

**Celebrating a Century of
Learning and Practice in
Medicine: 1913 - 2013**

100 YEARS OF MEDICINE



Message from the Dean

Henry Marshall Tory had a bold – many would say, audacious – vision for the frontier university he was recruited to lead in 1908. After Tory arrived from McGill University to be the first president of the University of Alberta, he was determined to transform the U of A into a flagship institution of higher learning for the newly confederated prairie province.

The fledgling university was more than a kilometre west of the small but bustling city of Strathcona on the south bank of the North Saskatchewan River, across from the provincial capital of Edmonton.

A history written by Elise A. Corbet called *Frontiers of Medicine* describes the U of A environs this way: “A thick growth of native willow and poplar, straggling bushes and tall grasses covered the university site. The land was marshy, crossed by Indian trails, and bordered by large areas of unsettled land to the west and south. Until construction began on the first university building in 1910, no roads connected the site to Strathcona, and it would be many years before any were paved.”

Notwithstanding all that, ambitious plans were soon underway to establish professional faculties at the U of A, including a medical school. Just five years after the university was founded, the Faculty of Medicine became a reality and accepted its first students in September 1913. So begins the history of the only medical school to be established in Canada between 1883 and 1945.

The straggling bushes are long gone. The marshy land has been paved over. The neoclassical buildings constructed during the early days remain, including the Medical Building (later renamed the Dentistry Pharmacy Centre). But they’re now surrounded by gleaming new edifices of polished glass and steel.

The U of A medical school has led the pace of development and has been ranked one of the top 50 in the world – home to internationally respected researchers in diabetes, obesity, virology, cardiology, cancer and spinal injury rehabilitation, among other things.

Our faculty has 20 departments, six stand-alone divisions, eight research groups and 31 centres and institutes. It boasts state-of-the-art labs and teaching facilities, award-winning teachers, graduating classes who score at or near the top of national medical licensing exams, and alumni who are making a difference in the health of the world’s peoples.

As we explore and commemorate our past, we will toast our present and plan our future. The one thing that hasn’t changed is our purpose – we remain dedicated to advancing health through teaching, research and patient care. Dr. Tory would be proud; we hope you will also take pride and join in our celebration.

D. Douglas Miller



UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY

Visit our centennial website at med100uofa.ca



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For more information and submission guidelines, please visit our website at www.uahsj.ualberta.ca.

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Editorial

How does one mark the 100 year anniversary of the Faculty of Medicine at the University of Alberta? One hundred years of teaching, learning and innovation; one hundred years of nurturing bright young minds; one hundred years of advancing the art and science of medicine...

This special edition of the University of Alberta Health Sciences Journal (UAHSJ) was conceived as a celebration of the medical school, and a way to engage alumni and current members as we celebrate this momentous occasion. In these pages, our aim was to highlight the passion and dedication of this extraordinary faculty – past, present and future.

The call for submissions to our “Heart of Medicine” special centenary issue invited medical school alumni, faculty, staff and students to submit original, unpublished works that provide a sense of the human side of medicine.

We were overwhelmed by the response.

Students at the beginning of their training looked forward to the arduous but fulfilling road ahead, while seasoned physicians reflected on lifetimes of practice. We read through lighthearted poems and solemn anecdotes; accounts written in well-trained narrative voices; and heartfelt expressions from novice writers.

The submissions surprised us: Vincent Hanlon showed us that baking bread can be an effective therapeutic intervention for struggling

doctors, and Alim Nagji shared an intelligent and nuanced story examining the competitive dynamic between a medical clerk and resident during a delivery. Verna Yiu reminds us that the imperative to “do no harm” in medicine may sometimes mean “doing nothing” for our patients, and in a simple vignette, Anna-Kirsten Siy shows us how “releasing hope” can seem an impossible betrayal for the family of a dying child. No topic was off-limits: fortune-telling, dementia, and even sexual dysfunction...

The UAHSJ has always been committed to exploring the humanistic side of health science practice. UAHSJ’s Musa section is dedicated specifically to this task. Our established readership and preexisting commitment to arts in medicine made UAHSJ the perfect venue for a supplement celebrating “the heart” of one hundred years of learning and practice in medicine at the University of Alberta.

The process of compiling this supplement was a true pleasure. We are sharing compelling submissions that challenged us, or moved us. We hope these pieces inspire conversation and creative exchange, and that you enjoy reading them as much as we did.

Happy 100th birthday to the Faculty of Medicine at the University of Alberta, and may we continue to celebrate many, many more centenaries!

Sincerely,

Tamar Rubin, MD

Senior Co-Editor

UAHSJ, “Heart of Medicine” Special Centenary Issue

Kathryn Wood (Med 2016)

Junior Co-Editor

Letter, “Celebrating the Centenary”

In recognition of the importance of providing a forum for communication of health sciences research and literary expression, the Faculty of Medicine & Dentistry (FoMD) has sponsored the University of Alberta Health Sciences Journal (UAHSJ) since its inception in 2004. On behalf of the FoMD, I am proud to welcome this special UAHSJ issue which showcases literary responses that reflect on the theme “The Heart of Medicine.”

During the past year we have visited different moments of our proud history and touched on different promising aspects of the future ahead. We are also ever mindful of the need to create spaces and opportunities for sharing our stories. It is through the sharing of stories that we find our way through the very human experiences of illness and caring that mark all of our lives, and that represent the guiding force of medicine.

Aristotle is attributed as having said, “Wherever the art of medicine is loved, there also is love of humanity.” At this pivotal point in our history, it is important that we engage in dialogue and creatively work together to promote health – the health of individuals, families, communities, and our health care system. And, of course, as we do, it will always be helpful to reflect on what, indeed, is at the “heart of medicine.” This special issue offers a wonderful collection of perspectives and experiences that relate to this theme.

I am delighted that we have an opportunity to symbolically recognize the generative pulse of the generations that are connected in ongoing conversations that relate to this theme, by sharing the paper-based version of this special UAHSJ issue with both those who have gathered for our 2013 alumni dinner and our incoming Med 2017 class – our 100th class! The digital version is available for all to enjoy.

I would like to congratulate all of those whose work appears in this special literary issue, and also extend a very special thanks to all those who helped produce it: editors Tamar Rubin, PGY3, and Kathryn Wood, Med 2016; UAHSJ editor-in-chief, Ori Scott, Med 2015; Dr. Pamela Brett-MacLean, faculty advisor, and director of the Arts & Humanities in Health & Medicine (AHHM) Program; and designer Andrea Van Der Ree. I hope that you enjoy this special centenary edition of the UAHSJ!

Fraser Brenneis, MD, CCFP, FCFP

Vice-Dean, Education

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Interlingua¹

Dawn Davies

¹*Interlingua: sometimes called universal language, a language intended to be used by people of different linguistic backgrounds to facilitate communication among them and to reduce the misunderstandings and antagonisms caused by language differences.*

The day is hot, languid, and blazing with sunshine. As I pull into the familiar driveway, I note that the chubby squat evergreens are now more than a foot tall, marching me up the driveway to the front door. The closed louvers of the foyer windows are the only clue to the divide between the carefree breeze outside, and the stillness of the concern within. I am beckoned upstairs by Liliana, who greets me at the door with a clucking sound of resignation and muttered Romanian.

I behold my little patient, lost in the upper corner of his parents' king size bed. As always, I am struck by the beauty of his face. His brown eyes absolutely sparkle. A smile flutters across his lips, trying desperately to flirt with the ladies, as always, but his inability to breathe gets in the way. His skin is pale despite the heat. Grandma Liliana motions to her mouth. "Sy-nose? Sy-nose?" I look more closely at the baby. She's right. Peri-oral cyanosis. (Sy-nose. Sy-nose.) I take the history from Liliana as we carefully move him from her shoulder, down which runs a shiny river of drool. Getting him to the bed is akin to holding un-bowled Jell-O, so floppy is this child.

Andrei has spinal muscular atrophy. Although his intellect and brain are the same as any other 10-month-old, his spinal nerves have no way to communicate with those in the rest of his body. He is profoundly paralyzed. Should he live so long, he will eventually lose his ability to swallow, and his smile will be replaced by an oddly triangular mouth that belies all emotion.

Mom and Dad have left town for just a few days, their first trip since disaster struck: since they got through the hellish first three months of their son's life, wondering all the while how other parents could truly enjoy this phase, and then learning at four months that

everything was explained by SMA, this foreign and frightening short form for spinal muscular atrophy that they have since grown to know so well. Of course, today is the first day that he's actually seriously ill.

I quickly remove his onesie, and try to mask my facial expression, so unprepared am I for the shock of seeing his sunken right chest wall. How could his anatomy so change in just a week? The entire right side is cratered, with a matching bulge in the left. His heart is racing at 160 beats per minute, and he grunts with every rapid breath. His nostrils flare to capture every available speck of oxygen.

Liliana and I take turns pointing and asking one-word questions. The problem is that mine are in English, hers Romanian. There is no commonality except the concern reflecting back and forth between our eyes. Somehow, I determine the following: He's drinking, but just a little. Maybe 4 ounces in 24 hours. Water only, he refuses his milk. Sy-nose. Sy-nose. There's something else. In his mouth? "Wha. Wha." Aha. White. Thrush. Everywhere. I motion to his diaper, and hold up fingers. One, two, or three since yesterday, motioning behind me? One.

Andrei chugs away. I talk to his Mom long distance at the appointed time, and so does Grandma. We share the phone. Mom translates for us. Despite the heartache, she laughs at the thought of Grandma and me figuring out as much as we have from one another. She struggles for composure. As always, she is the epitome of maternal love combined with a fiercely analytical mind. How long has he got? Can they get home in time? Or is there still some time left for hope?

Liliana and I, flushed and perspiring, lean over this beloved little boy, and make a plan to ensure his comfort. Medicines for his breathing. Infection. Thrush. Fever. All foreign words, even to English speakers. We practice drawing up the right amounts in syringes, and she labels bottles in Romanian from her daughter's translation.

The call to Mom is concluded, and Liliana turns to me, motioning to her chest. "Noise."

She repeats it, more motioning self-ward. "Noise." Does she have chest pain? No. She thinks Andrei's breathing is noisy? No. I try again. "Nurse?" she is jubilant. "Ja. Noise." A moment of true understanding. I motion likewise. I was a nurse, too, I wave behind me. "Before. Before a doctor, a noise." And that opens a floodgate. She pours her heart out to me in Romanian. She motions expansively. "Chine. Romania. Ca-na-da." I think I get the idea. It's all the same.

Yes, suffering is the same, the world over. "This must be so difficult." I say. She cries, accompanied by more Romanian. She motions to her heart, and to the struggling infant above us or to God, I can't tell. She takes my hand. "Yes, this is so very difficult," I say again. I can see how much she is suffering, and how frightened she is. And so the conversation continues, she in her tongue, me in mine. Our ears can make no sense of it, but it is a conversation, nonetheless. Despite the cruelty of the situation, and the torture they are enduring, we are both richer for it. Compassion is the universal language.

Dawn Davies' first career was pediatric nursing. Dawn received her MD from McMaster University in 1993, and completed her pediatric residency at the University of Alberta in 1997. She was awarded a McEachern Fellowship from the Canadian Cancer Society in 1998 to pursue additional training in palliative care. Since her return to University of Alberta in 1999, she has been Medical Director of the Pediatric Palliative Care Program. Dawn received her MA in Health Ethics and Law from the University of Manchester (UK) in 2011. She is currently an Associate Professor in the Department of Paediatrics and Associate Adjunct Professor with the John Dossetor Health Ethics Centre, University of Alberta. Her interests in health ethics include medical-decision making for children and resource allocation.

For Shirley Appleby [née Haynes], MD, University of Alberta Faculty of Medicine, Class of 1948

Sterling Haynes

Consider this as a biography of Shirl from the perspective of a somewhat doltish but doting younger brother.

My sister was a strong and compassionate woman with a great intellect. Shirley was a Latin scholar and a physics whiz. She took time to tutor Jimmy Stollery. Jimmy studied engineering. Recently he opened the Stollery Children's Hospital in Edmonton. Shirley's influence was strong and abiding.

Shirley was physically strong. As a teenager she became an accomplished horse woman. She used an English saddle, don't you know, at the Greening School of Horsemanship in Edmonton's Garneau area. Mrs. Greening was an English taskmistress and Shirley rose to the occasion, becoming a sophisticated rider. Shirley was a good ping-pong player too and won local tournaments with her fabulous forehand smash. Shirl could take me in arm wrestling until I was 14.

Her compassion for all living things, even as a little girl, was legendary. Her first dogs were Sealyham terriers, and they were her good friends. Her beloved dogs are too numerous to name.

Intellectually and academically, Shirl was tops. In grade 9, Shirl won the Lieutenant Governor's Gold Medal for the highest marks in New Brunswick's high school entrance examinations. She won the highest marks in Alberta's university entrance examination. She won the prestigious Tegler Scholarship and another three scholarships that paid her university fees at the University of Alberta for four years. In 2011, when we were visiting on the phone, she said, "I just wanted you to know that my education didn't cost anybody anything."

Shirl was a patriotic Canadian. Two of her male admirers were Sergeant Manoz Greening, who was killed at age 21 in the Italian Campaign, and Flight Sergeant Fraser Hollembach, bombardier, who was shot down over the North Sea and drowned. Fraser was 20 when he died. After those tragic deaths, and with the war still raging on, she felt an obligation to join the army.

In 1944, after her second year at medical school, Shirley joined the Canadian army. She was stationed in the army hospital in Dundurn, Saskatchewan. After the war, she finished her medical studies under the auspices of the Canadian army and received her MD in 1948.

In the last two years of medical school, a Yorkshire man-cum-Victorian, John Appleby, also a fellow medical student, became a permanent fixture at our house in Edmonton. During Shirl's romantic evenings with John, she would play the record "For Thee Alone" (ad nauseum, to my tender ears!) sung by her favourite Metropolitan Opera tenor, Richard Crooks. As her cheeky brother and short order cook, I made sure my smart remarks could be heard by them, as they cuddled on the couch in the living room.

On the last day of their final exams, that very afternoon, in fact, Shirley and John were married by a justice of the peace in Edmonton's City Hall. Our mother, the ultimate dramatist, loved John dearly but was not too happy about the austerity and lack of ambiance in their city hall marriage. That was Shirley: sure of her way and eager for the next adventure.

After her internship at the Royal Alexandra Hospital in Edmonton, Shirley and John took further training at the rural Ponoka Mental Hospital and then in Rhode Island where they both got residencies that were hard to come by. In Providence, their first child and my first niece, Margaret, was born.

Then Shirl completed three years of neurological training in Denver. During this time, John, Barbara and Mary were born. Despite birthing so many babies and studying hard, Shirl never missed a day of work or training. She was a tough and loving mother.

