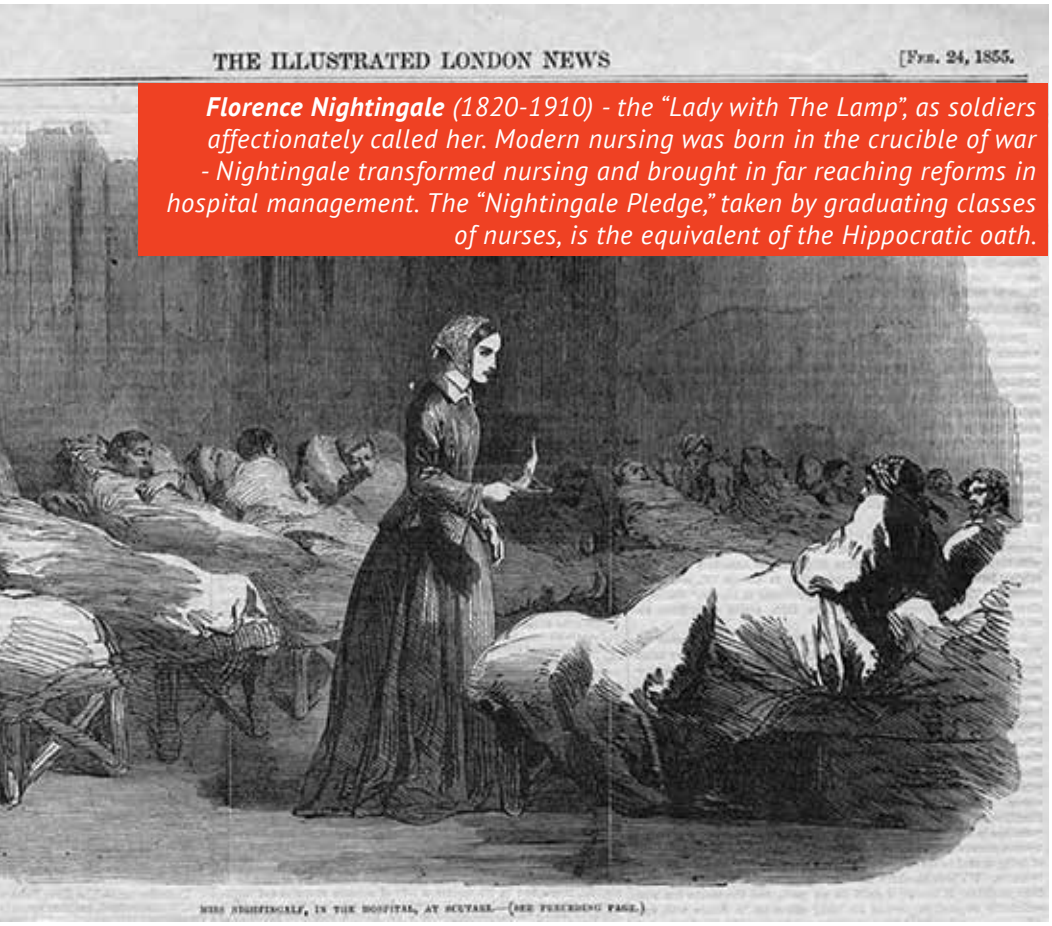
Together with the siren song of war that has sung so loud in the ears of leaders and armies and nations, a very different tune, sweeter than the Aeolian harp has called forth another breed of men and women to march in step with the bloody mayhem and madness of the battlefield. Where armies have deployed battering rams, muskets, cannon smoke and laser guided bombs, surgeons have deployed the scalpel, the suture, the soothing splint, the urgent shot of morphine; where soldiers, airmen, sailors have engaged in deliberate acts of destruction, surgical teams have sprung into action setting up field hospitals and makeshift beds; and where the telegraphed report back from the battlefront has reckoned success in terms of pieces of armoury taken out and enemy lives lost, the surgeon's success has always been measured by lives saved.



***Norman Bethune** (1890-1939) with one of his transfusion trucks, Spanish Civil War, 1937. Bethune brought blood transfusion to the battlefield and the "Servicio Canadiense de Transfusion de Sangre" deployed rapidly along a 1000 km long war front.*

Nor does the surgeon set apart friend from foe. The wounded warrior - or civilian - from either side must be treated the same, however fierce the battle, however cruel or villainous the enemy's reputation. And perhaps in this way the surgeon rebukes gently, the folly of war.

Epochal surgical advances have been made amidst the myriad, fast-moving challenges of the battlefield. The vine does not produce good fruit unless stressed and pruned - and if this logic is applied to war surgery, the vines of war have produced


THE ILLUSTRATED LONDON NEWS [Feb. 24, 1855.

Florence Nightingale *(1820-1910) - the "Lady with The Lamp", as soldiers affectionately called her. Modern nursing was born in the crucible of war - Nightingale transformed nursing and brought in far reaching reforms in hospital management. The "Nightingale Pledge," taken by graduating classes of nurses, is the equivalent of the Hippocratic oath.*

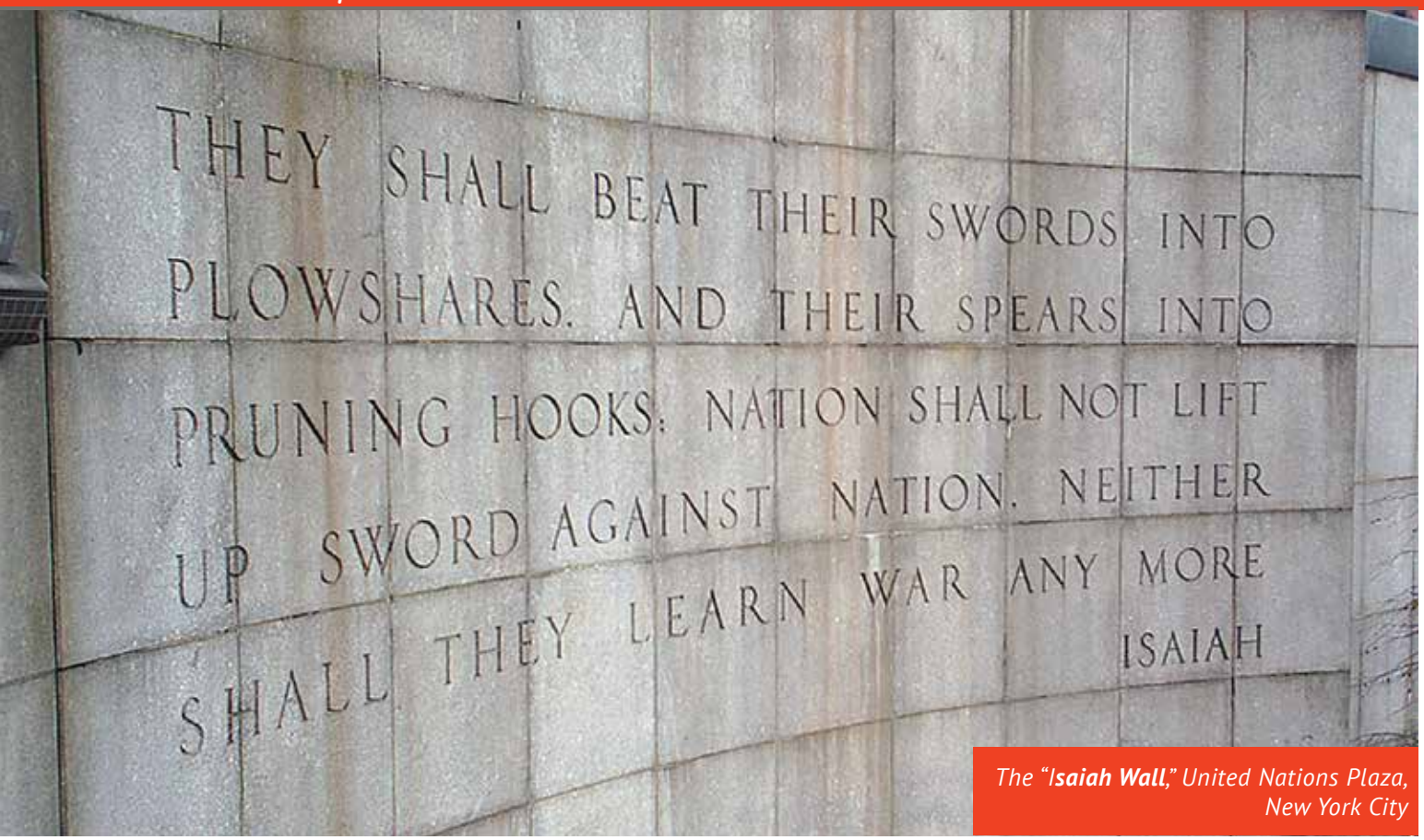
some of the finest surgical wine. The application of sutures to bleeding battlefield wounds by Susrutha[1,2] and later by Ambroise Paré[3] - both surgeons - presaged the modern, widespread use of the surgical tie. And the horse-drawn "flying ambulance" of Dominique Larrey[3] is different only in speed and mode from the airborne evacuations now common in both peacetime and war. The tourniquet that first saved soldiers' lives in war is now used to save the farmer's life as well. And but for Florence Nightingale and the Crimean war, nursing as we know it would not exist.

Wounds inflicted with the sword were reconstructed with the forehead flap by ancient Indian surgeons[4]. Several centuries later, wounds inflicted by exploding shell and shrapnel in the first and second world wars saw the birth of modern plastic surgery with the brilliant work of Sir Harold Gillies[6]. Canada too has been cast headlong into the cauldron flames of war and emerged with its surgeons flying high the flag of major surgical advances. Our own Norman Bethune of Gravenhurst, Ontario, first introduced organized blood transfusion on a massive scale to the frontlines of the Spanish Civil War. His "Servicio Canadiense de Transfusion de Sangre" (Canadian Blood Transfusion Service) arrived in Spain in 1937 and within 5 months, the Canadians were supplying a 1000 km long war front with up to 100 transfusions a day, 4000 blood donors, and 5 mobile transfusion delivery trucks[5]. Surgeons and poets alike have lamented the futility of war. Those closest to its horrors have also been the most averse to its repetition. The poets of the first world war fought in the trenches, saw and felt suffering as never before and sent back poems that would later strike the consciences of nations. In the months before he was killed in action (one week before the armistice to end the first world war), Wilfred Owen wrote what would today be called several, "anti-war" poems. They could also be called "futility poems" ... as in the poem that describes the death of a young British soldier on the killing fields of France:

Futility
by Wilfred Owen

Move him into the sun—
Gently its touch awoke him once,
At home, whispering of fields half-sown.
Always it woke him, even in France,
Until this morning and this snow.
If anything might rouse him now
The kind old sun will know.