After becoming certified in their specialties, John and Shirley moved to Toronto and worked at the Scarborough General Hospital. Jennifer, Sarah and Alice were born in Toronto. I was blessed with more and more nieces! Life was hectic and work became more demanding. In 1969, they sold their house and took all the kids on a four-month-long tour through Europe.

While in Italy, an innkeeper looked at Shirl and John and counted all seven kids as they entered the cafe – 1,2,3,4,5,6,7. He then jumped to his feet and shouted, "Bravo, Bravo!" and clapped his hands.

When the family returned to Canada, they settled in Prescott, Ontario. John became the chief psychiatrist at the Brockville Psychiatric Hospital and they both worked across the St. Lawrence River, in the Ogdensburg Psychiatric Hospital, New York. Later, Shirl opened her own office and practised family medicine in Prescott where she gave new meaning to the phrase "devoted doctor." She was county coroner for many years and knew many of the area cops by their first names when she investigated motor vehicle fatalities between Kingston and Cornwall along Highway 401.

She practised medicine for 60 years. Can you imagine being on call every third or fourth night for 60 years? Together we practised medicine about one 100 years, but never in the same place.

Shirley remained my best teacher and favourite mentor.

Shirley's legacy to the world lives on in her seven children and fifteen grandchildren, and her huge extended family including patients, friends and fans.

Her life was dictated by her code of ethics: compassion, love, honesty and fair play. Shirl died in Kingston on November 3, 2011. I miss her.

Sterling Haynes is an octogenarian writer and a retired MD. He completed his medical degree at the University of Alberta in 1958. His humorous short stories and zany poems have been published throughout Canada and the USA in journals, magazines and newspapers. His first book, *Bloody Practice* [Caitlin Press] was a BC best seller in 2003. His last book, *Wake Up Call: Tales from a Frontier Doctor* [Caitlin Press] is now an ebook with Chapters, Cole, and Barnes & Noble. Much of his recent work is available on the internet. The vagabond Vagus wanders through our hearts.

A Song for the Singer

Shirley A Serviss

Al strums and sings as people lie in ICU
monitored by instruments that play a different tune.

He serenades those stilled by stroke, gives voice
to words they can no longer say, although some try:

lyrics recalled from some forgotten place.
Faces change as they come back into their eyes.

Bodies thaw as limbs begin to move in time,
leaving nurses looking on in awe. Al plays

for people as they die—requests from families
for a favourite piece to ease the pain of passing.

Al wends his way through wards and halls,
witness to such intimacy, such intensity,

a mere guitar can't hope to shield his heart.

Shirley Serviss is a writer and a writing instructor. She works part-time as the staff literary artist for the Friends of University Hospitals' Artists on the Wards program. Part of her role involves coordinating the Shadowing Artists on the Ward elective for medical students, offered by the Arts & Humanities in Health & Medicine (AHHM) Program.

An Ode To Cadavers

Jonathan Pelikan

Their lives have ended, they've gone from here,
They've left their loved ones, those they held dear.

And as a token of their hopes and dreams,
They've given their bodies to medical teams.

To help us train and enhance our skill,
When treating the diseased and the sick and ill.

To make the world a better place,
To put a smile on a patient's face.

I extend my gratitude to the departed ones,
Who were once parents, daughters and sons.

I hope that I can live up to what is expected of me,
I will treat your body with the utmost dignity.

I hope that I can live up to what is expected of me,
And become the physician I have set out to be.

Jonathan Pelikan has wanted to gain admission to medical school in Canada for as long as he can remember, and his interests have always centered around the sciences. However, as is the case with most people, he has also always had interests outside of his academic and scholastic pursuits – weight training, cooking, and writing poems. He considers his loved ones to be his major poetic muse, but anything that strikes an emotional chord for him can find itself the subject matter of his next poem.

Fortune-telling

Meghan Doraty

Your name is Mrs. Allen. Mrs. Robert Allen from Nipawin, Saskatchewan. You wake up in your nursing home bed with a memory rocketing around in your head about the meat shop exploding in your hometown. 'Twas the backhoe that did it, snagged a gas pipe, it did, and kapow! The whole thing blew up along with the Swiss Chalet, the Nut Man shop and the Everything For a Dollar store. A great loss. You wonder why you remember this now when you can't even be quite sure what you ate for dinner last night.

You sit up in bed – such a squat little bed, so low to the ground; at home in Nipawin, you had a very high bed, a regal bed, with satin sheets, not the scratchy Pepto-Bismol blankets here. You fumble with the remote control and watch the news with the volume on quiet so as not to disturb your cantankerous roommate, who calls herself Rose, after Betty White from the Golden Girls, even though her name is clearly labeled outside your door as Edna. Over the door, Rose or Edna or whoever, has hung a lovely sign made of rustic-look-

ing wood that reads Home Sweet Home. You are waiting for her to die so you can get a new roommate.

When Edna stirs and reaches for her bottle of Tums, you offer to read her fortunes for the day. You do this every day and every day Edna says –

"Don't you know your Bible, girl?"
And you say, demurely, that you do.

"Then you'll know about the Witch of Endor and the summoning of Samuel's soul and how the good prophet was all perturbed at being awakened! Divination is devil's work." Edna sucks on her Tums with satisfaction and rings the bell for the porter to help her to the chapel.

Left alone, you wonder where Samuel was awoken from and if you are going to hell.

Ω

Your first memory is of old Mrs. Larson who was the pastor's wife at Nipawin Pentecostal. It's church day. You are swinging your legs from the first bench because for some reason Mrs. Larson believes that you are a trouble-maker and trouble-makers must be sat on the front bench and made to eat Licorice All Sorts throughout the service. You do not fancy All Sorts; they remind you of vulgar little beetles. The Reverend Larson is yelling about what is termed hell. This term alarms and frightens you. Apparently hell is a lake of burning fire. You remember what it was like to burn yourself on a candle flame because you were attempting to hold the flame sideways under your nose like a small clever moustache. The little triangle under your nose and above your lip still smarts. You begin to cry because you do not want to go to hell and you are fed up with All Sorts. The doxology starts up and you cry harder. Mrs. Larson bends over to you and wipes your face with her handkerchief.

"Do you see the angels?" she says. She points to the top of the brass organ pipes. You shake your head and blow your nose.

"The angels are beckoning you," she says. You concentrate hard on the brass pipes. You cannot see any angels and for this you are grateful. Angels – possibly more alarming than hell. You sniffle and try to wipe your eyes with your elbows. Your mother comes and gathers you up but as she carries you away, you catch the scent of cinnamon wafting heavy from the pulpit though no incense was lit.

Ω

You put on your nice lavender hat with the pearl hat pin and go down for breakfast. You sit with a man who reminds you of your late husband. His name is Duffy and he has a great love of babies. He tells you over scrambled eggs that he dreamt he was in the maternity ward of the hospital and that he was looking at all the babies in their little tubs and how precious and angelic they all looked. Duffy begins to cry when he tells you this but that is pretty well normal because Duffy has

something wrong with his tear ducts and he perpetually has a stream of water trickling down the side of his nose. The doctors want to do a surgery, a very simple surgery, but he refuses because if the good Lord wants him to weep, then he, Duffy, should do no different. Remember, the shortest verse in the Bible is "Jesus wept."

Duffy knows about your devil work and tolerates it. But this morning, he gets his gimp up and asks you to do his cards.

"What kept you?" you demand.

"I figured it wasn't Christian."

"And now?"

"Now I have a feeling something's about to happen."

You ask him if he believes in hydromancy. He says he isn't sure. You ask him to fetch a glass of water and some string. He goes off in his wheelchair and when he comes back, you tie the string to your father's ring and dip it carefully in the water. The ring looks like a fat little goldfish suspended at the surface of the water. You take it out, lean in close, and observe the ripples.

It does not look good.

Ω

When you were younger, you would visit Nipawan often. You would go back to the farm to visit your mother who touches your face often and hugs you tight as though she is afraid you are going to turn to vapor if she lets go. She sets you down in the kitchen and serves you some lemon meringue pie. You like the way the topping looks like stiff clouds. She wants to talk about how you should bury her when she dies. It is very important that you bury her in the family plot out behind the Pentecostal church so that she can be dead beside your father. Absolutely do not burn her in the hopes of scattering her ashes across the wheat field. Not even if she is in a horribly disfiguring accident. Her body must be present for when the good Lord comes back to call all the saints to rise. Wouldn't it be embarrassing to be called by the trumpet but have no body to rise with?

Also she would like to be buried naked. That's right. In the nude.

You tell your mother that you do not know if you can accommodate this request. She assures you it is entirely necessary in order to throw off the things of the flesh.

You ask her if she is expecting to die soon.

You are reminded that she is eighty-six.

You ask her if she would like you to cast her fortunes? You hold out your hand, palm open, for her to accept.

She stares at your hand a moment, then pushes her chair back.

I have to check on the chickens, she says. The coyotes been sucking their eggs.

The next morning you get up at the crack of dawn and pull on your mother's big manly gloves and massive work coat that smells of motor oil and head on over to the chicken shed with a pail of seed. You sprinkle a handful of seed on the dirt around the cage. There are five chickens and a rooster in total, and unlocking the wire cage door, you seize the closest chicken, a fat hen with feathers the colour of autumn leaves and set her down in the middle of your spread of wheat. She pecks about the circle and her toes make three-pronged leaf-like marks in the dust. You examine the markings for your mother. Geomancy.

You have not been home for a long time.

Ω

Your clairvoyance does come with a cost. It seems as though, now that you're older and you've moved in with your son, your memory is not as good as it once was and sometimes you say or do things out of the ordinary. Once remembering your father's penchant for cigars, you secretly acquire some from the gas station down the block. When no one is home, you take your cigar to the bathroom and for reasons you cannot say, remove all your clothes, light the cigar and settle down on the toilet seat to enjoy the long smoky scent of cinnamon. Unfortunately, you forget to lock the door and your darling grandson who is only just potty trained, followed by his mother, find you leaning back naked against the toilet tank watching the pearl grey smoke swirl into shapes like dragons. Capnomancy: divination by smoke.

Sometimes you find yourself forgetting, like the one time you find yourself in slippers and a housecoat about to cross the intersection of 16th Avenue to the Log Barn when suddenly you forget how to walk. You hover, paused, on the edge of the sidewalk, unsure of how to proceed for twenty minutes before a security guard from the mall finds you and calls your home. When you get home, your son, that

daft old bird, is wearing a hole in the lawn with his pacing and when he sees you, he gets up a big howl and says, "Where were you? I came home and you weren't here and I was so worried."

You go, "Calm yourself! I was having pie."
And he goes, "In your house robe?"
And you go, "Indeed."

The next morning your son calls up the nursing homes. He goes, I love you but I can't take care of you.

You have no words for this.

Ω

One morning at breakfast, you see the porters wheeling Duffy strapped to a stretcher up to the Lock Down unit. You sit in the stairwell and listen to him die. He screams because he does not want to go. He does not want to go. But he goes and he is in hell and his mouth tastes of salt and there are little red demons pinching him. They pinch the fat of his upper arm and his belly and his thighs. He wants someone to make them stop pinching him but in hell, he is alone.

You do not want to die in a nursing home. In Cree, Nipawin means "bed or resting place." You believe in onomancy.

Ω

After you cast the seed for your mother, you try to convince her to stay home. She was planning on hitching a ride with her brother Ted to Manitoba to visit some cousins, then taking the train back home. You beg and plead. Eventually, you get down on your knees and rest your head in her lap, your cheek pressed against her apron and you shiver and ask her not to go. She strokes your head, and plays with your hair – pulling her fingers through your braid to undo it, then plaiting the strands together again. If it's the Lord's will, if it's the Lord's will.

On the way home from Winnipeg, her train collides with the Transcontinental, resulting in the infamous Dugald train disaster. You remember the smell of cinnamon in her apron as she'd been dusting slices of apples for a pie that afternoon.

Ω

You stand at the window of your nursing home room and push back the yellow curtains and crank open the glass so a little air can get in and get rid of that godforsaken breadcrumb

smell. It's spring for smut's sake. But there's a screen in the way. You give it a little push with the palm of your hand and it gives. It's just a flimsy thing.

Edna is asleep. Beside her on the bedside table is a tray with her leftover roast beef and a steak knife balancing on the edge of the tray. You acquire it for your purposes and thrust it through the screen to make a hole and then a bigger hole and a bigger one until you have made a lovely large flap that lets in a good breeze.

Ω

You watch, for a time, a dove they have captured in a brass cage hung from a stand in the chapel. Something to do with an Easter celebration. The chapel smells spicy like incense; the candles are burning on the altar.

When your mother died, you wanted to bury her as she requested, naked. But they, the other people involved, your son and his daughter and the rest of the family, and the pastor who would bury her, all protested. The mortician would do a lovely job of arranging her clothes about her body as though she were chubby and in the pink of life and not bruised and broken from the collision, that is his job. So she was dressed up in her best suit with a string of pearls and he, the mortician, put makeup on her face and gave her a nice bright auburn wig and everybody agreed she looked real handsome at the viewing.

You never really worried for your mother's soul because you were too busy worrying after your own, but seeing her fully clothed in that doll-like way, you felt as though when she was raised in Christ, she would be ashamed of her pearls, her suit and their decadence.

Before the funeral service, when the casket would go down the aisle, you asked to be let in to see her again and you took off her wig and you pulled off her suit jacket and her blouse and her stockings and her skirt and all of the trappings and you shut the casket closed and sent her down the aisle naked as the day she was born.

You wonder if your son would do the same for you to save you from shame in the great beyond.

You open the brass cage, reach inside and wrap your hand around the dove's fat, soft body. It flutters a little; the inside of its wings are tawny. You tighten your grip and pull it out, lay it down on the pulpit. Before you can think

what you are doing, you plunge the steak knife from Edna's supper tray into the dove's chest at the heart. A curl of blood pools around the knife and spills down the bird's plumage. Its narrow eye is still open, a shock of feathers shadowing its face. The look of death is a glare: the bird is upset with you for killing it.

You remove the knife – the serrated edge catches as you pull it out – and reposition it on the sternum and let the tip rest there while you think about it and then when you are done thinking, you force the blade into the bird's sternum. The bone cracks. You wonder if you have forced too hard and if the knife has gone all the way through the bird but then you begin to saw down the bird's belly and it opens up and there is warm blood on your fingers. You use the crook of your index finger to scoop out the innards of the bird. You hold the heaps of tiny organs in your palm – a tangle of entrails, purple parts and white flesh covered in blood with fluffs of feathers, sticky. You poke through it and look for your afterlife: extispicy.