Think how it wakes the seeds—
Woke once the clays of a cold star.
Are limbs, so dear-achieved, are sides
Full-nerved, still warm, too hard to stir?
Was it for this the clay grew tall?
—O what made fatuous sunbeams toil
To break earth's sleep at all?



*The "**Isaiah Wall**," United Nations Plaza, New York City*

Surgeons have joined other eminent physicians in opposing war and their effective activism has resulted in the coming together of such groups as the Medical Association for the Prevention of War, International Physicians for the Prevention of Nuclear War (IPPNW) and Medical Action for Global Security. In 1985, the IPPNW received the Nobel Prize for Peace.

But if wars should come (as come they do), surgeons will once again answer the call to duty in the service of mankind. Once again will the scalpel challenge the sword and surgical teams race against time and against the odds … and once again will death and life march hand in hand together. When this happens, there is almost certainly no time to contemplate the relative merits of war and peace as surgeons, nurses, anesthesiologists start once again the charged, frenzied, often rewarding work of war surgery.

And yet, when the particular trial of the particular war is over, surgeons and poets must surely look forward together to what is etched into the granite wall of the United Nations Plaza in New York … a time when, in the words of the prophet Isaiah, "*they shall beat their swords into plowshares, and their spears into pruning hooks. Nation shall not lift up sword against nation, neither shall they learn war any more.*"

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MEDICINE and REVOLUTION

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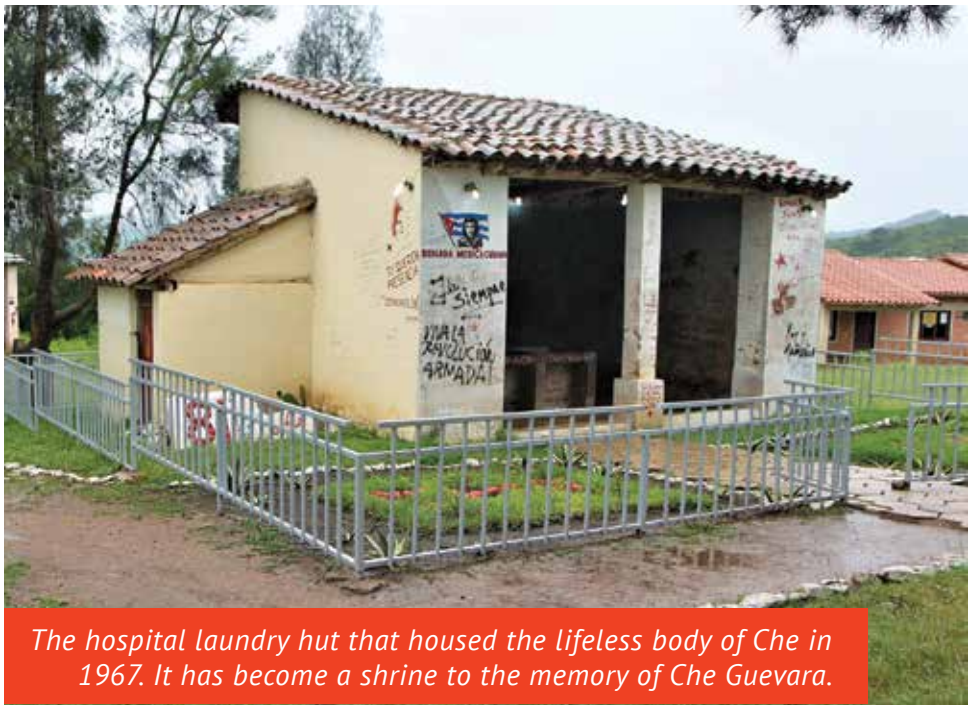
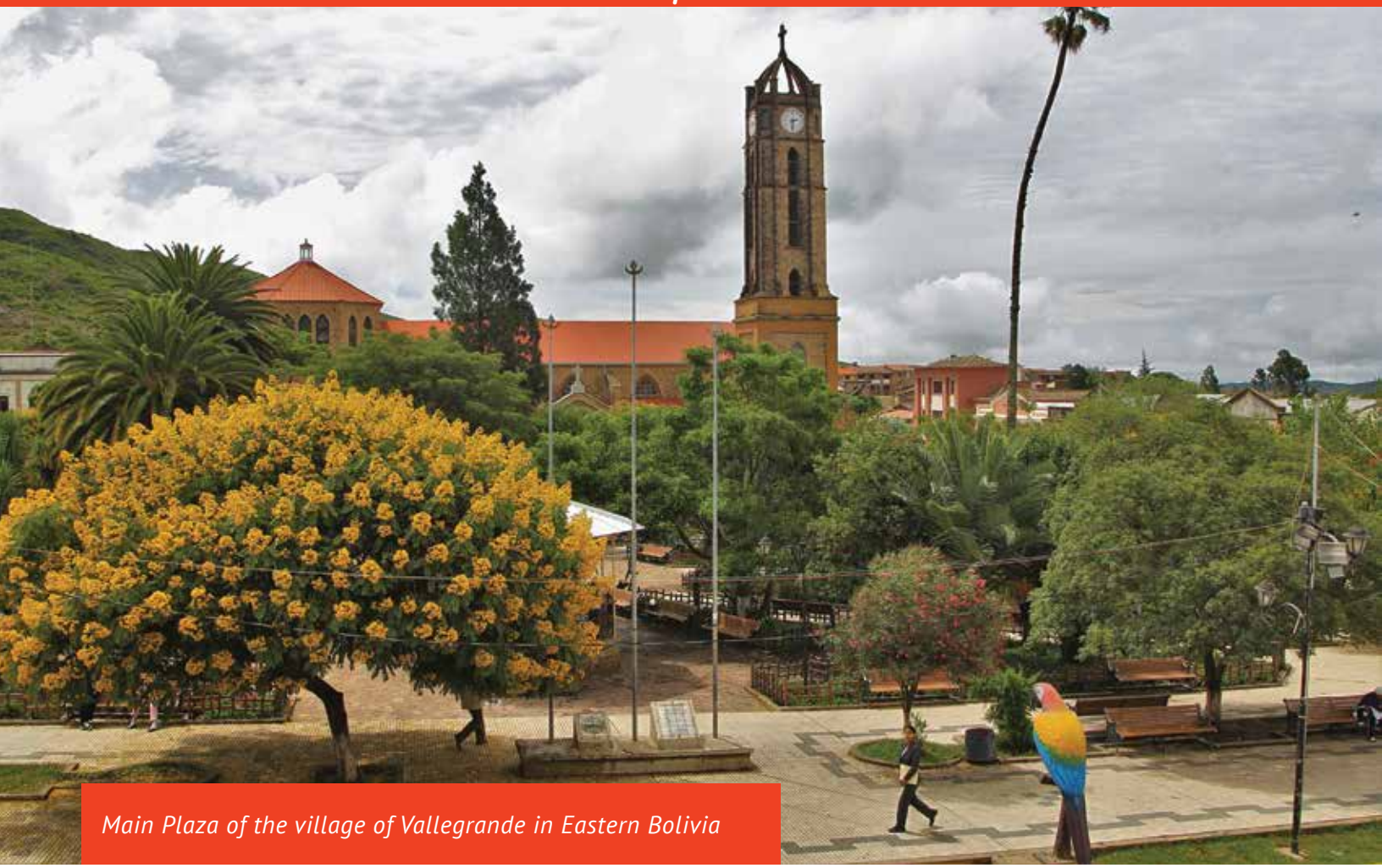
It was the mid-fifties and my father had just finished medical school in La Paz, the lofty administrative capital of Bolivia. He was assigned to do his one-year Rural Internship in Vallegrande, a small tropical village in the northeast corner of Bolivia. The Rural Internship is a requirement to obtain a medical license as a General Practitioner in Bolivia. This internship is designed to send freshly graduated medical students to practice medicine in underserviced rural communities in remote areas of the country. At the time of my father's internship, the intern was often the only physician providing medical care in most rural communities in Bolivia.



The hospital laundry hut that housed the lifeless body of Che in 1967. It has become a shrine to the memory of Che Guevara.

Vallegrande had a small hospital called Nuestro Señor de Malta, in honor of the patron saint of the town, and it was run by German missionary nuns. There had never been a physician in the village and the nuns were eagerly waiting for the first intern ever destined to Vallegrande. The long trip from La Paz was difficult as roads to the interior of the country were few and in very poor condition. Although this situation has improved marginally over the years, it is still difficult to travel in rural Bolivia. My parents had been recently married and my mom was expecting their first child, my older brother Gustavo. The only transportation available on a regular basis to Vallegrande was a cattle truck, so my parents shared the cabin with the truck driver and a full load of cows at the back.



Main Plaza of the village of Vallegrande in Eastern Bolivia

My parents remembered their time in Vallegrande with fondness. It was a time of simplicity, discovery and service to others. They lived in a small apartment within the hospital grounds next-door to the nunnery. The nuns not only administered the hospital but were the nurses that tended the patients. They also ran an orphanage for girls. With the help of the orphan girls, the nuns sewed all the linen, did the laundry and prepared all the meals for the hospital patients and personnel. My mom still remembers the delicious dishes coming from the nun's kitchen and the delivery of fresh milk and bread to their apartment every morning by one of the orphan girls.

As the only physician in town, my dad was very busy and gained a tremendous amount of experience treating all kind of conditions. With the assistance of the highly experienced nun nurses he delivered countless babies, attended all the emergencies and performed many common general surgery procedures. It was in Vallegrande that he made the decision to become a neurosurgeon, since patients with neurosurgical problems had nowhere to go for medical attention, as this specialty was almost non-existent in Bolivia at that time. Many years later, in a distant land, I followed my dad's footsteps and became a neurosurgeon myself.