You will take the train to Nipawin. You will sit in the meat shop, at the counter, by the cash register, with your purse on your lap. You will be wearing your good lavender hat. Hanging from the rafters will be racks of rib, flanks pink and white, swaying slightly in the breeze from the corner ceiling fan. Little fat roasts and chickens sit on the wooden countertops or on scales. There will be a hiss and then a spark and then an explosion and the smell of cinnamon.

Meghan Doraty is a third year medical student. She lives and writes in Calgary. She completed a directed studies elective offered by the Arts & Humanities in Health & Medicine (AHHM) Program in the spring of 2013.

The Vagus Nerve

Sterling Haynes

The vagabond Vagus wanders
through our hearts.

A compassionate nerve
that journeys to our voice box.
We sing to the day's beauty.

A parasympathetic force,
sympathetic to our needs for love,
gratitude, altruism and happiness.
When its neurons burst with zest
we feel a warm expansiveness in our chest,
as we listen to a Mozart symphony
or work in our garden.

But where do we go when challenged
by greed or violence?
Dendritic hairs stand on end,
triggered by savage TV visions,
war images that attack,
slow the nerve's impulsive rhythm
in its heart's core.

Let the Vagus, a melody of mirth,
turn us good hearted again,
like happy travellers.
A pacemaker
to the joys of this earth.

Sterling Haynes is an octogenarian writer and a retired MD. He completed his medical degree at the University of Alberta in 1958. His humorous short stories and zany poems have been published throughout Canada and the USA in journals, magazines and newspapers. His first book, *Bloody Practice* [Caitlin Press] was a BC best seller in 2003. His last book, *Wake Up Call: Tales from a Frontier Doctor* [Caitlin Press] is now an ebook with Chapters, Cole, and Barnes & Noble. Much of his recent work is available on the internet. The vagabond Vagus wanders through our hearts.

A Letter to a Future Patient from a Medical Student

Gregory Sawisky

To my future patient,

My name is Greg and we haven't met yet, though we will one day soon. I might introduce myself as Dr. Sawisky at that point. I don't know if we'll meet in a hospital or a clinic, nor do I know why we'll meet.

Perhaps you will be pregnant and I will be an obstetrician and deliver your child, a responsibility that seems impossibly difficult to comprehend at the moment.

Or perhaps you'll arrive in an emergency room and I will get to play the heroic physician barking out orders like they do on those television shows we've all seen: Fluids! Get me an IV bolus! What are her vitals?

Maybe we'll meet when you have a rash and I'm a dermatologist (but to be honest, even though they say not to try to choose a specialty in your first year of med school, I am ruling that residency out right now).

Maybe we'll meet on a quiet afternoon at a clinic when I'm building a family practice, and that meeting will mark the first of many meetings together over the decades as your family grows and our lives unfold.

Regardless of where we meet or why, I hope that I am able to help you. Having the ability to diagnose and treat illness seems very distant from the pages of my textbooks at the moment. I don't know how I'll ever learn enough of this information to feel comfortable trying to help someone else. But somehow other people have done it before me and I too will get through this.

That's why I'm writing this letter to you today: both to introduce myself to you now, and to remind myself that the reason I am here – studying late and working hard – is you. I hope when we do meet I will live up to your expectations and I will be able to help you, and that your faith in me will not be misplaced.

I don't know how I'm going to get to that point, but somehow I imagine that we'll bump into each other sooner than I think. I'm looking forward to meeting you.

Sincerely,

A first year medical student

Gregory Sawisky is currently a second year medical student at the University of Alberta. He holds a Bachelor of Journalism Degree and worked as a photojournalist prior to entering medical school.

The Door

Sarah Gauthier

you led me in a bright room,
you asked me to sit in the chair
you smiled and made small weather talk
as if I was not aware.
I watched you smooth your white coat
I watched your eyes wander over to my knee
which was covered with my hand
I know your fingers were tapping ever so slightly.
you pulled out a black stool,
sat on it, your elbows resting on your knees
you were watching me watch you
trying to put your whole body at ease.
I did not smile, I did not move
except for my fingers that were tapping
on my crossed over knee,
patiently waiting and sitting and watching.
you decided it was time to speak,
you decided it was time to share,
the results that would alter my life
and oh yes, I was very much aware.
I visualized the door in my mind,
I saw the details, the wood, the grooves, the paint, the feel of the knob and even the smell.
I had that door wide open for me for a long time,
and then I felt my tears start to swell.
you held your face firm and kind,
your lips didn't even move nor did your eyes.
wearing that white coat, it's a skill you learned over the years,
but when you go home, do you feel otherwise?
you stood up and put your hand on my shoulder
you told me I needed a minute,
when what I needed was that door to remain open.
you left the room and your words faded just a bit.
I saw the door in my mind
it became darker and darker as it closed shut,
I let my tears roll down my cheeks,
I couldn't breathe, like I was punched in the gut.
I let myself slip away, but I only allowed myself two days.
two days to lie in bed in a numbing daze.
then I returned to the living,
I turned around and faced a different direction,
I saw another door slowly open...
still bare, still simple, still just a door
not yet crafted to perfection.

This poem was presented to Dr. Ian MacDonald, an ophthalmologist and member of our Faculty, as a thank you for his presentation to the first meeting of the Edmonton Fellowship of the Deafblind on September 13, 2012 at the Alberta School for the Deaf in Edmonton.

The poem was written by Sarah Gauthier, a young woman, one of the Directors of the Fellowship, and a patient of Dr. MacDonald. Sarah has Usher syndrome, a heritable form of deafness and progressive vision loss. She is sharing with him her experience when she was told that she would no longer be able to drive a car.

See One, Do One, Teach One

Alim Nagji

Labour is a ridiculous time. It seems to me a helter-skelter of guesses and assumptions, with only some vague science. While these proclamations will be looked down upon by those with more experience, the simple fact that we cannot pinpoint exactly when a pregnancy happened, or when the delivery will take place, reminds us of the mysteries that persist despite numerous scientific advances. So when I received the phone call that my patient had reached a whopping nine centimeters of dilation, I bolted to the hospital, half-expecting to take off my coat and already hear the sound of a baby screaming. I was quite surprised instead when, on second inspection, she was said to be only three centimeters dilated and still in latent phase. Excited, nervous, and desperate to experience my first delivery as a third year medical student, I decided to wait in the hospital for her.

When the time finally came and she approached the magical number nine – her cervix becoming simply a wax paper sheet with a small anterior lip to it, like a misfolded piece of origami – I was the first in the room. I waited for the resident to rupture her membranes, that skill still beyond my tender experience. Anticipating a smooth delivery, I gowned and gloved and took my place between the expectant mother's legs, counseling her with soft tones as to what would happen next. As a "multip", she was already familiar with the process and seemed more interested in the prospect of being done than my nervous soliloquy.

As the urge to push became audible and her stomach rippled with the force of contractions, I steadied my hand and readied myself to guide it into her. I was thwarted, however, by the resident who, with her previous experience, leapt between us and guided her long fingers in to displace the edges of the cervix. Her urgent tones overtook mine, filling the air with her commanding presence and seasoned guidelines. The script flowed freely from her, commanding mom to push while stabilizing the baby's beautiful head of hair as she emerged from the enigmatic canal. I overlaid my hands on the resident's searching for flesh to grasp to make this experience as real for me as it was for the mother. I was uninterested in simply observing

the cacophony of noise and blood that I had come to expect from a delivery. Instead, I groped for baby, feeling her smooth hair against my gloved hand and feeling the rush of fluid cascade down my forearms and over my sterile gown.

"Get out of my light," I was ordered. I shifted to the side but, not wanting to lose contact with the newly flowing life force, I grasped for baby and helped guide her onto her mother's tummy. With baby's first breath, she let out a wailing screech, and mother and daughter were united in sound; their first connection. "Clamps," came the command and I reached for them, one on either side, while dad cut the life-sustaining cord, ushering baby into the new world and severing her ties to the old.

Baby was whisked away onto the table, checked and rechecked, suctioned and spanked and poked and medicated while I held onto the mother's fundus. I grasped the cord, afraid that if I let it go it would rush back into her womb like a tightly wound winch. I felt her uterus tremble against my hand like aftershocks from an earthquake that had torn cities to rubble. As the rope lengthened, the resident's hands encircled mine once again, her shoulder displacing me as she guided the placenta out. She cradled it to the table where she confidently announced, "2-vessel cord. But baby is healthy." Her bloodied gloves snapped as she threw them into the bin and, with congratulations to the new parents, left the room. I was left alone once again, the tumultuous moment had ended. I looked down at my own unstained white gloves and shook dad's hands. "Congratulations on your daughter."

Alim Nagji is a second year resident in Family Medicine at the University of Alberta and a graduate of the University of Alberta Medical School. An avid actor, director and writer, his work has appeared in numerous publications including *Canadian Medical Association Journal* and the *Canadian Journal of General Internal Medicine*. See more of his writings at: thealimshow.blogspot.com

An Organic Friendship

Rabia Bana

I made a new friend today. I don't know his name or where he came from. I know how many years he lived, and possibly why he died. That is all.

I met my cadaver today.

I stood in the anatomy lab with more than 100 people gathered around a metal table covered with a green sheet. Carefully balanced upon the green sheet was my group number. I could see there was a human form under the sheet, but could not decide if I wanted to unveil what was underneath. Was I scared that I would freak out or pass out? I don't think so. I've seen a dead body before. I was more scared of not knowing how I would feel.

Alas, the unveiling had to happen. I even helped pull back the sheet. It was a surreal feeling. Inexplicable. This was a person. This is a person.

A very special kind of person. He had been fixed up and wrapped up, almost like a present. Every part of him was frozen in time – a time that was no longer germane to him, but that was deeply significant to the medical class of 2015. The atmosphere in the room was eerie, like standing in the middle of a cemetery.

I touched him. He felt fake. His skin was tough and leathery. He looked like he had been young at one time. I tried to imagine him as a person: living, breathing, working, being a part of society – but it was difficult.

I think there is much value in deconstructing death through dissecting the physical body. In front of me lay a friend whom I would get to know on a level I will likely not know anyone else.

Rabia Bana is a third year medical student in the Faculty of Medicine & Dentistry at the University of Alberta. She previously completed a Bachelor of Science from McMaster University and a Master of Public Health from University of Alberta. In the midst of trying to understand the science of medicine, Rabia appreciates moments that highlight the humanity of medicine, such as her first anatomy lab. These moments are an important reminder of her reasons for being in this profession.

A World Apart

Bibiana Cujec

I lie awake at night listening to the dogs bark on and off. At 4:00 am the roosters start crowing and then the birds start chirping. I am in Kathmandu, Nepal, to teach in the cardiovascular block at the Patan Academy of Health Sciences, a new medical school devoted to developing physicians for rural Nepal. I fell in love with this country the year before when I came to trek and climb in the Himalaya, fulfilling a childhood dream.

Nepal is a low income country with rampant corruption and widespread poverty, particularly in rural areas. On my first trip here I was overwhelmed by the piles of garbage and dirty tap water; the roaming stray dogs, cows and monkeys; the constant honking of the motorcycles, tuk-tuks and lorries; and the stench of pollution that overhangs the Kathmandu valley. This time I noticed the flowers, birds, colorful saris and tunics, and the warmth of the people. I feel I have come home.

Ω

I am sweating in the hot classroom as 60 attentive students fix their gaze upon me. I smile at them and start talking about congenital heart disease. Congenital heart defects are common here because of maternal infections and malnutrition. I talk about ventricular septal defects and the importance of closing these defects to prevent irreversible pulmonary hypertension. I mention that in high-income countries, pulmonary hypertension can be treated with heart and lung transplantation. The students do not take notes but remember everything. There is a My Heart, My Art contest at the end of the block, for which students can submit any work of art related to the heart. One student writes a story about a young boy with cyanotic congenital heart disease who is very close friends with a girl. The boy has a heart transplant and is no longer cyanotic, but then is sad because his friend moves away. You cannot have it all.

Ω

Suraj is one of the Nepali tutors for the problem-based learning small groups. He has his MBBS degree and is applying for residency

positions. He is very bright and asks me many questions about cardiovascular problems and about healthcare in Canada. Suraj was employed by a foreign nongovernmental organization and traveled by foot from village to village in remote areas of the Himalayas as part of a healthcare team. I asked him what it was like in these regions: "It must have been so beautiful." He replied, "I was cold, tired and hungry." I reiterated, "But it must have been beautiful in the Himalayas." Patiently, and without expression, he repeated, "I was cold, wet and hungry for three months." I could not relate to his experience.

Ω

The boy stares unblinkingly at me. He is very thin and worn out from heart failure. He is 17 years old and has been re-admitted to the medical ward at the Shahid Gangalal Heart Center in Kathmandu. I look at his chart. His mitral valve has been destroyed from repeated bouts of rheumatic fever, a preventable infection related to streptococcal infections. He has severe mitral regurgitation and left ventricular dysfunction. He is dying. In my 30 years of clinical practice in Canada, I have seen only two cases of acute rheumatic fever. This boy has had many episodes of acute rheumatic fever during his short life. In the ECG lab there is a curtained-off area where patients line up to have their intra-muscular injections of penicillin every three weeks to prevent recurrent rheumatic fever. In this national heart center, there are more cases of mitral balloon valvuloplasty for rheumatic fever annually than there are percutaneous coronary interventions for age-related coronary artery disease. We have so many sophisticated cardiac interventions in Canada, like implantable defibrillators, percutaneous valve replacements, heart transplants and ventricular assist devices. On the other side of the world, however, people are dying because of poor sanitation and living conditions, and preventable infections.

Ω

In the intensive care unit, a 42 year old man has wildly fluctuating blood pressures and pulmonary edema because of pheochromocytoma.

Resection of pheochromocytoma is too risky an operation to be performed in Nepal. The cardiologist tells the family they must take him to India for surgery or he will die. The family would need to arrange for transportation and pay for his surgery. They cannot afford it.

Ω

I go on rounds in the hospital. The intensive care unit holds patients with organophosphate poisoning, malaria and disseminated tuberculosis. On the wards, there are a few nurses with starched caps, and fewer doctors. Families look after their relatives—feeding them, washing them, buying and giving them medications, transporting them to radiology. Oxygen tanks sit by some beds. Glass bottles of intravenous solution drip into veins. I feel like I have been transported back to a different time. I ask, "What happens if a patient does not have a family to look after him?" He will not survive long, I am told.

Ω

As I leave for Tribhuvan airport on my way back home, tears flow down my cheeks. I put on my dark sunglasses and stare out the window at life on the streets. The driver puts on a Buddhist chant, Om mani padme om. I cry harder. I'm back in Edmonton. It seems cold and empty.

Ω

I listen to the dean of the Nepali medical school: "We are not out to change the world, only make it a little bit better for a few people during the time we have here." I meet him in the hallway when I return for my third trip to Nepal. He opens wide his arms. I walk into them and am held closely.

Bibiana Cujec is a cardiologist at the Mazankowski Alberta Heart Institute and professor of medicine at the University of Alberta. She enjoys mountaineering mostly in western Canada but also in New Zealand and Nepal.

Health

Debbi Andrews

Health is what we have when we don't have to think about having it.

It sits on our shoulders and watches over our lives and we don't even know it is there. A weightless, benign presence that allows for possibility. An option to dream. A sense of future.

Health is what we have when we don't have to think about having it.

We do not feel its presence until its absence. Sometime, suddenly, we look around and feel the weight of that absence. We ask questions. When did it go? Where did it go? Why did it go? Always why.

Sometime, suddenly, we feel something new that wasn't there before. Age or disease now sit where health was, and we look wistfully at the place where it used to be.

Priceless health.

We nurse our regrets. We bargain. We ponder what we would give for a day with no pain, or a night of refreshing sleep. The opportunity to see clearly. To appreciate each sound, however small. To hear silence. To revel in the myriad of things that a body can do. To dance the night away. To be again as we were before.

Health is what we have when we don't have to think about having it.

I work with children with developmental disabilities. It is not easy work. These are chronic conditions. They don't go away. You just have to live with them.

This is what we were taught to tell the families we see. We say this so that people will have realistic expectations of what we can and can't do for them. Mostly can't do for them.

And when the patients are gone, when we are sitting quietly in our offices, we think to ourselves: at least it won't kill you. At least. Be glad for that much. Count your blessings. Our patients may not feel blessed. They go to

others who will promise something more than acceptance or resignation, something more palatable. A little hope, perhaps, to take home with them.

I understand this now.

I am no longer young. I am an aging pediatrician who no longer knows the diseases that I am going to encounter in my own life. It used to be that I only had to worry about my kids, and I could just call a colleague. But now my kids are grown, and so are my colleagues' kids. We can't help each other. The physicians I need now don't work in the world of children. They don't know me, and I don't know them. I get to be anxious and uncertain and just plain scared like everyone else.

Like the families who come to me praying that I will not find a problem, or that if I do, I will have a cure. Or at least an answer. Or at the very least a little hope for them to take home with them.

Now I know what it is like for the families I see who had the possibility, the dream, the future snatched away by the solemn pronouncement of a chronic condition. "These conditions," we declared blithely, "are life-long. They will never go away. You just have to live with them." Just.

I don't say "just" these days. I don't say "only." Or "at least." I don't tell people to count their blessings. I have learned that it is not up to me to decide which particular aspects of health and un-health are meaningful for an individual, or for a family, what is a blessing and what is not. They are the only ones who know the value of a day of health and the costs of its absence; how much they would pay to be able to think that tomorrow could be better, what it would be worth for them not to have to think about health.

Patients think about health all the time. They talk about health all the time. So do doctors. It's their job.

I try not to talk as much these days. I try

to listen.

And I try not to think about health, about my own health, but I find that I'm always looking for the places it used to be. I try for quiet times to breathe out worries. I try not to think about the pains in my joints and the hazy place in my left eye that constantly reminds me that a cataract is forming. I take my medicine. I look for blessings. I give thanks for a good night of sleep, a clear blue sky and the sound of my daughter singing.

I know there is only so much that I can do. "These are chronic conditions. They don't go away. You just have to live with them."

Health. . . is what we have. . . when we don't have to think. . . about having it.

I try not to think about health, about what I would give for health to come back and perch ever so lightly on my shoulder. I'd be paying attention this time.

Dr. Debbi Andrews is a developmental pediatrician, medical educator and sometime writer who works at the Glenrose Rehabilitation Hospital. She teaches medical students in the Neurosciences block at the University of Alberta and facilitates small group learning in narrative reflective practice.

Rehumanizing Medicine

Sahil Gupta & Sarah Stonehocker

The hospital environment can be a dehumanizing one. Focus is often on disease care, lab tests and medical devices. This approach diminishes a patient's personal identity and deprives both patients and practitioners the human element of care. Using photography, we hope to draw attention to this disconnect and highlight the value in "re-humanizing" medical care. We have taken two different photographs of patients: one highlights their hospital experience while the other their humanity, the very heart of medicine. This project explores the contrast between the human and dehumanized, through photography of patients at Edmonton Northeast Community Health Centre and the Stony Plain WestView Health Centre.

Sahil Gupta is a first year emergency medicine resident and Sarah Stonehocker is a fourth year medical student at the University of Alberta. Sarah Stonehocker is also a student representative with the Arts & Humanities in Health & Medicine (AHHM) Program.



Knowing the Ending

Anna-Kristen Siy

A day into my emergency paediatrics rotation as a third year medical student, a 10 day old neonate is brought in pulseless. She was found unresponsive in her crib early in the morning. Intraosseous access attempts by EMS failed. She didn't respond to epinephrine en route.

I stand in a corner, out of the way, as the resident runs the code. The airway is secured and respiratory therapy ventilates the baby by hand. CPR. Fumbling hands secure another intraosseous line into her tiny tibia. Fluids. Epinephrine. Blood gas sent. I am working through the resuscitation algorithm in my mind.

Time morphs. Each second takes forever, yet the five-minute mark comes too soon. Pulse check – I see some activity on the cardiac monitor, but no pulse. Another resident is brandishing the ultrasound probe: "agonal heart movements," she announces. Low odds drop lower. CPR continues anyway.

My attending, appearing at the foot of the stretcher, mentions that the parents are on the way. He asks for the baby's name, and we work out the pronunciation. Someone passes around the blood gas results. "Incompatible with life," murmurs the pediatric resident next to me, in case I missed the damning numbers.

And then the parents arrive. Dr. C has met them in the hall, done what he can to ready them. The crowd parts, and chairs are placed next to the stretcher. They stay standing, distraught. Dad is shaking and praying in another language, agony in his voice. Mom is silent and still, not bothering to touch the tears streaming down her dark skin.

They don't understand the futility yet, I realize. Or maybe they can't allow themselves to know, as though releasing hope were betrayal. We know the ending of this story, but we can't tell them yet. They need to see the whole tragedy play out. And maybe we need to act it out anyway, for our own comfort as much as theirs. Perhaps this is what it

means to do all that we can- to convince our own humanity that our compassion is still alive.

The next fourteen minutes are the longest. Dr. C gives atropine and bicarbonate. Pulse checks are fruitless. The monitor has flatlined. The heart is frozen on the ultrasound, the probe still clutched in the resident's hand. "I'm so sorry. We have tried everything," Dr. C is talking to the family, "We will keep trying for another two minutes, but... I'm so sorry."

Dad nods, his hands gripping the stretcher, his prayers rising again as we press our fingers into the little chest, push another ampule of epi. Two minutes. Nothing.

Dad isn't ready though. "One more time?" he asks. Dr. C pauses, then nods. "Two more minutes, okay?" he says. He waits five, then calls it. He says all the right words, with all the right emotion behind them. The hospital chaplain has arrived. Lines are disconnected and the little body, blossoming with bruises, is wrapped in colourful fabric. Mom cradles her child, instinctively, pulling her scarf over her face. Dad's prayers break into piercing grief, and I disperse with the crowd out of respect.

My senior resident and I stand awkwardly in the hallway. There is nothing to say, but I'm okay with not saying anything. I wander numbly back to the desk and the next thing I need to do. A patient sticker arrives on the desk from Dr. C. Scrawled on it: "New diagnosis, leukemia." He goes to tell the family, and I imagine he is saying the right words again, with the right emotion. The odds are reasonable, with approximately an 80% survival rate. But I don't expect that the family will be able to see the ending right now.

Anna-Kristen Siy is a second year rural family medicine resident in Grande Prairie through the University of Alberta. She hopes to work with rural and remote populations in Canada and overseas. Writing and hiking keep her sane.

The Camera as Voice: Children and Young Adults Document their Lives Inside the Stollery Children's Hospital

Gregory Sawisky

The use of documentary photography as a communication tool has long been employed by Hospitals and Health Foundations to solicit donations and increase public awareness. In recent years there has been a movement away from utilizing an outside observer to gather images, instead giving the camera to the subjects themselves.

In the summer of 2013, eight pediatric patients were given a digital camera at the Stollery Children's Hospital and encouraged to photograph anything of interest during their stay. Nearly 400 pictures later, the images provide a small glimpse of their lives inside the hospital.

The advantage of photography as an artistic medium is that photographs provide unadulterated documentation of a place and time, while at the same time allowing the viewer the opportunity to interpret what is inside the borders of the frame. We do not know exactly what each photographer is trying to say, but we know the environment in which the photograph was created, giving the viewer some direction and point of reference.

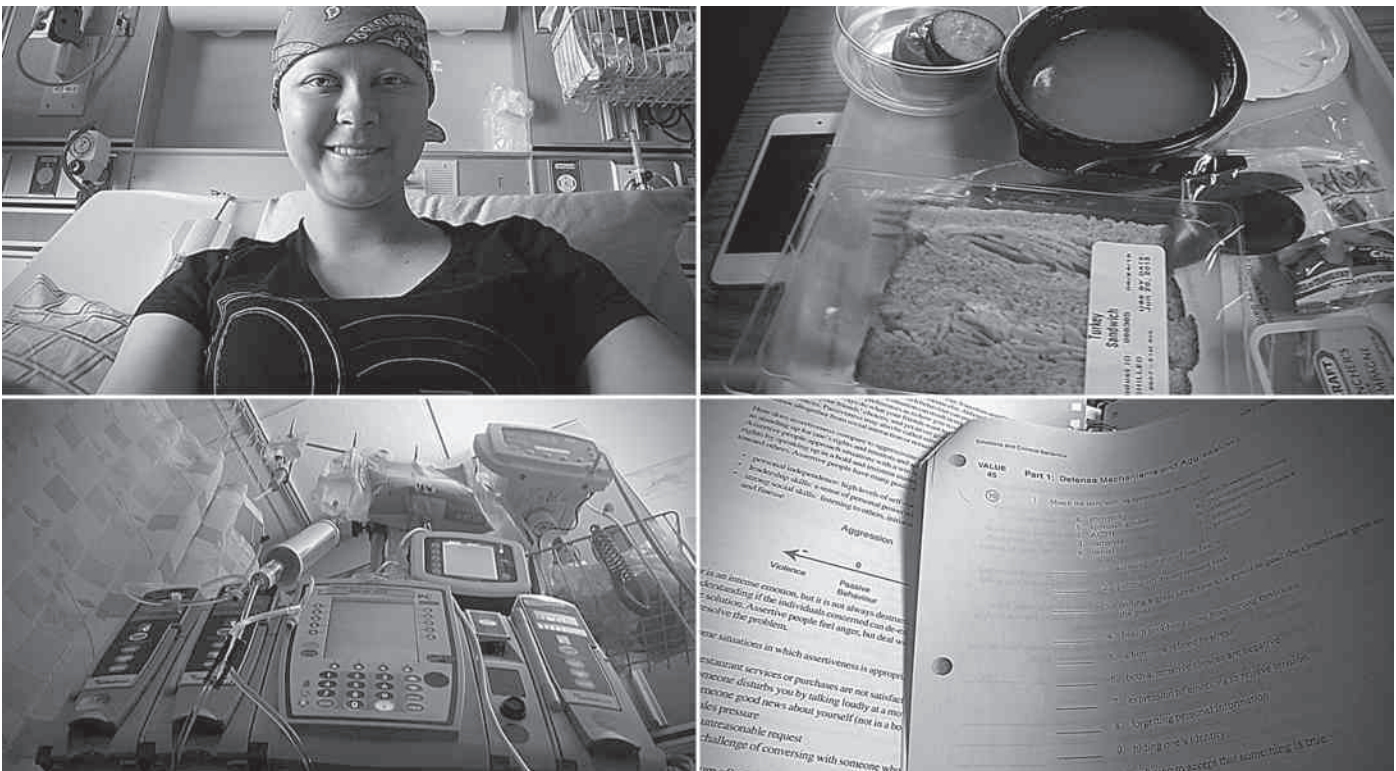
While these photographs were arranged into themes for the purposes of interpretation, a few sample images reveal the level of depth and insight documentary photography can provide.

We see a thin, uninspiring lunch; homework from a patient used to missing school for cancer treatment; a smiling nurse giving two thumbs up; a brother and mother on a day-pass; a video game controller that represents a cherished connection into another world. There are the photographs of IV poles – the ever-present dispenser of cancer-fighting drugs and pain medication; a self-portrait from a hospital bed; and a photograph of a young patient's beloved guitar next to her information board bearing the words, "Thank you for making me feel just like home."

We also see that many of the photographs are gazing upwards, whether to the moon and stars that adorn the ceiling tiles, or to the IV poles and staff. It is easy to forget as an adult that the pediatric perspective is one of eternally looking upwards.

Lots can be conjectured from these photographs, but the beauty and wonder of documentary photography is that these photographs are also standalone, simple statements of human presence. A photographer leaves something of himself in every photograph he takes. These photographs serve as both a window into another's world and as a reminder of the indelible human desire to create something of value and beauty that will remain after we are gone.

Gregory Sawisky is a second year medical student at the University of Alberta. He holds a Bachelor of Journalism Degree and worked as a photojournalist prior to entering medical school. This project was part of a funded summer studentship program made possible through the generous support of the Arts & Humanities in Health & Medicine (AHHM) Program at the University of Alberta.



Teachers

Sarah Aziz

"Oh, so I get the student?"

For one awful second, I think I'm out of luck again. The young man stirs drowsily, winces a little, and extends his right arm, sturdy and strong, over the covers.

"Well, we've all got to learn somehow," he says, with a slightly strained smile. With an apologetic thank-you I start fumbling with the tourniquet.

"The trick is to tie it really tight—more!—like that. That way, the veins pop out and they don't notice the needle so much." I laugh, and I get two full tubes.

As I wheel my cart back, mindful of his cast, I thank him again.

"No problem. If I can help someone learn to do what I do, I'm glad."

Sarah Aziz is currently engaged in the clinical internship year of her Bachelor of Science in Medical Laboratory Science at the Faculty of Medicine & Dentistry. Her installation, "Truth Serum," was featured as part of the international exhibition InSight 2: Engaging the Health Humanities. When she is not exploring the interface between the human and technological aspects of the clinical laboratory, she draws MRSA smiley faces on her chromogenic agar. Sarah Aziz is also a student representative with the Arts & Humanities in Health & Medicine (AHHM) Program.