The opportunity for me to visit Vallegrande came during a trip I took to the city of Santa Cruz to teach a brain tumor course to local neurosurgeons. Vallegrande is located about 250 km from Santa Cruz and it is a popular stop in the now famous tourist loop named the "Ruta del Che" in honor of the mythical guerrilla fighter Ernesto "Che" Guevara who died in this area during his failed Bolivian guerrilla campaign in the sixties.

On October 8, 1967, Che and his exhausted guerillas were ambushed by the Bolivian army in a brushy hollow called the Quebrada del Churo. Che was shot on the left calf and

another bullet disabled his M-2 carbine. He was captured and taken to the small village of La Higuera a few miles from the Quebrada del Churo. The wounded Che was held in the one-room adobe school of the village, interrogated and executed the next day by orders of the High Command of the Bolivian Army. His shattered body was flown by helicopter to Vallegrande and exhibited on a concrete washbasin of the open laundry hut of the Nuestro Señor de Malta Hospital. A procession of people from the village gathered at the laundry hut to see the body that appeared eerily alive … and quickly the rumor spread among the nuns of the hospital and the people of Vallegrande that Che's body had an uncanny resemblance to Jesus Christ.

It is raining when we arrive to Vallegrande, the eight-hour drive from Santa Cruz has been difficult and exhausting as the rains have made the gravel road a mud pit and we had to stop several times to push the 4X4 vehicle free from the mud. The main plaza of Vallegrande betrays its colonial origins that date to 1619 when it was founded by the Spanish. The classical Spanish square configuration is delimited by a prominent church with a single stone tower and colonial buildings with arched promenades. The wet cobblestoned streets and the grey skies gives the plaza a melancholic feel and a deep sadness invades me as I feel the presence of my dad who had passed away a few years ago.

I am eager to visit the hospital where my dad started his medical career more than sixty years ago, it is easy to find it as it has become a tourist attraction thanks to Che Guevara. The hospital has not changed much since the time my parents were stationed here. It stills conserves its Spanish tiled roof and has an inner courtyard with an overgrown garden in the middle. The courtyards is enclosed by covered hallways supported by white columns. The wards and clinic rooms can be accessed from the hallways. Although parts of the structure are in disrepair, the hospital is still in full operation. The German nuns are long gone, the hospital is now run by a contingent of the Cuban Medical Brigade that has been providing health care services to the population of Vallegrande for the past decade. The Cuban physicians are part of a program of medical assistance established by the Cuban Government that has exported hundreds of Cuban health personnel to Bolivia.

The colonial fountain of the Vallegrande Plaza after a thunderstorm

I speak with a Cuban physician that has been working in Vallegrande for the past two years, He is from the Province of Holguin in Cuba, and tells me of the special significance for Cuban physicians to work in the area where Che fought for his ideals and the revolution. Justo is his name, and he will be staying a total of three years in Vallegrande as part of his commitment to the Cuban Medical Brigades. I tell Justo about my dad and his internship in Vallegrande, we talk about medicine, the Canadian system of health care, Bolivia, Cuba, Che and the Revolution. Justo invites me to do "rounds" and we visit the hospital wards and interchange ideas about some difficult cases. I think about my dad and the challenges he faced as a recent medical graduate in a remote rural community with few resources and the heavy burden of being the only physician in town.

It is time to visit the "shrine" Justo says; we walk out of the main hospital building to the ground behind the buildings. There in the middle of a grassy space is the open laundry hut that housed the lifeless body of Che in 1967. This humble hut has become a shrine for Che Guevara. Its walls are covered with graffiti, poems, slogans and deeply felt words of homage to Che. The washing basin on which his lifeless body was exhibited still stands. A few artificial flowers deposited on its surface gives the bleak concrete a touch of color. The rain and the grayness of the day permeates the scene with solitude and sadness. We are the only visitors at this time, but Justo tells me that the place receives scores of visitors that take the "Ruta del Che" tours, the majority from mere curiosity, attracted by the worldwide fame of Che - but for some it is a sort of pilgrimage.

The Vallegrande hospital, Nuestro Señor de Malta

For the people of Vallegrande, Che has not only become a source of badly needed tourist-generated cash but a kind of a saint. People light candles and pray for "Saint Ernesto" and people have faith in him as a positive spiritual force. "Saint Ernesto" has become the unofficial and widely venerated patron saint of the people of Vallegrande, having displaced the Nuestro Señor de Malta. By the time I finish my visit to the Hospital and Che's shrine, it has stopped raining and the sun is timidly peeking behind some dark clouds. Justo invites me to have a coffee in the main square. We climb the crumbling stone stairs of one of the colonial buildings flanking the square, a busy coffee shop is bustling with activity in the second floor. We are given a table close to the window with a magnificent view of the town and the church bell towers. We order coffee and cheese empanadas.

An elderly lady that appears in her late seventies brings the coffee and the empanadas, she is the owner of the coffee shop and she asks me the reason to my visit Vallegrande. I tell her the story about my parents and their time in the

The author in front of a mural in commemoration of Ernesto "Che" Guevara

village, she seems surprised and immediately says -El Dr. Mendez! She tells me that her name is Margarita and that she was one of the orphans that delivered milk and bread to my parents every morning; she remembers them well. Her eyes become teary and she gives me a spontaneous hug and somehow in her gentle arms and warm embrace I feel that I have closed an invisible loop of time and space.

About Dr. Ivar Mendez

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

Dr Grondin performing the first heart transplantation in Canada

Dr. Michel Carrier is a cardiothoracic surgeon working at the Montreal Heart Institute. Dr. Carrier specialised in heart transplantation and mechanical hearts and this explains his interest in those who pioneered the field of organ transplantation. He is the Chair of the Department of Surgery at the University of Montréal, largest department in North America offering surgical training in the French language and the second in Canada for its overall clinical, teaching and research activities.

Road biking is his favorite physical activity and he always carries his camera. Nowadays, a simple cell phone can make good pictures, but he remains loyal to his Nikon digital camera.

CARDIAC SURGERY IN CANADA: A French Language Perspective

Michel Carrier
Montreal Heart Institute

I did all my medical training in Quebec, from medical school to general surgery, ending with the cardiothoracic and vascular program. After completing these degrees, I spent two years at University of Arizona under Dr Jack Copeland, chief of cardiac surgery at the time, training in the heart transplantation program. One day in the OR, a colleague resident in training asked me the following question: " Do you really practice cardiac surgery using the French language in Canada?"

At the time I was, and still am, quite a bit surprised by this question. It was so obvious to me that cardiac surgery would be performed in our native language, French, especially in Montreal and in hospitals across the province of Quebec. But where did it all start, who pioneered cardiac surgery in Quebec?

Many renowned French Canadian surgeons were instrumental in developing cardiac surgery in Montreal and Quebec hospitals. One particularly stands out however for his dynamic and innovative approach to cardiac surgery, Dr Pierre Grondin, who performed the first heart transplant in Canada in May 1968 at the Montreal Heart Institute. He was the first pioneer in cardiac surgery to really strike the public imagination and he did it in French first and foremost, and he did it in a brilliant and dominant way.

Following this first heart transplantation, several generations of physicians, anesthesiologists, cardiologists and cardiac surgeons followed in Dr Grondin' steps with important research and discoveries helping to establish Montreal and Quebec as world leaders in the field of cardiovascular medicine. All these achievements came while naturally using French to exchange ideas, living in a French Canadian culture and in a French Canadian environment.

In the cultural mosaic of the Canadian environment, this should be seen as a thing of beauty, and we should be truly proud of it.

THE TOUR

Ron Nguyen
Geneal Surgery Resident
Queen's University, Kingston, ON

PREAMBLE

This is a true story, but it is not an honest story. It is a story about the Canadian Resident Matching Service (CaRMS for short) and the tour that medical students embark on to hopefully be matched to the training residency of their choice. In particular, it is a story about my own CaRMS tour to hopefully be matched to a general surgery residency program and the experiences that came along with it. However, I have chosen to leave certain damaging details out of the story as it involves individuals that I work with or will ultimately continue to associate with, and that is why it is not an honest story. While some people may be disturbed that a person cannot fully express themselves with their writing, that is the reality of also being a participant in a professional workplace. With that being said, I feel that this is still a true story, one that will have to be serialized in separate parts because of my own emphasis to remain truthful and my article having run quite long as a result.

Ronald Haisen Nguyen is a general surgery resident. He was born and raised in Calgary, AB, and cmpleted medical school in Saskatoon, SK. he is now a general surgey resident in Kingston, ON.
His first publication, a short story entitled "Something Happening Somewhere", was printed in "Unsettled" magazine.

PART I

It was the night before I was about to head off to Edmonton for my first elective on general surgery, and I was sitting on a chair in a new backyard patio that my girlfriend had spent the whole day setting up and making a small haven for us. On this warm August night, we sat on these new patio chairs, breathing in the unsettling scent of freshly cut grass mixed in with the smoky, ashen air that had originally risen from the forest fires in British Columbia, trying to enjoy these last few moments before I planned to be away for the next six weeks on this electives tour. My girlfriend was looking at the skyline, with a cold beer in her hand, the moisture from the bottle dripping down to her thighs, the skin stained with muddy imprints from her hands. The sun was still high, coloured with an unusual palette that the smoke had dabbled with its paintbrush across the sky. It was brushed with hues of muted orange and light blue that made it seem like a world not of our own but perhaps out of the imagination of a dystopian writer, although the skis had its own unique beauty and sense of wonder attached to it. As for myself, I had a guitar in hand, trying to strum together a melody that would bleed like the madras shirt I was wearing, bleeding into night and colour the air like this summer sunset.

The next morning, with my car packed with what I needed for the next six weeks, I had a long embrace with my girlfriend, then I gave a good pat on the head to our dog. She was planning to go for a walk with the dog right after I would drive off, and as I drove away, I kept looking at the rear and side view mirrors at their figures, and then eventually at the remnants of their shadows, until the law of optics wouldn't allow me to do so anymore.

The drive was around five hours long, and it was nice being on a double lane highway. What that meant was that I could have the time and space to think and contemplate, not having to worry about passing cars and oncoming traffic. Although the storm that came interrupted that contemplation a little, I was still able to think about my life and how I got to where I was at that moment. Of course, I got here physically by following the directions of an application on a phone, but the question I was thinking about was how did I end up in this particular position, in this particular time? My life had not gone as I had expected since my first leave from medical school six years ago. All my plans, all the things I had thought for myself and for my life, none of those came true.

I then started to remember the feeling I had just before I left from Saskatoon. I was in a cafe, reading Haruki Murakami's, "Kafka on the Shore", and there was a scene that had one of the characters, a young boy named Kafka, looking upon himself while his physical body slept in a bed. That passage made me think of another scene I had watched in the new Twin Peaks television series, created by David Lynch and Mark Frost, where the main character, Cooper, arrives at the climactic scene and the image of his face with a stunned expression was superimposed upon the scene that was playing out before him, his physical entity still in that scene.

I felt like Cooper, like Kafka, with the realization that at a certain point in one's life, if you have experienced enough of life, to have the feeling that after having 'been deserted at the bottom of a well, to have traveled to the edge of the world' as Haruki Murakami would say, that you emerge from those experiences as someone else, as something else. Another self, a self that is the same in appearance and in collective memory as your previous selves, but a different being as a whole. At that moment, I felt like the person from the last six years was not the self that I was now, and the self before the last six years was not the same as the self before that. This new self, with the ability to look upon its past selves, like dreamers that live inside a dream, would be embarking on this tour and this tour would be the culmination of past, present, and future… of both time and of identity. All of the lessons that I had learnt from the last six years, all of the pain and confusion that had come along with it, would collide all at once during this time in my life and direct me

onto a lost highway, deciding the fate of where I will go and what I will ultimately do...
I finally arrived in Edmonton late into the night. The apartment I was staying in had belonged to the partner of a resident I had worked with earlier in the year. All I was really told that it was in a great location and that there would be parking for my car. That was what she told me, and I had assumed that there would be the usual amenities that comes along with modern households. That wasn't to be the case though, and I didn't realize that until I pulled into the apartment building, looking at the text from the resident who had finally mentioned that there was no internet and that the apartment, 'still had the air of a bachelor pad.' When I entered the apartment, I thought that a more accurate description would have been a bachelor pad after a party. After looking around the apartment, I settled on the best solution of just setting up a single fan that laid in the corner and sleeping on the couch that was positioned across from it. It was around midnight when I finally got to bed, and rounds would be at the hospital started at 6 AM, and I slept with beads of sweat dripping along the back of my ears.

I woke up at about 3:30 AM, before my alarm clock that had been set at 4 AM. I had learned on my surgical clerkship rotation that waking up early was the best for me, as I felt I could study with a fresh mind and in solitude, without having the wear and tear on my mind that often comes with long surgical days. I showered quickly, dressed in a pair of scrubs, and ate a quick breakfast. I studied a little bit, trying to cover some points of the vast field of topics associated with surgical oncology, a subspecialty of general surgery that I didn't have much exposure to during my clerkship rotation in medical school. Before I knew it, it was 5:15 AM, the time that I thought it would be best to leave the house.

I followed my phone's map applications directions to the Royal Alexandra Hospital. I eventually found the atrium of the hospital, the area still bathed in the moonlight of the fading night, but approaching the time of the day known as the blue hour, with its very particular hue of blue that filled in the cracks in which the moonlight did not fill in. The moonlight seemed to blanket the workers that were sleeping on the benches and chairs, and by their scrubs they were wearing, it seemed like they could have been the nursing staff or care aides of some sort.

Through the atrium, I entered a glass elevator, riding up to the fourth floor where the general surgery lounge was and where I was to meet for handover at 6 AM. After getting off the elevator, I went a short way down a corridor before I was able to quickly find the room. The lights were on in the room but there didn't seem to be anyone in there. I tried to open it, but the door was locked. I waited by the side, watching as the custodial staff were doing their duties before their work would be trampled upon again by the day workers. Soon enough, another elective student joined me waiting by the side. It turned out this elective student was also from the University of Saskatchewan, and she was even in my class, but I didn't recognize her because she was at the Regina site and I was not originally a part of her graduate class. She told me that she would also be there for two weeks, but she had two different preceptors and were on separate teams for each week because of it. I then felt like I was a little lucky to only have one preceptor for the next two weeks, which meant that I was likely to be on one team for the duration of my elective, and that they would hopefully get to know me as a hopeful candidate and the real person behind that candidacy.

My preceptor for this two-week period was Dr. McCall. I had asked a couple people I knew in Saskatchewan, that had gone to the University of Alberta, if they knew anything about him. They both had said he was very nice and that he was a "good dresser." At the time, I didn't think much of that comment, although maybe I should have since it was mentioned by two separate people, but my initial reaction was, "I've seen physicians dress before. How well could they dress?"

It was around 5:50 AM when the doors finally opened

to the surgical lounge. A couple of residents were on the computers, a few other residents walked out from the side rooms with bed head hair. I placed my bag down in a corner, looking around to see if someone would guide me in the right direction.
The first person to help me, Kieran, was a first-year general surgery resident and he was actually on the same team as I was as the junior resident. He quickly introduced me to my chief resident, Aman, and my senior resident, Jessica. After these brief introductions, 6 AM had struck, and the room fell silent. The three chief residents sat at the main table, while the rest of the residents and medical students either sat in surrounding chairs or were standing around. I stood as I listened to one of the chief residents make a statement.

"Hi everyone, this is a new block. We have some off-service residents, some medical students here. The Alec is the busiest hospital in Alberta. There is a lot of work to do and we work hard here, and you are expected to keep up with that kind of work." After that brief and direct statement, the chief residents handed over the patients and issues from the night before. This was all done in about 10 minutes or so.

Once handover was over, we met with our teams. We were each given a list with the patient's name and location. I was told to follow Aman and Jessica, and we were then split into the different sections of the hospital with the patients on the list.

When we left the room, I looked down for a quick second to look at the list I had been given and which section we would all be going to. When my eyes looked up from the paper, it seemed like my team was more than halfway down the hall, and I speed walked to catch up to them, with a pace that seemed like it would be able to qualify for a position in the speed walking Olympics. When we reached the first section on the chart, I looked for the patient's name, but before I could find the name and the corresponding chart, I had the chart shoved in my chest. I looked at the chart and its dividers, looking for the section for progress notes and orders. I could find the section for progress notes, but not orders. I would soon find out that these sections were split in half on the same page, a clever way that I would not see replicated by another hospital, as it helped by not flipping back and forth. After finding the progress notes, I walked into the room with the chief and senior resident.
My patient was second on the list, and I was told to go and get started on the note, but when I got there, I couldn't find the vitals chart. By the time they got to me, they pointed out where it was and they quickly said, "AVSS, afebrile TMax _, O2 Sat was…". I tried to get all the values down, the ones that I had been taught in medical school to clearly delineate, but they took it away before I could. They asked their questions to the patient concisely and with precision, and I quickly abandoned my longhand notes for shorthand abbreviations that seemed more like codes, so that I could catch up with their diction. I wrote down the orders that I thought they would anticipate, and when I presented it to my senior resident, she said, "Always write an order designation for IV line and diet, for every patient". It was an interesting protocol, one that I also never see replicated in any other hospital I went to on the tour.

The rest of the rounds went on in the same manner, with the same kind of frantic frenzy with becoming familiar with a new system and a new set of expectations that seemed to always be just a little out of my hand's reach, just at the distance that a Olympic speed walker would leave a normal pedestrian walker behind.
The rounds ended before 7:30 AM, which was the time that the operating rooms were starting to get prepared and handover to the attending staff physicians would happen.

However, this morning, none of the surgeons on Team 1 had any surgeries, and there would only be clinics. I met Dr. McCall at around 8 AM. My first impression was that he was indeed a very well-dressed individual, and not only was Dr. McCall well-dressed, but he was sartorially inclined. He wore a royal blue suit that was patterned with a red windowpane, with the cut of the suit in the fashionable and

softly constructed Neapolitan style. He accessorized the suit with a maroon 1/4 roadster zip sweater, with a white spread collar shirt and navy silk grenadine tie in a four-in-hand knot underneath. With his relative youth and build, he looked like he could have walked off the pages of a catalogue for a bespoke Italian tailoring house.

That being said, even though the topic of clothing would be something Dr. McCall and I would bond over the next two weeks, I knew that my knowledge of tailored clothing or sartorial understanding would not contribute to any sort of first impression as a medical student doing an elective in general surgery, and all that mattered for this morning would be my clinical skills and surgical knowledge.

By the time he had arrived, there were two patients already in the rooms. He asked me to see one of the patients, and after making some quick notes from the information in the chart (I did not have computer access yet), I went to see the patient in the room. I had spent about twenty minutes seeing the patient, and after leaving the room and making some quick notes, I turned to Dr. McCall and said, "I'm ready to present."

"Go ahead", he said.

"So, our patient is a 45 year old male coming to the clinic with regards to...his presentation started with...on examination, he did not appear in any distress and looked stable... looking at past investigations and notes..."

"On assessment, we have a 45 year old male presenting with... in terms of a differential, I was thinking of...in terms of a plan, I was thinking we could do..."

When I had finished, Dr. McCall said, "That was very good! I'm impressed." When he had said that, there was a sense of both relief and validation as the training I had received could meet the standards of this seemingly lofty centre. I had heard from people in the past that the medical students at the University of Saskatchewan were well-trained in terms of clinical skills and it felt good to know that I had not been spent my efforts in vein.

The rest of the clinic went as smoothly as the first visit, and when the clinic was finished, I met up with the rest of my team. It was summertime, which meant that physicians could possibly be on vacation or at conferences, a time known as, 'Summertime Slowdown'. With none of the surgeons on our team having anything for the afternoon, the senior resident told the junior resident and I that we could have the rest of it off. Kieran, the junior resident, was surprised at this as if this had not yet happened at all during his brief start to residency, and he offered to take up all kinds of duties for his senior residents. The senior resident, Jessica, then said to him, "Trust me, I just came off a research year, and there won't be many days like this, but there will always be surgery. Go take the time to do the things that you don't have time for when you have busy surgical days."