Mapmaking

Niresha Velmurugiah

A night shift in emergency is a scrambled map of the city. Eagle Ridge and Boyle Street converge abruptly onto a canvas of scuffed linoleum floors and fluorescent lights. The coordinates switch with dizzying frequency and the zones have no boundaries. The heat of the ambulance lights has evaporated the contour of the North Saskatchewan River till the suburbs jumble with the urban core.

Edmonton is strange in the way of most cities. The busker on the street corner is classically trained. The most popular restaurant in Chinatown has barely any Chinese clientele. The girls sporting feather headbands veer away from Aboriginal street people. At the transit centre, the city organizes; Indian families heading to the Millwoods bus stop, the university crowd lining up for Whyte Avenue. Unknowable rules.

But tonight at the Royal Alex Hospital, the downtown Hope Mission is shoulder to shoulder with the gated west end. From behind a wisp of curtain, the south side ravines listen to the stories from 118th Avenue. The uptown cul-de-sacs share a meal with central low-income housing. Norwood Seniors' Home drifts off to the unfamiliar conversations from the northeast Somali community.

This unruly atlas will scatter its contents back into the cold streets of Edmonton. With locked doors, crossed roads, and averted gazes, the city will regain its inscrutable order. Yet each night, behind the glowing red signs of the ER, a temporary rebellion stirs. Laid bare by shapeless gowns and exhaustion, people hear and see one another with new boldness and curiosity. Edmonton finally finds the rhythmic breath of community.

Niresha Velmurugiah is currently a fourth year medical student at the University of Alberta. She is intrigued by the way in which film and writing can be tools for social change and is interested in getting more experience with these media forms both within and outside of her medical career.

Looking Back: Former Dean Doug Wilson Reflects on Ten Years 1984-1994

Douglas Wilson

As the first dean of the Faculty of Medicine & Dentistry from outside the University of Alberta (and from Toronto of all places!), my first and lasting impression of the school was of the warm Alberta welcome extended to me by faculty, staff and students.

In the 1980s, medical education was undergoing an 'almost revolution', as the traditional lecture-based curricula was increasingly supplanted by new methodologies such as small group and self-directed learning. The students then, as now, had an immediate and continuing impact on strengthening our educational programs. They provided critical curriculum reviews and embraced the new opportunities to experience rural practice, care for the elderly, and engage with medical ethics curricula and problem-based learning. Perhaps most importantly, the students created a social environment where, despite the hard work, their medical education was an enjoyable experience. Two of my most exciting experiences as Dean were being surprised by the presentation of white gloves at Convocation, and receiving the news on more than one occasion that our students had led the country on the national examinations.

A new initiative to support Aboriginal students' careers in medicine was strongly endorsed by the Faculty. Additional positions for admission were established, and with staff and community support Aboriginal students were attracted to the University from across Canada. Now, after 25 years, the Faculty of Medicine & Dentistry and its partners can point with pride to 77 Aboriginal medical graduates who are advancing health care in the province and beyond. (The Faculty had only one Aboriginal graduate prior to the 1990s.)

The celebration of the Faculty's 75th anniversary in 1988 included many enjoyable events and succeeded in raising our profile with alumni and community partners, as well as with faculty, staff and students. The theme 'Preparing Physicians for the Future' was widely promoted and our first major fund development program was

launched (making us only the second faculty in the University to do so). New graduate scholarships and the first endowed chairs in the Faculty were among the long-lasting legacies of this program.

Research in the Faculty advanced on many fronts with the recruitment of over 120 highly qualified young faculty and department leaders, based on support from the Alberta Heritage Foundation for Medical Research (AHFMR) established in 1980. The Heritage Medical Research Centre (HMRC) was built and opened in 1988 to include new interdisciplinary research groups of basic and clinical scientists in areas such as rehabilitation neuroscience, lipid metabolism, cardiovascular disease, diabetes, and microbiology and infectious disease. It was a source of great satisfaction to see the Faculty emerge as a major contributor to health science research in Canada, moving from 10th to 4th place in funding from the Medical Research Council, increasing funding from industry 15-fold, and doubling our numbers of graduate students.

There were many challenges along the way, particularly as University budget reductions hit home in the 90s, but the faculty, staff and students never flagged in their commitment to work together to achieve excellence by international standards. To use a current phrase - it was an 'awesome' experience to be involved in a leadership role with the community of the University of Alberta Faculty of Medicine & Dentistry.

Douglas Wilson is a nephrologist who came from the University of Toronto to serve as Dean during an exciting time of expansion of the Faculty from 1984-1994.

Limitations: A Reflection by Former Interim Dean Verna Yiu

Verna Yiu

Studying to become a physician consists of endless years of training: taking a history, doing a physical examination, treating diseases, healing the spirit, operating on tumours, injecting medications – the list goes on. The medical profession is about action, and consequently, trainees do not often learn that sometimes doing nothing is the best course of action.

Despite having been in active clinical practice for almost 20 years, I have never forgotten one particular patient, her family, and the impact they all had on me. At the time, I felt hopeless. Useless, even. Yet this experience revealed an aspect of medicine that can never be taught. Something that I hope every medical student or resident eventually learns: that you don't always have to be "doing something" to or for a patient. In fact, the ability to listen and express empathy can be the most important tool a physician uses.

I was a second year resident in pediatrics, which was a very busy time. I was on call one out of every three nights, covering for 4 wards on each call duty. We admitted patients from emergency, looked after sick inpatients, and did all the procedures after hours. We seldom slept, and when we finally did, it was only for 1 or 2 hours at most. So, one could say I didn't have a lot of free time. I was always occupied or "doing something": putting in an intravenous catheter, doing a lumbar puncture, injecting some lasix or antibiotics, putting down a nasogastric tube, or inserting a Foley catheter. And I was pretty good at it—or at least I thought so. I was confident, at the peak of my clinical skills, and felt very comfortable dealing with any acute illness. After all, it had been 7 years since I started my medical training, so surely I had come across everything I could expect.

During one of my call nights in the middle of winter, I received a phone call from the pediatric oncologist on service. "I have to sign over a patient to you - someone who is very sick and likely dying. I'll be available but you'll have to pay extra attention to her tonight."

"No problem," I replied. I thought I had experienced all there was to experience through my many years of clinical exposure. What could be so difficult? I'd had sick patients before and I was familiar with the tragedy associated with the practice of medicine, so I knew what to expect. Or at least I thought so.

"The patient is a young girl, 11 years of age with end stage hepatoblastoma—a complication from a vertical transmission of hepatitis from her mother. She is slowly bleeding to death through her gut. Besides receiving pain medication, you are NOT to treat her. No blood transfusions, no antibiotics, no medications or fluids. If her blood pressure drops, remember, nothing! I have spoken with her parents and they are aware of the plans and know that there is nothing else that we can do for her. Do you have any questions or concerns?" said the oncologist with a very matter-of-fact attitude on the phone.

I felt a little numb after hearing this summary from the oncologist. First, there was no emotion or sadness in his voice that I could appreciate on the phone. And the language was so harsh in discussing the death of another human being. I was angry and disturbed at being put into such a situation. I was tired: it was my tenth night of call that month. I wanted the oncologist to be there to deal with the patient. It shouldn't have to be me. I don't even know the patient. Why should I be the one to have to deal with this poor family whose child is dying? So I asked for some clarification: "So, you're telling me that I have this young girl who is slowly dying from bleeding whom I could easily treat with a transfusion to prolong her life but you don't want me to do that? You expect me to sit by her bedside and watch her die while I do nothing?"

"Yes, you have it right. Just check in on her occasionally and don't do anything unless she is in pain. And if she dies overnight, give me a page."

I had to digest what I had just heard. The staff oncologist wants me to sit with the patient, wait for her to die, and page him when it's over. Well, I'd been in tough situations before. I recalled being on call for critical care for the first time as an intern, when the first patient I admitted was a 20 year old woman with end stage liver disease admitted with a hemoglobin of 20 and bleeding to death. She died, too, but not for lack of trying. The two situations, although different, still both dealt with death. But this time, I wasn't to intubate the patient, transfuse her, or give her pressors and fluids. All I was supposed to do was to sit and do nothing. In many respects, it seemed a

lot simpler than handling a sick patient in ICU, so I got off the phone, took a deep breath and walked over to the oncology ward.

As I entered the ward, I noticed that it was very quiet. The lights didn't seem as bright as on the other wards and the nurses were speaking with hushed voices. There was an eerie "calmness" on the unit, which was not the norm in most acute care units. I asked the charge nurse about the young patient and how she was doing. "Fine, she's in bed and seems to be comfortable. Her dad is out in the parent room and the mom is sitting with her right now."

"Thanks," I said with a silent sigh.

I entered a blackened room with little light coming from the hallways. I could just see the outline of the mother sitting beside the bed, holding the hand of the young girl.

"Excuse me, Mrs. Smith, I want to introduce myself as the resident on call tonight. I was wondering if it would be okay to turn on the light a little just so I can take a quick look at your daughter. I promise I won't disturb her, and if I do, I'll stop whatever I'm doing right away."

Taking out my stethoscope and putting it around my neck was routine for me. I felt comfortable doing that. I was not, however, comfortable having to look at this young, dying girl, pale and jaundiced. And dying.

As I examined her, I noticed how emaciated she looked. She was sleeping but her breathing was laboured and deep. Was she really asleep? Or was she in a coma waiting to die? I went back to my routine examination, to put some familiarity into what I was doing. I took her pulse, which was rapid, weak and irregular. Her skin was clammy and cool to touch. As I listened to her chest and examined her distended abdomen full of fluid and tumor, I looked at her mother, sitting there with her eyes closed, as though she was praying to someone to take her daughter to a better place. As promised, I quickly finished examining her and softly asked the mother if there was anything I could do. I wanted to make sure that the message about not doing anything further for her daughter was understood by them also.

"Your daughter looks very comfortable to me right now. Is there anything I can do right now that will help?" I said quietly, almost in a whisper, not wanting to disturb the strange peace that was in the room.

"No, there is nothing we need right now," the mother said.

"Please let me know if you or your husband need to speak with me. I'll come by throughout the night but the nurses can also page me any time." I put my hand on the mother's shoulder, hoping that it might make things better, and left the room.

I wanted to get off the ward fast, to try to get back to a sense of "wanted normalcy. But as I did so, I noticed the father pacing back and forth in the hallway leading to the unit. He was a slightly built man, in his forties, and had his head down, pacing and pacing and pacing. His lips were moving as though he was muttering something to himself, perhaps praying. I didn't know if the family was religious but that didn't matter. What mattered was that I had to say something to him, something I thought would make things better since I was not permitted to do anything else for the daughter. So I interrupted his pacing, patted his shoulder and introduced myself and left the conversation the same way that I did with his wife, and then went back to my typical call routine, knowing that nothing would be typical from this point on.

Throughout the night, I went back to the ward every 2 hours to check on the young girl. Her pulse became weaker and weaker as time went on. Her breathing became more labored and rapid. She must be getting acidotic from reduced perfusion by now. And what would her potassium be? I would never know but I was constantly trying to rationalize what her medical state was within that hour, and I was not sure why. Perhaps it allowed me to put some distance between my own emotions and the feelings I had about this young girl dying before me.

At 3 am, I was still up and decided to go back to check on the young girl. This time, as I was about to go into the unit, I noticed that both parents were now outside in the lounge area. The mother was sitting in the corner with her head in her hands crying softly. The dad was in the other corner standing, looking out the window expressionless. I walked over to the mother and sat down beside her, putting my hand on her shoulder. And I just sat there. I didn't say anything, because there wasn't anything I could say.

And we sat there, for what seemed like hours saying very little of anything. She finally lifted her head from her hands and looked at me and started telling me about her daughter. Her daughter was born a little too early but then, she was always early for everything. Like the

time that she was so eager to start playschool that she put her dress on for school before she went to sleep so that when she woke up, she would be ready. Or the time that she bugged her dad so much about going to ballet class one weekend that they ended up getting there an hour too early. She was smart, full of mischief, and happy. Always smiling and laughing. And then she got sick. She started turning yellow and couldn't eat. She started losing weight and within 3 weeks, the doctors diagnosed her with cancer. But even then, she never lost her spirit for life.

I thought about the hepatitis that was transmitted down to the young girl from her mother and whether the mother knew that there was a connection. Should I mention this? Should I not? Will it help if I tried to alleviate her guilt? Could I alleviate her guilt?

The mother looked at me and asked me while I was thinking all these tumultuous thoughts, "Why do you think she got this? Why would God do this to an innocent young girl?" I looked at her and just shook my head, "I don't know." Again, the feelings of helplessness overwhelmed me. So again, I just sat there with her in silence. I could see that for a second, when the mother asked this question of me, the father looked in our direction. But he quickly went back into his trance after he heard my response.

I spent the rest of my night call with the mother. I sat with her and listened to her stories about the young girl. Around 6 am, we were all exhausted. The mother and I went back into the young girl's room. Her pulse was weaker and quicker. Her breathing was shallow and rapid now. There wasn't much time left now. The mother sat down beside her and put her head down to sleep. I put my arm around her and then left the room.

I never returned to that room. The young girl died peacefully the following day, without any pain or anguish. I went to the funeral a week later. It couldn't be an open casket due to the underlying hepatitis- even at the end, the parents would be reminded of where the disease came from. The picture of a young girl sat propped up beside the small coffin: a beautiful, healthy-looking girl sitting on a swing laughing, not at all like the young girl who had lain dying in the room. I never went to another patient's funeral after that. I realized that this was my limitation in clinical practice. As painful as this experience was, I was grateful to her for helping me see that we all have limitations. And knowing our limitations is how we sustain ourselves in this difficult albeit rewarding profession.

Dr. Verna Yiu is the Chief Medical Officer, Quality and Medical/Academic Affairs, for Alberta Health Services (AHS). Prior to joining AHS, Dr. Yiu completed a one-year-long tenure as the interim dean of the Faculty of Medicine & Dentistry at the University of Alberta from 2011-2012. She graduated from medicine with distinction in 1986, and went on to a pediatric residency at the University of Alberta before completing a fellowship in pediatric nephrology at the Children's Hospital, Harvard University. She was co-director of the Arts & Humanities in Health & Medicine (AHHM) Program from 2006-2009.

Antiquity

Marie Gojmerac

In the back of the antique store, the dust settled behind my footfalls. I wandered through the creaking, wooden-framed shelves, searching for treasures hidden by stuff. Stuff surrounded me; stacked to the rafters.

The store was one of those out-of-the-way places caught in the cross of two rural Alberta roads. Not much else for miles, but in it, there was a rambling labyrinth, with years and years of old devices instead of the monster in the middle.

I felt curiously depressed. Boredom seeped from the objects – an old frying pan, a juicer, a collection of tawdry shot glasses– and into me. I felt their second handedness, their participation in memories that were not just anachronistic to me, but dead, or dying.

Other people's pasts enveloped me. At least I was sequestered by the shelves, unlike my former work. In longterm care, elders stared when I walked in and interrupted their dreaming. Perhaps they dreamed of someone familiar coming to return them to a place that existed only within their sepia-stained memories. They would tell me about their old belongings, like this doily crocheted by someone unremembered, or this picture frame that was missing not only the story behind the stiff people in a picture, but also the picture itself.

People were more likely to come to the back of this shop in nowhere-land than they were to visit their aged relatives in their housing. I can't call it a home, not when the resident's heart moves out as the body moves in. Efforts like the Eden alternative, which advocated plants and natural light and no large dining halls, could only remove so much of the institution in institutionalization.

None of my medical training provided insight on the central struggle of institutionalization: how to make a place not just seem like, but actually be, home. How could we expect a resident to recognize home when around them was a jumble of objects either alien or, at best, out-of-place. Yet surely it was worse to store them somewhere out of the way.

I pressed on through the store. The aisle narrowed, became more tangled and less often disturbed, fell deeper into a slumber. These things had not been touched for a long while, had not woken to use in decades, like burnt-out synapses that were fast forgetting how to fire. Signs advertised products that had flashed and gone, and kitchen gadgets were doomed to remain on the shelves, no match for anyone's modern decor, next to clocks that had stopped caring about the hours in the sixties.

Wanting to hold something, I picked up a bright green teacup and its saucer. For me, something has to be at least a hundred years old before it's really antique. That goes for both objects and personalities. Much in North America is not that old. A lot of things won't age that well.

Morbidities—that is, diseases, disabilities, problems—tend to snowball around a patient as they age. The rates of diabetes and cancer rise, rise, rise with the age of a population, and the growing swell is the geriatric. They could take up all of the resources in our system. It seems like such an obvious fact, yet I did not awake to this reality until one summer of research in med school. Western medicine was aware of the tremor, could sense the wave coming; there was scrambling, but the tsunami was already casting its shadow on the seafloor.

Not long after, slide after slide about diseases flickered past my face in lectures, but did not dispel my unease. I sat, distracted. Medical school, which is wonderful at outlining problems and problem lists, has yet to suggest a solution.

From my work in longterm care, I know that staff and facilities were already stretched to capacity.

If and when we broke, we would crack from the inside.

I held the teacup and traced a cracked line in the glaze. It spread along the interior of the cup, revealing the ceramic beneath. It stood out from the green as a bloodless white scar, rendering the cup useless.

The old, yellowed light seemed to take years to shine. The only movement was my occasional reflection in a mirror, cracked and oxidized. I was caught among the wreckage, bricked into the recollections of people whose memories were now crumbling at the edges. Falling in on me, and them.

I balanced the teacup on its saucer and thought about the resident who had snarled at me, then thanked me moments later when I brought her tea. A memory wipe every five minutes creates automatic forgiveness. My hand holding the cup trembled, and the ceramic tik-tik-tiked meaninglessly.

I wondered if the other resident, the one with Broca's aphasia who couldn't say "tea" if he wanted to, could forgive what we did to him, when we placed him in this seat for lunch, that for games, this for exercises. I didn't know if he could understand what was going on

around him, or if he just couldn't talk about it. Most of the time, he sat quietly at his spot, just waiting.

The antique store's clerk had told me, it seemed eons ago, that a couple who helped out weren't in very often anymore. It was becoming difficult for the wife; she had to cover all the mirrors so that her husband wouldn't be upset by seeing an unrecognized face staring back at him.

I had not met this man who had lost his own face, but I had met the man who had forgotten that it was rude to say "I want to get into bed with you" flat out to a young lady; and the woman who would tell you all about her career, over and over and over, because that was all that was left in her mind; and that wanderer, or those bound to their chairs, those who needed feeding, the occasional oracle who would talk about rising tides.

These waves swelled, knocking my hands aside. The shatter was swallowed by silence.

Time, in its dispassion, offers one untenable, prevailing solution to our problem. It is in some ways convenient, as we do not have to do anything to make time solve this problem for us. Eventually, this struggle with resources and needs would smooth out, leaving few mementos. Perhaps grief; the occasional wreckage left half-covered in the sand as the tide sweeps inexorably out to sea.

Like a broken teacup lying forgotten on the floor.

Marie Gojmerac is a student attending the University of Alberta medical school, scheduled to graduate in the class of 2015. She was also a volunteer with the Artists on the Ward program at the University of Alberta hospital for four years. Presently, she is one of the directors of Art in Medicine, a Medical Student's Association Club.

Looking Back: Former Dean Lorne Tyrell Reflects on years 1994-2004

Lorne Tyrell

My experience as the Dean of Medicine at the University of Alberta was certainly at a time of some constraint and at a time of opportunity. Shortly after taking the position as Dean, the Government announced a significant decrease in the University budget as well as regionalization of the healthcare system.

Seventeen regions were struck and the Edmonton region had a very significant decrease in its budget. The University experienced a near 20% decrease in the University of Alberta grants from the provincial government. It was a time of tremendous constraint and the number of faculty and support staff was contracted by a total of approximately 86 people.

However, there were some very good times and I particularly note the event in June 2000 when the Islet Cell Transplant Group published a paper in NEJM showing the reversal of Type I Diabetes with islet cell transplants. This reached international press with over 200 calls from the press to the Faculty in the first day. This was particularly gratifying, as the group had lost a number of their major grants in the previous CIHR and Juvenile Diabetes competitions. Dr. Stewart Hamilton and Ray Rajotte came to my office and we arranged for some bridge funding until they had an opportunity to reapply. It was in this inter-

val that the publication in the New England Journal of Medicine came out and resulted in the tremendous press and subsequently much improved funding.

Another key event was a tour of the Faculty of Medicine & Dentistry research space with Honourable Ed Stelmach, who at the time was the Minister of Infrastructure. As we toured the basement of the Dent/Pharmacy Building, Mr. Stelmach recognized the smell of mice and it was at that time that I told him the preparation of islets for human transplantation were occurring in this building and we needed to get a much better space as this did not meet the standards required. We also toured the old Alberta Research Council. It was raining when we toured the 3rd floor and there were several pots and pans on the research benches catching water coming through the ceiling. I think this was a very important tour, as shortly after, we worked very hard with the government to have a commitment to build the new research buildings now known as the Li Ka Shing and the Katz Rexall buildings. A few weeks later, on a visit to Premier Ralph Klein, he inquired as to how much money it would take to start the planning for the new buildings. I indicated \$5 million for both Edmonton and Calgary. It was about two weeks after this visit that a cheque arrived in my office for \$5

million to begin the planning of the buildings. This was indeed a red-letter day.

A very interesting meeting occurred shortly after the Premier had announced the creation of the Heart Institute in Edmonton and the Bone and Joint Institute in Calgary. Dr. Grant Gall made a trip to Edmonton from Calgary at the request of the Deputy Minister and we met in a small conference room on the 1st floor of the Walter C Mackenzie Health Sciences Centre administrative suite. As the Deputy Minister began to tell us the purpose of the meeting, every time she mentioned it was to discuss the Heart Institute in Edmonton and the Bone and Joint Institute in Calgary, Dr. Gall refused to allow the meeting to continue if this was the agenda. After the third time of trying to present this agenda, Dr. Gall closed his books, walked outside and caught a cab in full view of all those at the meeting. It was a rocky start for the new research institutes.

These are a few of the memories during my tenure as Dean.

Lorne Tyrell MD, PhD, FRCP is former Dean of the Faculty of Medicine & Dentistry and Professor of Medical Microbiology and Immunology, and also director of the Li Ka Shing Institute of Virology, University of Alberta.

To Follow a Question: A Creative Path to Learning and Caring

Pamela Brett-MacLean

In medicine, as in other educational fields, curricular experiences must adhere not only to “best practice” standards, but also to changing values and expectations regarding patient care and provision of health services. In addition, there is increasing recognition of the importance of supporting the development of the personal/professional identity our learners’, including ways of being and relating, as part of the journey that leads them into clinical practice. To support our students on their “self-altering journey” (Montgomery, 2006), I have aimed to ensure a symbiotic openness and responsiveness to their values, hopes and expectations for all they hope to contribute to their health profession. Since its inception, I have imagined the Arts & Humanities in Health & Medicine (AHHM) Program as offering a space, among other spaces that exist in the Faculty, for learners to follow their own unique questions relating to medicine and health that may not be fully covered in the curriculum. By contributing to an expanded learning environment, I have hoped to foster an aptitude for reflection and other more embodied forms of ethico-existential learning that exist beyond technico-rational bases of knowledge.

As director of the AHHM program (2009 - present), and previously as co-director with Dr. Verna Yiu (2006 - 2009), I have helped to introduce a number of elective opportunities to support students’ learning paths. Among others, the AHHM-sponsored “arts in medicine project” elective and “directed studies in medical/health humanities” elective offer students time for independent study along with mentorship, so they can explore personally relevant questions. Often, students are interested in relating their pre-existing scholarly interests (in literature, film, critical and cultural studies, etc.) to their current medical studies. We have introduced other innovative electives which have involved shadowing artists on the wards and hospital chaplains. These experiences have not only served to introduce medical students to other members of the inter-professional health care team, but have also helped students connect with patients simply as people, rather than through a prematurely adopted medical façade, or “gaze.” Given reports of students’ positive response to these electives over the past few years, aspects of these learning experiences are finding their way into the core curriculum.

I have witnessed the power of simply providing space for individuals across disciplines to gather together to share questions, approaches, and practices in an open-ended dialogue. Examples include our interdisciplinary collaboration with the Department of Art & Design which has resulted in *InSight: Visualizing Health Humanities* (2012) and *InSight2: Engaging the Health Humanities* (2013) exhibits which have provided opportunities for medical and health sciences students to collaborate with design students in workshops and course experiences. Pattison (2003) has argued that the medical humanities should aspire to be “broadly inclusive of many languages and kinds of performance and analysis, in which bridges are built and conversations occur that reveal things to participants that they could not have learned within their own original limits and worldview.” By supporting our learners’ personal and inherently creative learning journeys within interdisciplinary contexts, I believe we can best support them in realizing their sense of personal integrity and commitment to do well by others. Toni Morrison (2011) describes this natural inclination to goodness as the “ethical bend of the human heart.”

I have learned much from the many initiatives undertaken by students in relation to the arts, humanities and medicine – many have been presented in this special issue of the *UAHSJ*, and in previous issues. I have become convinced of the importance of offering challenging, liminal spaces, which may introduce disorientation and ambiguity for our learners. This is particularly apparent in relation to the “certain truths” that shift and change with an enhanced imaginal ability and empathic intelligence. Some-times our students and residents introduce us to these liminal spaces when they challenge the presumptions that characterize conventional approaches to teaching and learning. Just as patients are teachers to our students, so too our students offer us insights and lessons. We learn together, from each other.

It is a challenge to describe how fulfilling it is to support the brilliant and impassioned learners, faculty, alumni and other members of our community as part of the Faculty of Medicine & Dentistry. It is a happy challenge; the opportunity to provide a space for those intent

on creating a better world is a great privilege. I am reminded of Heidegger’s observation that much of the art of teaching is in learning to let students learn, or “letting learn.” Humility and respect are fostered by an enlivened sense of being with, and living through, one’s compelling questions. This kind of learning provides a ground for being and becoming, while helping to foster commitment to caring for each other.

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Breaking Bread: The Wednesday Afternoon Bread-Baking Therapy Group

Vincent Hanlon

I've had a passion for baking bread for more than three decades. I've been "in medicine" about as long as I've been "in bread." And bread has been in me even longer. As a child growing up in a large family, I remember watching my mother kneading by hand enough dough to make 20 loaves of white bread every Monday.

I baked my first loaves of bread in October of my second year of medical school (class of '82). They were two heavy and misshapen loaves of cracked wheat from a recipe I found in *The Fanny Farmer Cookbook*—a birthday gift from my parents to help me get through medical school. The loaves looked more than forlorn, but they were scrumptious nevertheless when sliced, toasted, and slathered with raspberry jam.

I thought of those substantial little twins this October as I pulled a pan of fragrant, golden brown pumpkin buns from the oven, and then delivered a half-dozen to Farmer Dan, an emergency medicine colleague (class of '83) who loves to garden and supplied me with the home-grown pie pumpkin that I steamed and added to the bun dough.

These days, I sometimes hear residents opining about the length and demands of their residency programs. Little do they realize! My apprenticeship to become a master baker was a far-flung odyssey spread over a quarter of a century that took me to five continents. I baked equatorial cinnamon buns in Embu, Kenya. At the 1988 Edmonton Fringe Festival I performed "Bread is the Mother" on stage with a lump of live dough. At the chilly confluence of the Teslin and Yukon rivers, I coaxed sourdough to life. I brushed egg-wash onto loaves of Heidelberg rye in the suburbs of Jakarta. Under the watchful eye of Stephane Neugebauer, the best artisan baker in Languedoc-Roussillon, I patiently learned the art of shaping loaves of "sept céréales" at five in the morning in his bakery, *Le Fournil des Bergers Bleus*.

Like any long and intense training program, it was hard work to become a bread specialist. Taking my passion for bread to the next level came about when I realized the nature of bread baking is less about individual expertise and more about the communal activity of coming together to share not only the bread

but also the knowledge, skills and enthusiasm that create it.

I started working for the AMA's Physician and Family Support Program (PFSP) in 2005. Taking calls on the PFSP 24-hour helpline gave me a new appreciation of the pervasiveness of relationship and family problems within our profession. The majority of calls for assistance involve relationships in difficulty or problems with anxiety, stress, and depression.

A few years after starting to work with PFSP, I was sitting in the Round Street cafe chatting with a colleague going through a painful marital breakdown, drawn out divorce and associated family issues. This territory was now very familiar for me from my work with the program, but I wasn't on call that day. I was beginning to feel impatient in my role as supportive listener. Was there something else I, or better yet we, might do as an alternative to cafe commiseration?

I was familiar with the work of Dr. Jane Lemaire, a Calgary internal medicine specialist, and physician health researcher and advocate. Support, according to Lemaire, is threefold in nature: emotional, informational, and instrumental. When confronted with a friend or colleague in difficulty, we can listen attentively, provide some advice or information, and lastly, do something. I felt I was looking after the first two but neglecting the third.

It was time to take action. It was time to do something together, rather than sit passively in the cafe. I invited my friend to join our Wednesday Afternoon Men's Bread Baking Therapy Group—which, until that moment, didn't exist.

A med school classmate, Able Baker Bill, and I had previously baked together a few times in each other's kitchens. Sometimes we'd invite Pieman Dave (not a physician, but medically curious and gastronomically capable) to teach us the invaluable technique of making flaky pie crust. I invited our divorced friend and colleague to join us at our next Wednesday meeting. He agreed to come along.