I woke up at about 4 AM the next day, without an alarm again. I tried to review the notes that Kieran had given me, and I tried to read a little bit more into colorectal surgery. I was able to get a few salient points through the fogged lenses of my mind, but before I knew it, it was once again time to drive over to the hospital.

Handover was at 6 AM again, with the subsequent rounds finished at a lightning pace once again, except I didn't seem so out of place this time. I was able to remember to put the designation of IV and diet for each patient, writing down the orders for what I believed the residents wanted for the patient, and able to write a concise and precise note for the patient.

Dr. McCall had operations scheduled that day, with all of the patients presenting with colorectal cancer and their operations typically revolved around removing the half of the colon that contained the cancer.

The operating room was busy with people around the table. Not only was there the scrub nurse and one of the nursing trainees, there was Dr. McCall, the chief resident, the senior resident, the junior resident, and me. Kieran wouldn't be

there long, only staying for the first case before going back to the wards to take care of the patients on the ward, as typically expected for the first two years of a surgical residency. I had the task of what junior learners are to be expected to do when other senior residents were around: helping retract the surgical space and cutting the suture scissors. With that many people though, I didn't get to see very much of the surgical space, so my eyes focused on the position of my hands on the scissors.

When it came time for me to cut the suture, my scissors came together to make a dull thud along the sutures, and it took me a few times to cut it. There was nothing said for this first incidence, but the next time it happened, Dr. McCall said, "Were you taught how to hold the scissors properly?" I had cut sutures plenty of times beforehand, but when it came to the question of whether I knew how to hold the scissors properly, I could only respond with, "Uhs, um, uhh"...

Dr. McCall asked for the scissors and showed me that the hinge must always be faced upwards, and that the blades had to come together. The senior resident took the scissors afterwards and showed how the scissors were for right-handed people, and how the scissors could be used effectively with the left hand while the right hand could use a pair of clamping devices to hold the sutures in place while one could cut with the left hand afterwards. I tried the left-hand technique for a little bit, but it did not go well, and I went back to trying to perfect the right-hand technique.

Who knew that so much technique could be associated with suture scissors?

At that point, I had already felt that I wasn't making the greatest impression, when the questions started coming. Some people in the medical community call this pimping, when the questions just start coming about the task at hand. They can be relentless and sometimes can feel humiliating to the person who receives it. I was both lucky and unlucky in this case, as I was lucky that Dr. McCall was not the kind of person to humiliate another person about their lack of knowledge on a subject, but I was unlucky because I kept getting the answers wrong to his questions. "What is the blood supply to the terminal ileum, what vessel supplies the right colon? What structure lies over the transverse colon?" These are all fair questions for a hopeful surgical resident, and unlucky is probably the wrong term as I should have known these answers, but its hard to know something without actually seeing it in person. After getting these questions wrong, Dr. McCall showed as much as possible the anatomical structures that were the answers to these questions.

Later in the case, Dr. McCall said, "I hope you didn't feel too bad or pressured with all of those questions."

"No", I said, "that's how you learn."

"That's true", Dr. McCall replied, "That's what the questions are for, to learn."

Emotion and memory, it's funny how closely tied those two are together, isn't it? Like a marriage of conscious consciousness, that consummates to give birth to the child known as understanding, that's how my two weeks on my elective at the University of Alberta felt like. This general surgical residency program had the reputation as one of the finest in the country, and while my home program at Saskatchewan trained me very well, this centre would provide me with the high expectations and standards I would carry with me throughout the rest of my electives tour. While the elective felt like I was constantly tripping on my own feet, every night, I would read and read and read so that I would not try and be in the same position of not knowing what I ultimately needed to know to be a surgical residency candidate. That effort would be eventually be rewarded with a reference letter from Dr. McCall, the first letter of reference of my tour.

The reward of faith, a belief that is so difficult to regain once it has been lost after emerging from the bottom of a well, from the edge of the world...

TO BE CONTINUED

Poetry Corner

BHAVNA POONI

Bhavna is an operating room Nurse and Operative Nursing instructor in Saskatoon. Originally from William's Lake, BC, she will be moving back to BC later this Fall - and to the wilderness and mountains of her youth.

Of her love for Poetry, Bhavna says: "as a young child I was encouraged to express myself. "Bhavna" in Hindi means feeling, or inner-most desire.

I first started writing poems in Hindi and the multiple avenues I seek to explore through my poetry are those of love, sorrow, kindness and joy.

TIRAMISU

Cake flickers:
Mountainous candle lit
He felt the ocean free
The breeze can take this wish
And let it be

Standing in smoke
Drenched uncertainty

Lost in this haze
Eyes welled full

Blanketed pillow top clouds
Drifting into thunderous
emotional storms

Deleted old heart
Bi-passing burnt love

No more stitched routines

Happy tiramisu

CHRONICLES OF LONGING

(in no particular order)

Aug 15, 2014

Some days, I'd rather have eternal blindness...
Frustrated ...not meeting your gaze

These matches all damp
Has left this lantern unlit

Searching for sweetness
I receive empty promises

Searching for fullness
I am left in empty corridors holding ...
meaningless compliments

Searching for your curious soul...
I stumble upon self serving minds

As each of these paths.. lead me closer to you
I walk forward with patience

For I will wait a million moons

April 26, 2014

Trite eyes
Characterized by hackneyed expressions
Your long lensed ideas
What did, should and could banter
Sickens this soul

Shake off your laze
Your reservations about the future
Drenched in yesterdays tellingly pains
Your hesitant fearful heart looms on ur horizon

What did u show up to do?
nonentity

December 01, 2015

The holiday season of giving is among us.

There is always a choice of what to give.

Being able to give ...can feel good.

To give hugs, give light, give time, give smiles, give gifts and give more... More more more.

But most importantly ... There's another kind of giving ..

To forgive.

To forgive ourselves, those around us and beyond time

When we are truly able to forgive... we allow ourselves to let go and feel peace.

As my parents would say.. Maybe even some shanti (translation-peace)

Aug 28 2017

I'd kiss you like I want you
And I want you more than a kiss!

The only kiss I don't know
Is the kiss I haven't felt

I know the feeling of the
Kiss of the moon
Kiss of the light
And the kiss ...I have never felt ...
I patiently wait

Aug 18, 2014

1+1 is you

I lay awake
Awaiting for your arrival
My patience is growing slim
I would rather .....wake up with amnesia

Waking in a daze
Thoughts blurred in love drenched .. honest hope
1+1 is you

Laying in this empty monotonous day
Why not ...wake up with amnesia?
If I can't feel your embrace

May 21, 2018

Sometimes
Some days
I think about

What it would feel like
When someone says..

I love you first ..
I love you ....in between perhaps my day
An .... I love you morning

What would it feel like
To not feel like an inconvenience

Wondering, waiting ...
when I will be someone's exclamation
.....sealing my heart at the end of love!

May 08, 2015

Milky Ways

Rising from the ground
Reaching
Focusing
Head tilted back
Eyes above
Beaming towards the star
The star I see
I bestow my hopes
That ur eyes meet me upon this gaze
Filling the hunger of this sleeplessness
Into heartfelt hopes
You see my love
Tired soft eyes of mine
Search for you every night
Tell me where you rest your soul
For I will wait
A million moons

April 23, 2018

I am awake
Because you are not here

My first thought was to write about him
The past

But now
I am writing about you
The future

Dec 17, 2017

Maybe the right timing
Maybe the right reason
Maybe jus the right maybe

However .... it feels real...
It feels now
It fills the half ounce ...of forever

Birds don't plant roots of faith ....
We sit
Sit upon branches of uncertainty
Uncertain vision
And take flight.....

To find the comfort in discomfort!

May 21, 2018

Unsteady
Not ready

Let it go;
Set your self free

And her.
When will it make sense here
The Sun is unavailable
I'll listen to the moon

Wading moon
Crescent moon
New moon
Full Moon

Crescent mobile moon
Leave me alone
Don't care
Do not disturb

Feb 09, 2019

To lay
Or to lie
Lay beside
Lie to self ...that no love is okay

Oct 23, 2014

Come find me at the edge of discomfort
Where your bliss is said to lie

Meet me in this hollow eerie space and feel .. this truthful soul

The lantern in your heart .... will guide you through this haze

For I will wait a million moons

March 13, 2015

To wake up everyday, to meet eyes of love
To exchange every silent thought, in every blink
And kiss with excited hearts of trepidation
As if it were the last
You are which made this soul faint....
Let's make life more dream like!

Oct 08, 2017

I've been happily lost in the forest
.... lost with in a cloud
.... lost in a river
.... lost on a mountain top

When will I be happily... lost in love?

Nov 02, 2016

When you aren't around, I miss that feeling

I know how the wind feels
how the light feels
how the river feels

But I never know how love is going to feel

Oct 01, 2017

There is a beauty to this fall
Falling in love

I fell in love
He fell into, "I like you"

Luckily, fall is just a season...
and so was his love!

Jan 05, 2018

Hear the picture
Paint the music

Sept 28, 2017

Open doors
Closed mind
You like me
You don't love me

The only like, I love ..... is like-minded

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.

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. This issue of the Journal of The Surgical Humanities concludes Jerry's life story with Chapter 8. Around the world and equally in the schools of life and surgery, his influence continues to guide, to educate, to encourage, to inspire ... toward a better world for us all, a better tomorrow..

LIFE STORY

Excerpts from the memoirs of R. M. Kirk

Chapter 8

Peptic Ulceration, Obesity Surgery, Seldinger Methods

I now embarked on some animal work related to what became an obsession. Chronic peptic ulcers were firmly believed to be related to the presence of gastric hydrochloric acid, secreted by special cells lining part of the stomach wall (named parietal cells; L paries = wall). The ulcers were nearly always discrete, singular and limited to certain parts of the stomach and the bowel just beyond it, the duodenum so named because it extends approximately 12 fingers breadth L duodeni = twelve). If acid is secreted into the stomach it would be expected to cause ulcers in the dependent part of the cavity and be diffuse, which they are not. I felt that if I could identify the reason for the site, singularity and discreteness I might contribute to less aggressive operations than were then employed to reduce the acid output. I applied successfully for a licence to carry out operations on animals, mainly rats and guinea pigs. I was supported by the animal house superintendant at the Royal Free Hospital. Any animals that were in excess of requirements by other teams were passed to me. I published my results. I never solved it. In the meantime Barry Marshall in Perth Australia earned the Nobel prize in 2005 for elucidating the background susceptibility to ulceration. The factors determining the site, singularity and discreteness have still not been explained. Marshall's development of a means of treating or preventing ulceration have removed the drive to explain the features I sought. Alongside my ulcer studies I developed a possible procedure to reduced weight in overweight patients. It had the advantage of being reversible. Patients were then referred to me for operation – but I could not bring myself to submit to a major abdominal operation when the obesity was simply the result of over eating. Britons were not overweight during the war, in fact it was claimed that we were healthier than ever before because of the well planned diet manipulation of rationing. At that period the subsidiary risks of obesity such as diabetes and the risks of aggression in some cancers were not recognized and the comparative costs of attempting conservative or surgical methods was not assessed. By chance I recently heard from a team in Moscow that they

had adopted my procedure in their bariatric unit. The increasing expertise of radiologists in passing fine catheters (hollow tubes), within body tubes including blood vessels for diagnostic purposes, excited me and I tried to design fine guidable catheters. I struggled without success, having failed to identify the method already worked out by Sven-Ivar Seldinger (1921-99). In 1952, after ineffectively trying to pass catheters within hollow needles inserted within blood vessels, he looked at three pieces of equipment on his desk – a needle, flexible guide wire and catheter. He explained, 'I had a sudden severe attack of common sense.' By first inserting the guide wire and then removing the needle, he inserted the catheter over the guide wire. The head of Radiology at the Karolinska Institute did not consider the method sufficiently important to merit a thesis, so Seldinger then applied the technique to catheterization of the bile ducts. We could not anticipate the subsequent explosion of therapeutic methods that would outdate many previous open operations and create the sub-speciality of 'Interventional' radiology.

Oesophageal Surgery

Although some operations had been performed on the oesophagus it was fraught with the need to open the chest. It was finally conquered in 1903 by Ferdinand Sauerbruch (1875 – 1951) working in what was then German Breslau, now Polish Wroclaw, by enclosing the patient in a negative pressure chamber. After the Second World War he worked at the famous Berlin Charité Hospital in what was then the Eastern German controlled part of Berlin. Later he became demented and was discharged but continued to operate in private – too eminent to be stopped.

Oesophageal cancer surgery in Britain carried a dreadful prognosis; indeed it is no triumph even now. The first difficulty was the lack of good imaging in order to assess the operability and likelihood of cure. I learned that in the Henan province of China it occurred at an epidemic rate, frequently, even in early adulthood. The local surgeon, Professor Huang had learned of a similar incidence in South Africa, where wheat grown in trace-mineral-deficient ground and used to brew beer, produced nitrosamines which are carcinogenic. The earth in Henan was also deficient in trace minerals. He evolved a screening test which allowed him to diagnose cancer at an early stage and treat it before it had spread. I was fortunate to be able to arrange for Professor Huang to become an Honorary Fellow of the Royal College of Surgeons of England. In Britain, too often we explored our patients only to find that the growth had already extended too far. Attempted radical (L radix = root; by the roots) resection was impossible and attempts carried a considerable operative mortality. Nevertheless, I was reluctant to leave patients condemned to oesophageal obstruction and a distressful death. I was able to introduce a palliative (L. pallium=cloak: mitigate or alleviate) procedure by adapting an operation described by Leslie Le Quesne (1919-2011), Professor of Surgery at the Middlesex Hospital. He had mobilized the stomach and drawn it up to the pharynx following excision of the larynx and pharynx for cancer. I was able to excise or bypass the whole length of the oesophagus within the central compartment (mediastinum) of the chest and draw up the stomach to the neck as a replacement. This was later popularized by an American surgeon.

Hiroshi Akiyama (1931-2012), brilliant Japanese surgeon, who pioneered many new techniques in the treatment of esophageal cancer.

I had some challenging problems with non-malignant oesophageal conditions. At one stage we had a team of Italian workmen to replace the terrazzo operating theatre floor. A concrete base is laid and before it is set, marble chippings are

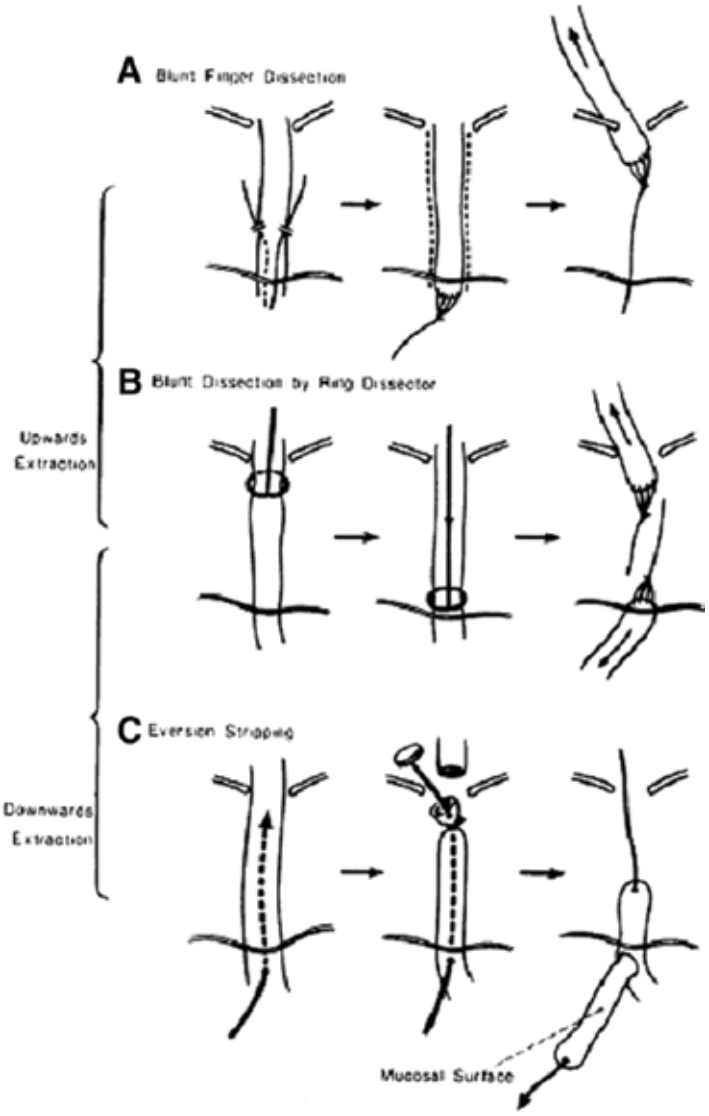
set in it; when the concrete is hard the surface is ground flat leaving facets of polished marble flush with the surface. One day a workman was rushed to me, the victim of an insane 'joke.' I was told that he had been given to drink what he thought to be coffee but was diluted Lysol disinfectant; Cresol in soap, which is highly corrosive, as a joke. I hastened to pass a large tube down his throat to wash out his stomach. Out flushed some fleshy rugose soft material. I held it up in order to decide if it was detached gastric mucosa. The conscious patient was able to see it and immediately tried to tell me something. I withdrew the gastric tube. In his broken English he managed to tell me that it was olives. They had been bitten but not chewed and the soft fleshy interior became everted, giving the appearance of a mucosal surface. Some joke!

My admirable teacher Dick Franklin had described to me a method he had once devised to relieve an impassable oesophageal stricture. I was able to repeat his method when I was sent a patient from another unit with a similar condition. He needed to be fed via a gastrostomy - a permanent stoma (G. = mouth) through the abdominal wall into the stomach. I made use of a radio-opaque thread of the type that is routinely woven into abdominal swabs/sponges. They can thus be traced radiologically if the swab is inadvertently left within the wound. I tied one end of such a thread to a long silk thread. After passing the free end of the radio-opaque thread through the patient's nose into the pharynx I fixed the loose external silk thread to the cheek with adhesive tape. As the patient unconsciously tried to swallow his saliva it carried the thread through the stricture, identified within the stomach by radiography. The lower end of the thread could be captured by forceps passed through the gastrostomy. By exerting gentle traction on the withdrawn lower end, more thread could be drawn through. The proximal end was attached to successive lengths of thicker thread. Eventually the tip of fine filamentous dilators could replace threads. Thereafter, thanks to Dick Franklin, the stricture became amenable to conventional methods of dilatation, insertion of stents and closure of the gastrostomy with resumption of oral feeding. Sadly, on another occasion a soft voiced, soft eyed Irishman was brought in having intended to commit suicide by swallowing some corrosive substance. In spite of our desperate efforts to resuscitate him he died, unable to speak but with his eyed fixed on me as I stood with him. The tragic pleading eyes following me, the almost tangible feel of them on the back of my neck when I turned away, were to me more intensely moving than any spoken word.

I was eventually fortunately able to establish a wonderful relationship with a brilliant Japanese surgeon, Hiroshi Akiyama (1931-2012). Using the latest high resolution imaging, allied to superlative technical skills, he transformed the surgery of oesophageal cancer surgery. I visited him and sent two of our trainee surgeons to work with him in Tokyo. He thereafter wrote the appropriate chapter in my operative surgery textbook which is still extant, Kirk's General Surgical Operations. Sadly he has died but his successor continues to contribute to it. I was delighted to obtain for him and for Professor Huang, the Chinese surgeon from Henan, the titles of Honorary FRCS.

Writing

As I read and watched in order to increase my knowledge, I became aware of the personal and professional problems faced by beginners. Tony Rains, the first Professor of Surgery at Charing Cross Hospital, had given me advice on the structure, though not the content of my thesis. He was struggling to compete with the other London academic departments in producing research results from his department. I no longer had any official connection with him but had successfully presented my thesis, acquiring the meaningless but important Master of Surgery (MS) to my name, and published clinical and animal research. Tony asked me to cooperate and strengthen his team. I was delighted at the invitation and we presented work to most of the academic groups. I was becoming more and more interested in writing and in reading critical research.