We welcomed him into the brotherhood of bread. He eagerly began to learn the art of dough-making, and showed an aptitude for loaf-shaping and caring for the yeast. He

proved to be an innovator. He established definite bread-cred with the group by surprising us one Wednesday with a powerful sourdough starter he'd produced from scratch. Sourdough Man had arrived! Over time the acrimony and unhappiness of his divorce and his need to talk about it receded into the background.

Since those early meetings of the group, we have changed our name to the more inclusive Wednesday Afternoon Bread Baking Therapy Group and now have female members- it's amazing how long it took a group of intelligent men to learn one of life's important lessons. We drink a little wine, listen to music and discuss interesting cases. We tap the wisdom of the group for practical solutions to thorny issues like patient wait times, physician human resources, fee equity, medical education, and work-life balance. We emphasize the life-giving qualities in bread, and also in the wine. We are what we eat. The experiences are both gustatory and spiritual. We are ever-so-slightly transformed by our Wednesday afternoon experiences. Prior to dispersing, we divide our daily bread.

Bread baking among friends is an exchange of gifts. Sourdough Man was a productive member of our group for five years. He recently left our city for a new life in a new community, and I hope another bread baking group. Before he departed he graciously gifted us his sourdough starter, and three pails of organic grains: oats, rye, and kamut.

We miss him and we'll remember him on future Wednesdays. Able Baker Bill is planning to buy a grinder attachment for his Bosch dough machine, so we can grind Sourdough Man's gift of grains into the miracle of new loaves.

Vincent Hanlon graduated from the University of Alberta in 1982 and did a residency in family medicine at St. Mary's Hospital in Montreal. He practiced emergency medicine for 20 years, first in Fort McMurray and then in Lethbridge. He worked for 8 years doing weekend locum replacement in small towns in southern Alberta. Since 2005 he has worked part time as an assessment physician and educator with the AMA's Physician and Family Support Program. He contributes book reviews and essays about life in medicine to a variety of periodicals. He enjoys photography and cycling. He and his spouse, Teresa, live in Lethbridge. They have two grown children and one grandson.

Auntie Zita's Old-fashioned White Bread

Ingredients

4 cups/1000 ml warm water
1 tbsp/15ml salt
1 tbsp/15ml sugar
3 tbsp/45ml margarine or butter or oil or lard
2 beaten eggs
1 tbsp/15ml instant yeast (check the "use by" date)
10-12 cups/2500-3000ml all-purpose flour

Method

Add all ingredients including 5 or 6 cups/1250-1500 ml of flour to large bowl. Mix until smooth batter (300 turns with a wooden spoon if making bread by hand). Add the remaining flour a cup at a time to make a smooth elastic dough. A stainless steel dough scraper is a great tool for working the dough on a countertop as you add the remaining flour. Don't worry if you don't use all 12 cups.

Set dough aside in a greased bowl. Cover with plastic bag or towel. Let rise until doubled in volume (usually 1-2 hours). Deflate dough by gently turning the bowl of dough onto a lightly floured counter-top. Divide the dough using your dough scraper into 4 pieces if making loaves, or 48 pieces if making rolls. Fashion the four loaves and place in greased pans (or 48 rolls onto greased baking sheets—olive oil and margarinework well, or onto sheets lined with baking paper). Cover and let rise until nearly doubled in volume.

Bake loaves in preheated oven at 375 F for 25-35 minutes or until loaves sound hollow when turned out of pan and percussed on bottom of loaf. If making whole wheat loaves, bake for 35-40 minutes. Rolls take about 20 minutes.

Variations

1. Add 1 cup/250 ml of partly cooked wheat kernels [boil then simmer for 45 to 60 minutes, cool], and add to the other ingredients.
2. Substitute whole wheat or stone ground flour for half of the white flour.

Zita Lang was one of Vincent Hanlon's mother's sisters. She died in Regina in 2012 at the age of 95.



Suffering: A Patient History and A Common Journey

To live is to suffer. To survive is to find some meaning in the suffering. — Friedrich Nietzsche

Danny Aceytuno

Suffering is a universal part of being human and of the human condition. Meanwhile, the journey of suffering—how we suffer and who we suffer with—is unique in every person. In the case of illness, in addition to the physical and physiological components, a person's history contributes unique psychological, social, emotional, and spiritual dimensions to their suffering. The resulting combination and dynamic interrelation of psychological and social (psychosocial), spiritual/existential, and physical/physiological suffering is often personal and complex. In caring for the dying and terminally ill, this unique subjective experience of multifaceted suffering is what fifty years ago, the nurse, social worker, physician, writer, and pioneer of the modern hospice, Dame Cicely Saunders, identified as "total pain."

But I think that hand in hand with suffering, built deep into our common humanity, lies the desire to transform suffering in others and ourselves. What I have seen, and what seems to me the best approach I have so far seen, is people cultivating both wisdom and compassion: wisdom to provide effective direction to caring, supportive, and empathetic acts, and compassion to drive wisdom, knowledge, and expertise toward practical kindness.

With the goal of growth in wisdom and compassion in mind, I think back to the complex and universally unique nature of total pain, which always makes me ask how—given current experience and lack of access to another's subjective experience—can I most effectively improve the well-being of others at this moment? What, beyond treating disease and physical symptoms, can practically be done to transform suffering in others? How can I better understand suffering? And how can I make those that are suffering feel better understood? I think about the question that Russian author Aleksandr Solzhenitsyn poses in *One Day in the Life of Ivan Denisovich*: "Can a man who's warm understand one who's freezing?"

Over the past five years, I have been a volunteer within pediatric oncology outpatient and inpatient units, an adult palliative care

consult service, and a children's cancer society. I have had the opportunity to be with patients, their friends, and their families, as they struggle with the challenges of new diagnoses, receiving treatment and care, survivorship, and loss. I have had the privilege of being allowed to share in their journeys, sit and listen to their stories, and glimpse the fullness of the lives and histories of individuals who are directly and indirectly dealing with childhood cancer, as well as life-threatening, terminal, and otherwise life-limiting illnesses.

During these five years, I have worked with a purposeful intention to cultivate wisdom, and to better understand the foundations and causes of total pain, as well as compassion, so that I may better empathize when encountering total pain. In that time, while providing company and support to people, I have been offered a window into how total pain can come together in a person burdened with serious illness. But throughout my time as a volunteer, there were also events and periods in my life and the lives of my friends and family that were marked by significant pain and distress. From these experiences, and later reflection upon them, I have made forward strides in both compassion and wisdom: I feel that I have a better understanding of what it is to be in anguish, and new insights into what makes up that pain. And outside of personal life experience and reflection, I have also learned how invaluable the words of others—not just primary research articles or textbooks, but internet blogs and classic literature—can be in guiding understanding and inspiring empathy.

Through a combination of experience, reflecting, and reading, I feel that I have improved my understanding of some of the subjective and objective elements of total pain. I have gained experience with, and knowledge about, psychosocial suffering in the forms of anxiety and depression, as well as spiritual suffering in the form of existential distress. I have seen commonalities in the narratives of individuals with diverse histories with respect to the causes and subjective experiences of their suffering. Some of these commonalities are, for example, a perceived lack of meaningful choice and

powerlessness in the face of uncertainty and changing external circumstances, or slowly losing control of one's mind and body over the course of progressive degeneration. Many people have to make difficult choices with incomplete information and uncertain outcomes: they have to constantly shift their expectations while trying to be positive, while balancing hope and reality. Parents, children, and friends try to be supportive and appear strong for one another while suppressing their own emotions and personal struggles; The onset of illness often leads to decreasing mental and physical capacity, and a loss of independence, which can change someone's perception of self-identity. Indeed, feeling unable to live in accordance with one's authentic self, and no longer being able to do the things that give one's life meaning reappears again and again on the wards and in counseling. Illness and pain make people feel isolated and disconnected not only from their community but also from the ability to understand their own situation, which seems deeply unjust. People can lose their connection to the world through this defeat and hopelessness: nothing greater or significant seems to bestow meaning anymore. I have seen people who feel as though their personal history—past, present, and future—has been erased, who feel disoriented in both time and space, and trapped in their body. Across all diseases, individuals, and situations, pain and illness break down the foundations of selfhood, community, and personal meaning.

In summary, in my past five years alongside people suffering from life-limiting, life-threatening, and terminal illness, I have learned a great deal about total pain and the elements of psychosocial and spiritual suffering that constitute it. But no matter how many years of experience, reflection, and reading I gain, I do not ever foresee a time where my best attempt to empathize will not be, "I don't know what to say. I can't imagine." A complete understanding of suffering, or perfect empathy, are goals that will always remain just out of reach. But I recognize that they are significant goals still worth pursuing—and that my deep curiosity about people and the world and my passion to try

to improve the well-being of both will always drive me towards these goals.

At the same time, while I was busy looking in a different direction two simple unexpected, but arguably more important lessons, snuck up on me that I keep to heart in my pursuit of wisdom and empathy and in trying to improve others' well-being.

First, I learned that the task of alleviating total pain in people can be extremely challenging and can often seem overwhelming. However, I can take comfort in knowing that this task is not my load to bear alone. I am part of a greater team with unique strengths who can support me and whose members all working toward the same goal.

The second thing that I have learned is perfectly encapsulated by a quote from Dame Cicely Saunders: "I once asked a man who knew he was dying what he needed above all in those who were caring for him. He said, 'For someone to look as if they are trying to understand me.' Indeed, it is impossible to understand fully another person, but I never forgot that he did not ask for success but only

that someone should care enough to try." In five years of spending time with patients, their friends, and their families, over anywhere from a single hour to weeks, months, or years, nothing else has ever rung so true. As I try my best to be fully present with a person for a time in their journey, and show them care and compassion, I always feel a deep sense of positivity from making a meaningful contribution to their experience. I feel a deep sense of personal meaning when I think I have helped even a little to mitigate fear and despair, and to help someone re-establish a sense of personhood and normalcy in, and connection with, the world. By spending time with a person and trying to make them feel heard and understood, I have often borne witness to the transformation of suffering that is manifest in the most simple, yet beautiful, of sentiments: a sincere smile or a heartfelt, "Thank you."

In *The Emperor of All Maladies: A Biography of Cancer*, physician, scientist, and author, Siddhartha Mukherjee prefaces a similar sentiment with the words of American novelist Thomas Wolfe, who experienced lifelong struggles with serious illness in his family and

later, at age 38, in himself. In his final letter to a close friend, Wolfe wrote, "I've made a long voyage and been to a strange country, and I've seen the dark man very close." Mukherjee follows, "I had not made the journey myself, and I had only seen the darkness reflected in the eyes of others. But surely, it was the most sublime moment of my clinical life to have watched that voyage in reverse, to encounter men and women returning from the strange country—to see them so very close, clambering back."

Danny Aceytuno completed a BSc Honours in Physiology and Developmental Biology at the University of Alberta. He is currently a PhD candidate in the Department of Biochemistry in the Faculty of Medicine & Dentistry at the University of Alberta, where his research focuses on the molecular foundations of DNA repair and cancer. He was previously a volunteer in the Stollery Children's Hospital in Pediatric Oncology in both the Outpatient Playroom and Inpatient Unit, and has been a volunteer with the Kids with Cancer Society for over four years. For the past two years he has volunteered with the Adult Palliative Care Consult Service at the University of Alberta Hospital. He is a member of the University of Alberta and Stollery Children's Hospitals and Mazankowski Heart Institute's Clinical Ethics Committee.

Humble Beginnings

Keith McKenzie

The son of homesteaders, I had no earth-shattering goals in mind, but my parents gently pushed for a college education. Fast forward to the class of 1957 at the University of Alberta. Our small class of 47 favoured a close-knit relationship between us and the teaching staff – a real boon. This gift of education opened many doors, leading to a successful professional life as a Family Physician, and then on to the specialty of Ophthalmology. In the face of such good fortune, I searched for a way to "pay back".

Today, I can look back on 22 years of medical mission trips to Guatemala. My patients have been the underserved, and ignored Maya population. What drew me back year after year? The revelation was slow to come to me—although yes, these people have almost no chance for specialty care otherwise, my tie to the mission trips is deeper than that. Unlike my patients at home who seek care before they become disabled, the Maya come to me with advanced disease, and are truly functionally disabled. By the time they receive care, they require nearly full time assistance, which means that a simple cataract surgery can

positively alter the family dynamic. The depressed and disabled patient becomes productive and self-sufficient. The caretaker, often an older child, is released from the burden of family responsibility, and can return to school or work. These families, who generally live at subsistence level, become just a little bit more prosperous. Other surgical specialties such as General Surgery, Plastic Surgery and Orthopedic Surgery can bring similar benefits to these poor families.

On a personal level, I have gained a great deal. We feel a "high" when we see advanced and exotic disease, including those peculiar to subtropical areas: the diseases you would never see at home in your own practice. We get to share that experience with Guatemalan Ophthalmology residents, teaching them how to problem-solve and helping them improve their surgical skills. Then, mix in adventures like the power going out, or not having the right instrument, or deciding how to deal with such advanced disease. Your problem solving skills have to sharpen in order to meet the challenges that every day provides.

The dynamic of group sequestration also provides a rare experience: after work, people have to actually talk to each other – here there are no distractions like TVs and phones. Much like my childhood homestead days, musical instruments appear, along with other forms of entertainment; discussions delve deeper and bonds form. Lifelong friendships have been my good fortune as a result of my experiences on medical mission trips.

Meanwhile, all around us is an unfamiliar culture, lived by small gentle brown-skinned people, many dressed in woven garments of their own making. They speak in Mayan dialect. Their small communal villages dot the towering volcanic slopes. Colorful central markets serve as a place to sell their goods. Members of the medical team love to stroll these market places and buy weavings or other exotic things. We stand out in the crowd because we are so much taller, and have such long pale faces. When our time in the village is over, we take side trips out of Guatemala City to the sites of ancient Mayan cities before leaving the country.

My first trips to Guatemala were with a multi-specialty surgical group, for which I directed the eye section. During this time I developed a close friendship with Sister Mary Waddell. She would bring patients from her village 3 hours away to be cared for by our group, and after 5 years of arm-twisting, eventually talked me into setting up an eye program at her village clinic. We overcame many challenges in outfitting surgery and exam rooms in the clinic, but that program is now in its seventeenth year, and Sister Mary remains one of the most inspirational people in my life. She is completely dedicated to the welfare of the indigenous people in her area, tending to

them seven days a week, all year long, making our three weeks per year pale in comparison.