Diagrams from the pioneering 1975 paper by Japanese surgeon Hiroshi Akiyama, illustrating his techinques for transhiatal esophagecotomy. *Akiyama H, Hiyama M, Miyazono H. Total esophageal reconstruction after extraction of the esophagus. Ann Surg. 1975;182(5):547-552*

I wrote a small handbook, 'A career in medicine,' with advice on basic attitudes for newly qualified doctors. It was not a success (in 2016 I wrote a short paper updating some of the advice; it suffered the same fate). I then embarked on an introductory book 'Surgery,' recruiting two friends who had special skills and knowledge beyond mine, together covering between them about a third. I asked the publisher to advise me on the legal requirements for incorporating them. He insisted that there should be my name alone as author. My contributors agreed. I asked the publisher's advice on formalizing the agreement; his advice proved to be fallacious. My two contributors agreed to be named only as contributors but when they saw the printed covers they changed their minds, demanding to be named as joint authors. The publisher refused but when they took out injunctions, he abrogated his responsibility, leaving me to face them. In my ignorance I paid for expensive legal advice and also for the covers to removed and replaced with the added names. Thankfully our friendships were later restored but I had learned the lesson. Thereafter I insisted on retaining the copyright on all my books. The duplicity of commercial publishers was a revelation. My publisher, an international leader, announced that the German branch had decided to publish one of my books in German. It turned up, re-written by two Munich surgeons as named authors under the publisher's copyright. My name was diminished to 'based on' status. Despite their bare faced illegality, they refused to destroy the books until I mounted several authors' associations capable of challenging them. I made the publishers destroy all the 4000 books they had printed, even though it deprived me of becoming widely known in a prestigious market.

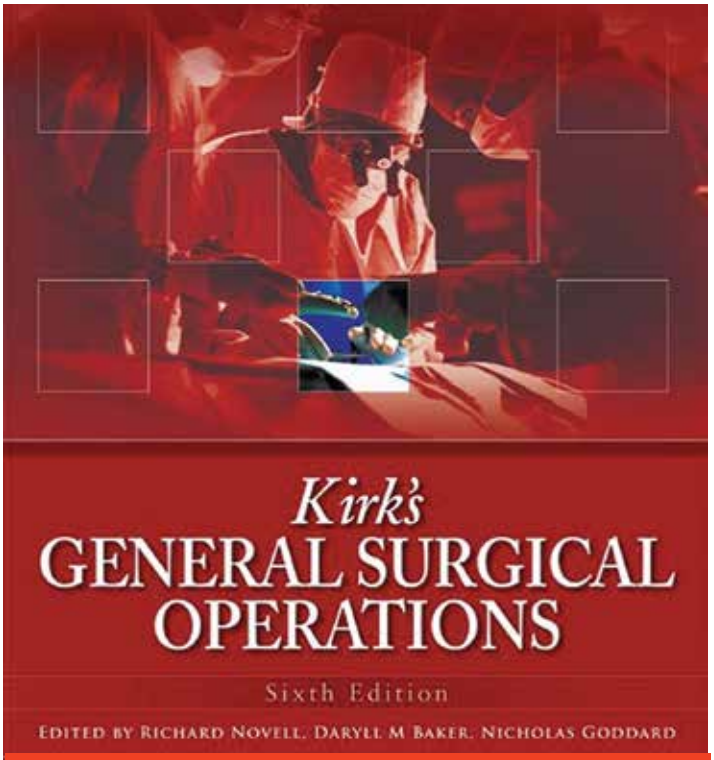
Tony was already Editor of the Annals of the Royal College of Surgeons of England and invited me to join him as Assistant Editor. It is remarkable how small incidents trigger momentous results. This appointment opened the editorial and authorial doors for me and drove me to acquire some scientific rigour. It brought me into closer contact with the College of Surgeons and to the attention of the leaders of the profession. I worked ferociously, running between two hospitals, reinforcing my upper gastroenterology knowledge and experience. Because of the intense competition for adequate numbers of specialist operations in London, I did not accumulate large numbers of patients but I managed to devise and publish new approaches and techniques. At that time nearly all surgeons pursued individual techniques. Very few followed the original descriptions and the differences made it unscientific to compare series. Success was often attributed to some individual technique or material.

Many years later, one of my former students, Professor Andrew Kingsnorth, had achieved the Presidency of an international hernia society. I asked him to take over from me the chapter on repair of inguinal (L.=groin), hernias that I has edited for some years. The almost universally employed operation in the first half of the 20th century had been described in 1884 by the Paduan surgeon Eduardo Bassini (left 1844-1924). My friend was now too busy but suggested that I read the original article by Bassini, since the description I had written in my book differed markedly from Bassini's. He was correct. He later asked me to present at an international meeting the reported results following Bassini's operation. I could not. Why? I could not find a genuine Bassini operation. Almost every surgeon had developed his own version. Selection, incision, anatomical replacement, technique, materials, follow up, differed from one operator to the next – not to the next but all the next! The reported outcomes? My memory is uncertain but I believe the 5 year rates of recurrence varied between 2% - 30%. These were the reported rates; what of the un-recordable, undisclosed results? Even an ignorant amateur statistician such as me could detect something amiss. I am converted to the need to prove the benefits of individual methods. Individual performing alone, with unreported outcomes is no longer permitted, being condemned as 'cottage industry' methods.

Edoardo Bassini (1844-1924) - Italian surgeon. Apart from describing the operation that bears his name, Bassini introduced Lister's antiseptic methods to Italian surgery.

When Tony retired from the Annals editor-ship I inherited it and worked hard to raise its profile. It had been an 'auntie' journal. Nearly every paper alluded to John Hunter (left 1728-1893), the 'patron saint' of the College and of 'scientific surgery.' It seemed impossible to read a paper which failed to mention his contributions. Papers were accepted by the editor 'on the nod.' I determined to introduce rigorous reviewers for every submitted paper but retained the right to refuse well-reviewed papers if they did not conform to my ideas of a progressive viewpoint. I abandoned the Editorial committee and declared that I was not interested in hero worship, even of Hunter. Annoyingly, there remained 'in-house' reports including committee announcements. I was soon able to sequester them in a separate Annals Bulletin. I had found my round hole in which I could flourish. The reputation of the Annals climbed and we were rewarded with a better standard of proffered submissions. By good fortune I was helped by a series of excellent hardworking colleagues and assistants. I gradually realised as my hunger for surgical success diminished, that here was where I could use my energy – and feel that I was making a useful contribution. I owed a great debt to Barry (right, now Sir Barry) Jackson, an eloquent writer who quietly and assiduously edited the contributions. He followed me as editor and vastly surpassed me by becoming the President of the Royal College of Surgeons and of the Royal Society of Medicine. I survived a few encounters with seniors, refusing to publish an article for the then current President of the Royal College. On another occasion, a previous one accosted me in the corridor. I was obviously not quite the 'right stuff,' so did not merit being addressed by name – 'You,' would do. He told me that he had left the notes he had made for his eulogy on some former well-known colleague, on my desk and I could put them together for the Annals. I did not highly rate the scientific or surgical importance of the subject's contributions and offered to write 5 lines, since I was anxious to promote the College's future rather than its past. He never spoke to me again. By now I had embarked on writing a series of textbooks; counting new editions I produced well over twenty books and at one period had four in print at the same time. Medical journals

seem to be written in passive, circumlocutory clichés. I presume that this gives greater weight to the content. An action was described, 'The surgeon should take the scalpel in the right hand. The incision should be...' I changed the mood into the imperative, addressing the reader directly, 'Incise the ....' To my astonishment and great delight, I gained a reputation as an effective writer – one I had envied but never expected to achieve. Two of them are still in print. I am proud that a group of Royal Free Hospital colleagues under the leadership of Richard Novell have produced Kirk's General

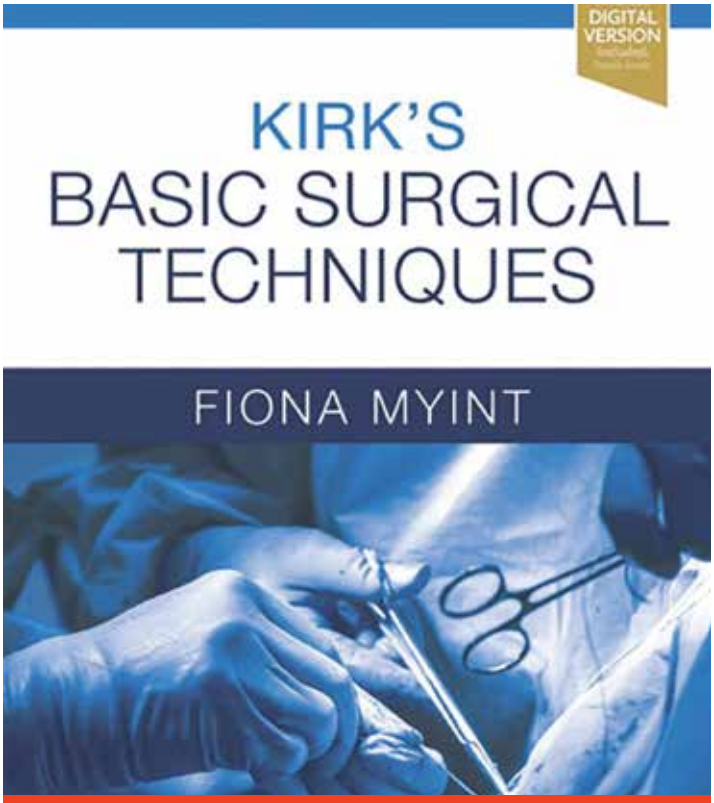


Cover of Jerry Kirk's very popular textbook of operative general surgery - which takes a direct, practical approach to teaching general surgical operations to surgical trainees and surgeons at all levels.

Surgical Operations 6th edition (right). An esteemed teacher, vascular surgeon and member of the Royal College of Surgeons' Council, Miss Fiona Myint (left) has produced Kirk's Basic Surgical Techniques 7th edition; under her editorship it has won the 2019 BMA 1st prize in Surgery. All the contributors have delighted me by retaining the style of the previous editions. In retirement I struggle in my attempts to write more elegantly. At some stage I came across the advice to avoid unnecessary modifiers – adjectives and adverbs, by eclectically identifying appropriate nouns and verbs. This brought me to Roget's Thesaurus. It reveals the justified claim that English is effectively the richest language of all. We have avoided having a committee ordering which words we may and may not use. We have absorbed words from every nation that we have come into contact with, including many from our vast Empire. Essentially, one third is Teutonic, two-thirds Romance (Latin, French etc). A probably correct statement was made by an American Philologist that only 2% of English words were coined locally. Countries that insist on local words only, will in the future always fall behind, because in the explosion of international communication the advancing countries will coin new words as necessary. At present American dominance ensures that English will be the lingua franca.