Over time, I have worked with many wonderful dedicated volunteers, and met other volunteer groups on our way in and out of Guatemala, primarily from the U.S. and Canada. I have gained wonderful professional and personal relationships; I have developed my own leadership and problem-solving skills; I have a better understanding of the problems of developing countries, especially those with large indigenous populations; and I have done all this within an ancient and remarkable culture, set in a beautiful subtropical part of

the world. It is a far cry from my days on the homestead, and never fails to remind me how lucky I was to be born in a part of the world where I could gain the education that brought me here to make a difference.

Dr. Keith McKenzie graduated from the University of Alberta Faculty of Medicine & Dentistry in the M.D. Class of 1957, and practised as both a family physician and an ophthalmologist. He believes in the power of a quality education to create positive change in the world. He notes that those interested in doing medical mission trips in Central America, such as he described, might wish to contact the Vancouver group "Poco a Poco".

Downbeat

Alim Nagji

I push back the MRSA-laden curtain with the edge of my pen, peering into the near darkness. My senses are assaulted from all angles within the confines of this artificial room. The stifling stench of age mixes with the warmth of inactivity, creating a caustic aroma of sweat and neglect. Groans rush through my ears, twanging my vestibulocochlear nerve and resonating through my temporal lobe before sliding and tumbling down into my heart.

But my heart is full. After 16 hours here and seven years of practice, it's been full for a long time. And so the cacophonous tones spill over and are rapidly drowned out by the drone of my stomach, grumbling with its own demanding cry. Why is it that my presence escalates her pleas? She clutches at her back, her right knee, her left breast, my hand, pulling me close enough to gaze into her glazed eyes and see the vast emptiness that lies behind them. I learned in medical school that pain that becomes worse when someone is in the room is a sign of malingering, but isn't that just human nature? To plead when someone is there to listen?

"Where is my baby?" She cries. She rolls in bed, panting desperately and drenching herself. She is drowning in fluid; her raspy rales perforate her every sentence while the sweat of her palms slips down the side rail.

"Dear, you're in the hospital. Do you know why you are here?" I respond. Calmly, at first. Louder, the second. Impatiently, the third. Annoyed, the fourth.

"They took her away. My little girl. She is only eight. Bring her back to me please, doctor. Find my little girl."

I tower above her. Even if she were standing, her long body unfurled from its permanent cocoon, I would dwarf her, this shrunken once-woman. I grasp her hand tightly.

"Your daughter is all grown up. You're in the hospital now. I need you to tell me about your pain." She rambles incoherently. The words are there, but strung together at such a slow illogical pace that any rationalization becomes impossible. Questions blend together and decades are skipped in seconds. Pain from childbirth remains most vividly with her. She describes that quite thoroughly.

I glance at my watch as she attempts to draw a clock, the numbers spilling out of the jagged circle like marbles racing out of a leaky jar. The hands move forward for me; backwards for her.

False empathy spews from my lips. I could speak to her in Hindi for all it matters. Her mind, like an etch-a-sketch, is reset with every pulsatile movement. Her pulse beats irregularly against my hand and for a moment I am drawn back in. My exhaustion and frustration are lost with each missed beat. The silence in between beats speaks volumes. I feel her story coursing through her veins. Here I am. She says. Alive. Her flesh feels warm to the touch, the thin skin bunched and stretched to either side. I see her neck flicker with each explosion of blood. She nods along, like she hears the

music. As if she understands me. Her grey eyes are suddenly sharp again. She focuses on my face. "I am sorry," I whisper.

But it is too late. Clouds have filled her corneas, her pupils straining behind them, widening to take in the whole entirety of her world, to watch the story of her life race by in images. She is her own soundtrack: her irregular beat, her harsh breathing. The sounds escalate, melding in with the beeping of the monitors and the whisking of curtains as hands surround her, prying off her clothes, lowering the bed rails. Her head sinks back as the bed unfolds beneath her. She gazes skyward now, her head bent awkwardly, anchored by her twisted spine. Masks try and silence her. Her breathing is overshadowed by the force of the student, crushing her ribs with a certain gusto: the conductor's downbeat.

Her music, once reassuringly against my finger, slips away, replaced only by the mechanical sounds of our work. The masks succeed in suppressing her. Her broken ribs creak no more. She is still holding my hand. I twist it away, severing our link. The silence hangs heavy in the tight space. I pull back the curtain, life flickers in; I re-enter the world.

Alim Nagji is a second year resident in Family Medicine at the University of Alberta and a graduate of the University of Alberta Medical School. An avid actor, director and writer, his work has appeared in numerous publications including *Canadian Medical Association Journal* and the *Canadian Journal of General Internal Medicine*. See more of his writings at: thealimshow.blogspot.com

toodle pip*

Danielle J Lewis

the MEC backpack

i could always recognize the faded blue MEC backpack with the tattered and dangling cords.

inside you were sure to find a notebook, a book on physics, philosophy and a cucumber and cheese sandwich.

the halls

through a myriad of eager newly minted high school graduates there stood a face unique to these university halls. one that “belonged” to years past.

a man more familiar with the way the halls creaked, the lights overhead flickered and the brick smelled.

chance encounters

it was sometimes in these halls rife with laughter and talk of last night’s outings that our chance encounters would occur.

more often it was in the cafeteria where my eyes were always drawn to the most wonderful, peaceful man engulfed in a doughnut, coffee and inevitably a book. with an egg salad sandwich in hand, tears would well up in my eyes as I dodged the slew of lunching students. i was so proud.

a granddaughters monument

his insatiable desire to learn

his courage to carry on

his presence

his ability to slide in a joke at just that right moment

donald frederick lewis

my grandfather

a physician

a university of toronto alumni

a father to three

proud that he would be proud of my choice to study the art of medicine at the University of Alberta

toodle pip

toodle pip

toodle pip

* To toodle pip a dear friend, means to say goodbye in a very friendly way. My grandfather used to say that to his children as he was leaving to go to a house call or off to the hospital.

Danielle Lewis (Med 2015) is a mother and medical student at the University of Alberta. Her grandfather, Donald Frederick Lewis, practiced medicine as an internist in Medicine Hat, Alberta for many years. While completing his medical studies at the University of Toronto, he met Aurline Tanner, an Alberta native. In 1955, Donald and his family lived in Edmonton while he completed post-graduate training at the University of Alberta. Dr. Donald F. Lewis was also president of the Alberta Medical Association in 1966-1967. Donald and Aurline retired to Victoria British Columbia, where Danielle had the pleasure of attending the University of Victoria with her grandfather. Sadly, Donald Lewis passed away before Danielle Lewis graduated with a Bachelor of Economics, and before he knew that she would also enter medicine and what a significant role he played in that decision. Danielle Lewis is currently completing the Integrated Community Clerkship in Hinton, Alberta.

Mettā: Loving Kindness in Medicine

Steven KH Aung

Medicine involves a blend of the sciences and the humanities, and an integral part of its successful outcome with patients is “loving kindness,” which is known in Buddhism as mettā. While the sciences provide the objective and empirical evidence for the various treatments of patients, the arts and humanities of medicine are linked with the healing of the patient. However, medicine without mettā is incomplete and nonsensical; it is without emotion and thus unable to completely heal the patient physically, mentally and spiritually. Without treating all of these aspects in a patient, there is an imbalance in health. If a person is physically fit but his or her mind is troubled with baggage, the patient is still not completely healed.

In order to have physical healing, the art of communication through the 6 senses (sight, hearing, smell, taste, touch and intuition) is essential in delivering a comprehensive treatment of the whole body. Mental healing takes place if both the practitioner and the patient are pure in spirit and have no emotional pollutants in their minds. Spiritual healing will only occur when our bodies, minds and spirits are healed with loving kindness and blessings. Mettā enhances the art of healing in the body.

In Traditional Chinese Medicine, the heart is associated with the spiritual part of the body. If the heart is healthy physically and spiritually, and if it is complemented with a healthy, positive and energetic environment, the healing process will automatically follow. The spiritual aspect has a vital role in healing, therefore it is important to develop one's spiritual energy to enhance the body's healing process.

I would like to share my most treasured experience with His Holiness, the 14th Dalai Lama during my meeting with him on January 21, 1991 in Dharamsala, India. I was very fortunate to have had the opportunity of personally meeting with him, even if I was only given 15 minutes. Prior to the meeting, I prepared three questions that I wanted to ask His Holiness on this rare occasion. However, before I could ask any of my questions, his assistant had asked me to leave as my 15 minutes were up due to some introductions and short exchanges of pleasantries. My heart sank upon hearing that I had to leave. The

thought of not being able to ask the questions that I had so carefully prepared was very unfortunate. But to my complete surprise, the Dalai Lama leaned toward his assistant and whispered loud enough for me to hear: “Dr. Aung still has three questions in his pocket to ask me. Let him stay.”

Until then, I had told no one – especially His Holiness – that I had three questions neatly scribbled in my pocket. Then it dawned on me. He knew why I came to see him. From that point, I knew that the meeting would change not only the way I practice medicine, but more importantly, how I would see and live life.

My first question to His Holiness was: “What is the most significant contribution of Tibetan Medicine to the world?”

He replied that Tibetan Medicine has introduced to the world a kind of medicine that is not simply focused on the removal of illnesses of patients. It has taught practitioners that medicine is also about giving an overall positive effect of wellness – not only to the patient but also to the practitioner. This includes giving blessings, treatments, and self-cultivation by regularly practicing Qi Gong, yoga, meditation and exercise.

From this, we can say that the practice (would service be an acceptable word here?) of medicine that doctors provide should not be just medicine. Medical practitioners should provide medicine that has been endowed with blessings of loving kindness for the patient. We should be wholeheartedly giving patients more enriched and enhanced treatments, not simply relieving them of their pain and symptoms. In order to do this, Tibetan medicine emphasizes that physicians should be able to cultivate their own purified positive healing energy in order to treat and heal themselves and their patients.

Some physicians treat their patients with pharmaceutical or herbal medicine, while others perform surgery or acupuncture and provide rehabilitation. In specific situations, physicians may provide psychotherapy and counselling. However, beyond the physical and mental healing that modern medicine is

able to give, every patient deserves spiritual and emotional guidance from their physicians and therapists in order to initiate the spiritual healing process and enrich the power and effectiveness of the treatment.

My second question was: “What should I bring back to Canada to contribute to Canadians and the world?”

Because I practice medicine, His Holiness suggested that I bring back 8 Medicine Buddhas – 8 statues of Buddha with various healing hand mudras (hand positions) that signify various traits and ways of healing that are needed for medical practitioners. I was very fortunate that His Holiness himself ordered the 8 Medicine Buddha statues for me to bring back to Canada. It took 5 arduous years to get these holy gifts to Edmonton, but in the end, it was worth the wait. The 8 Medicine Buddhas are among the most treasured possessions that I have received in my life.

Having the 8 Medicine Buddhas has caused an overall positive effect in my medical practice. I learned to discipline myself by doing the practice of changing the water daily for purification, lighting the incense for blessings, lighting the candles for respect, and offering flowers as a sign of my commitment. The 8 Medicine Buddhas have also helped me to learn more about Buddhism in medicine as part of my commitment to His Holiness. I have dedicated myself to giving the blessings of the Buddhas to all my dear patients, friends, colleagues and to all the citizens of Canada and the world to have good health, peace and harmony. I have placed the 8 Medicine Buddhas on the top floor of my office where the Buddhas can constantly shower my dear patients with blessings of loving kindness. I have also published a book entitled “8 Medicine Buddhas – An Integrative Approach to Inner Harmony and Good Health” to share my experiences and commitment.

My third and last question was: “What is the contribution of Buddhism to Medicine?”

His Holiness emphasized that Buddhism has introduced the practice of the 5 Precepts that are important for medical practitioners to follow: (1) not taking another person's life;

(2) not stealing; (3) not making false accusations; (4) abstaining from sexual misconduct; and (5) abstaining from alcohol and illegal substances. His Holiness also reinforced the 5 treasured principles which have been taught to me by my first spiritual teacher, Sayadaw U Thila Wunta when I was 7 years old: mettā (loving kindness), karuna (consider all patients as family), saydana (providing unconditional treatment), muditta (treating all patients with respect), and uppaka (treating all patients equally regardless of their age, sex or status). I have always integrated all of these values in my medical practice. His Holiness also advised to practice self-cultivation, purification, and to always treat patients with good intention and with love. Medical practitioners learn most from our dear patients and the most complicated patients are our supreme teachers. This has always been the core of the Buddhist approach in medicine.

After my meeting with His Holiness, I have always tried my best to embody his wise words and advice in my practice of medicine. Although the arts and sciences in medicine

are inevitable parts of its development and future, we should always remember that the heart of medicine is not simply about curing the patient: it is more about treating them with loving kindness and respect so that they can have more enriched and empowered lives. It is also important to understand that recycling of negative suffering energy into positive healing energy is vitally important to being a healer.

Every single healing process has an action and reaction. The most important idea that practitioners have to understand is how to transform the negative energy into its positive form in order to wholeheartedly heal our patients. Practitioners have to learn how to take care of themselves physically, mentally and spiritually so that we all become “healers” and not simply medical practitioners.

I wanted to share this experience with all my friends, colleagues and to all the readers of this journal. I hope you enjoyed reading about this short but very meaningful part of my life.

Dr. Steven KH Aung is a highly respected family and geriatric physician, a Traditional Chinese Medicine practitioner (TCM), researcher and teacher. At the University of Alberta, Dr. Aung is a Clinical Professor in the Faculty of Medicine & Dentistry and an Adjunct Professor in the Faculties of Extension, Rehabilitation Medicine, Pharmacy and Pharmaceutical Sciences and Public Health. Dr Aung was awarded the Alberta Order of Excellence in 2002, the Queen Elizabeth II Golden Jubilee Medal in 2002, the Diamond Jubilee Medal in 2012, Physician of the Century Award in 2005, and the Order of Canada in 2006. He is also a WHO advisor and consultant in acupuncture standards and cancer pain control, and the Vice-Chair of the World Federation of Chinese Medicine Societies. Internationally, Dr. Aung is known as an advocate of the integration of TCM and Western biomedicine, and his efforts have made Canada a world-renowned centre in complementary and alternative medicine.

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A Centennial

Jody Paulson



The look, feel and colors of a brand.

The plans, meetings and budgets of a project.

The talking, listening and ideas of the people.

The ice sculpture, cake and proclamation of the launch.

The students, staff, faculty and alumni of the school.

The lectures, challenges and contests of the year.

The marketing, communications and delivering of the message.

The images, memories and impressions of the celebration.

The wrap up, legacy and goodbyes.

Jody Paulson was the centennial project manager for the 100 Years of Medicine celebrations. She has close to 20 years of event management experience and her submission is a reflection on the seventeen months of preparation and execution for the centennial year.