The facility for writing and communication has undergone a miraculous growth during my life. The slate on which I started has been transformed. I was recently amused to hear a discussion about the truncated words and acronyms used by youthful text messagers. I was reminded that in my youth telegraphic information transmission was expensive – I think a penny a word – when a penny was valuable. Recourse to word-shrinkage was rife – but for economic reasons. Amusingly, on one occasion, some important activity occurred at a location in which the London Times did not have a correspondent. They discovered that an Australian journalist was present and patronizingly requested him to send a report by telegraphy. They sniffily criticized it when it arrived and demanded an edited account. He responded as cheaply as possibly, paying only two pence – 'Jobstuff arsewise.'

As I tried to improve my use of words, I lamented my neglect of classic languages. I became obsessed with word origins – etymology (G etymos = true). So often in science, they derive from Greek, sometimes passing through Latin. With the advent of electronic and web transmission we have almost instantaneous access to literature and information. While I



Latest edition (2018) of Prof. Kirk's book on basic surgical techniques which describes common techniques required of all junior surgical trainees, regardless of their surgical specialty.

was writing my thesis, I spent almost the whole of every free Saturday in the basement of the Royal Society of Medicine looking up references. Often the volume I sought was missing or the title proved to be misleading. If I knew what I needed I could apply statistical methods to measurements – using a six-inch long slide rule. Now I luxuriate in the possession of a mobile telephone cum reference encyclopaedia. If I need information I can obtain it now!

Teaching

WB Yeats, (1865-1939), the 1923 Irish Nobel literature laureate expressively stated, 'Education is not the filling of a pail but the lighting of a fire.' Somewhere, I read a quote, 'Experience is as to intensity not as to duration.' It was attributed to revered Wessex novelist Thomas Hardy (below, right 1840-1928). I scanned my copies of his books without success. Many years later, searching for bed-time reading at a daughter's house, I inadvertently dislodged a book. It fell on its spine and lay open on the floor. As I picked it up a sentence caught my eye. Yes, here was the original quote which I had seen, slightly modified. I looked at the title – 'A Pair of Blue Eyes,' – by Thomas Hardy. I had never previously heard of it. But I value its message! In concordance with it, I recall the sting of failures that have motivated me to prepare better and try harder next time. After delivering a paper at a surgical meeting, wife Peggy quietly said that it was sloppily presented. The realisation that she was right, sharply made me determine never to repeat a behaviour that would lose her respect for me. I have but to look back to my teachers at all periods of my life to appreciate the value of the ones who were committed and inspiring. They made the subject alive, of value. How propitious to spend almost the whole of my career within teaching establishments – medical school, hospitals, King's College London, Royal College of Surgeons and participating in international skills and teaching courses. Virtually all the many books I wrote or edited were intended to transmit and impart knowledge and skills.

To earn the gratitude of a pupil is an invaluable reward. I have been deeply moved by the occasional gentle tap on the shoulder from a former student giving me a smile and a quiet, 'Thanks for the teaching.' On occasion we are remembered for light-hearted reasons rather than brilliant inspirations. It was my habit to send one of the students to buy coffee and slices of ginger cake for the team to enjoy while relaxing between operations. On many occasions former students have subsequently thanked me for the ginger cake rather than for any transferred surgical skill.

Thomas Hardy (1840-1928), English novelist and poet.

I acted as a tutor to overseas trainee surgeons and frequently sat them on Hampstead Heath for discussions, bringing along my dog. When travelling abroad, senior surgeons I had taught when they came to the United Kingdom for basic training sometimes approached me and recalled their tutelage sitting on the grass - but mostly remembered watching Jason sitting quietly, ears pricked, head to one side, brow wrinkled – as though he was mentally absorbing the discussion.

I have earlier mentioned the fortunate discovery in my local public library of a book written by a Canadian academic entitled, 'So you want to be a doctor.' From it I gleaned a life-time recognition that passive reading is a fatuous method of learning. He admonished us first to recall what we already know, in so doing identifying and highlighting what we do not know or of which we are uncertain. We consult the source to supply the missing knowledge, before repeating the recall process – not once only but repeatedly, preferably at progressively long intervals. The more essential the knowledge, the more vital the process. I did not thereafter use the method invariably but I did convince myself of its excellence as a tool to engrave important facts and ideas in our brains.

I had, throughout my career, enjoyed teaching at every level from pre-clinical anatomy to undergraduate medicine and surgery, to junior trainee surgeon and eventually on to higher surgical specialities. This was in spite of being only a modest technician. My particular enthusiasm was the acquisition of skills. Another source of inspiration and reference was in a brilliant study, Personal Knowledge by Michael Polanyi (Routledge and Keegan Paul, London, 1973). He studied the acquisition and transmission – and loss of skills. He cites the loss of skills of Antonius Stradivari (born ?1644 died 1737). He died aged 90 and his two surviving sons had not absorbed his unique skills. Despite innumerable investigations and measurements, no one has been able to replicate violins matching those he fashioned 300 years ago. I regret the loss of skill in clinical examination; present day doctors fire off a series of investigations without examination, sadly, even without looking at the patient, as eyes are focused on the computer screen. Clinical examination reveals the effect of the condition on the patient and the texture of the tissues. The findings help to build up a knowledge of the limits of normality and one of pattern recognition. My favourite Polanyi aphorism is, 'By watching the master and emulating his efforts in the presence of his example, the apprentice unconsciously picks up the rules of the art, including those that are not explicitly known to the master himself. I have a treasured memory of talented friends I recruited to help with skills training.

I became passionate in promoting the importance of using the minimum effective force and also of performing the steps of a procedure in the correct sequence, with checks of each before proceeding to the next. The importance of this was humorously displayed by a pair of television comedians, Morecambe and Wise. Morecambe claimed to the eminent conductor and concert pianist André Previn that he also could play a piano concerto. He produced a cacophony derided by Previn as being the wrong notes. The retort came, 'No. All the right notes, possibly not always in the right order.' Simulations offer a method of practising the corrected sequence but during a surgical operation the texture of the tissues vary so that force must be adjusted during each activity. In order to accomplish any complex procedure, every component must be perfect every time. Watching a skilled expert generates confidence and admiration. Observing a clumsy performer if almost painful. I had one assistant who was clumsy and always looked as though he was on the brink of disaster. I almost could not bear to watch him. Since I could not inculcate the necessary gentle manipulations I was relieved to see him embarked on an administrative career - though still asserting his true vocation was surgery.

Student and students: I have learned throughout my life – avidly, reluctantly, from seniors,

contemporaries, students and from my own actions. I learned the ultimate determination behind the sometimes trite assertion, 'I want to be a doctor.' Outstanding future doctors can often be identified among students. A surgeon friend at Aylesbury had two students allocated to him for two months at a time. He always set them a simple clinic surgical problem to study during the period. At the end of their attachment, he invited a colleague to lead a ward round and then listen to their findings One had identified an important but ignored delay in the service. The surgeon's main field of interest was in colorectal cancer. On the wards, in the outpatient clinic, the student asked every patient who presented with rectal bleeding how long was it before they reached a surgeon. He collected a large number. Because rectal problems are embarrassing, patients were often reluctant to seek advice. He discovered the almost invariable story of shyness while shrugging off the bleeding with, 'probably haemorrhoids;' a visit to the pharmacy for an ointment or suppository; a visit to the GP who sometimes carried out a cursory examination; finally wrote a referral letter to a surgeon. The average time lag was one year! This was in the 1970s. Is it better now? I hope so.

Conclusion

I am writing this while sitting in our lovely 1745(?) listed Georgian house, with original Chinoiserie stair bannisters. It is at the pinnacle of Highgate Hill in London. The North Road ascends from the City of London along the path taken by Sir Richard Whittington (1354 -1423) Mayor of London, born in Pauntley, Gloucester. As a young member of a large family he did not inherit his father's estate but was sent to London to learn the trade of mercer (dealer in textiles). Allegedly, he did not at first succeed and decided to return home but as he walked with his cat up Highgate Hill, the London church bells began to ring, pealing out what he interpreted as, 'Turn again Dick Whittington, Lord Mayor of London'- which he obeyed – achieved four times. Indeed, in 1407 he was Mayor of both London and Calais (English from 1347-1558). He was beneficent in many areas, notably improving the city drainage and also providing a hospital ward for un-married mothers to give birth. A Victorian iron statue of his cat stands at the side of Highgate Hill road close to the Hospital named after him. Peggy and I are but humble and grateful concierges of the house.

Born just 20 years after the first powered flight by the Wright brothers, I have witnessed a transformation. Triumph and despair are striving antagonists in my almost century life. On the one hand I have witnessed the triumphant explosive development of science and technology beyond the imagination of my predecessors, bringing magical advances in radio, communication, artificial intelligence, flight, astronautics.

In developed countries developments in agriculture, medicine, education have resulted in increasing life expectation often freed of chronic, limiting disabilities. There have been patchy improvements in inter-human relations nominally signalled by the Human Rights Declaration of 1948.

On the other hand the profligate demand for heat and energy have been met during not much more than a century by the generation of vast amounts of carbon, releasing it into the atmosphere, raising atmospheric temperature. Meanwhile the world human population has increased from 2 to 7 billion while we are succeeding in threatening every other living animal. Alongside, we denude the earth of any vegetable that impedes our unprincipled spreading of growths to satisfy our insatiable demands. These are all unstoppable and have terrifying possible consequences.

Mankind shows no sign of becoming more civilized. During the present and previous century we regressed. The Holocaust revealed the deepest descent into tribal atrocity in history. We continue to settle our differences with war, descending into two world wars and the development of a nuclear bomb. I fear for my successors the fulfilment of the prophecies of the 4 horsemen of the Apocalypse in response to the rapacious transgressions of mankind – Conquest, War, Famine and Death.

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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