**Room for a view**

**The rookie**

He sat slumped in the back seat of a small car, under the yellow glow of the emergency department entrance. We pulled him out and threw him onto a stretcher. It was 2 am, the night suddenly coned-down and focused.

“He’s not breathing, let’s go.” We dashed with the gurney through the automatic doors, past the triage desk and into the resuscitation room.

Under the bright lights Stuart, as I’ll call him, revealed himself. He was young — 20 years old, it would turn out — blond, athletic-looking, but with blue lips and ashen skin. He still had a pulse; his pupils were pinpoints. A plastic airway was slipped into his mouth. A mask was placed over his face and oxygen bagged into his lungs. His chest rose and fell with each ventilation; his colour turned a healthy pink. I relaxed; we were in control; he would live.

He was disrobed to his underwear, which was soaked with urine. An IV line was jabbed into an engorged vein in his arm, leads were placed on his chest, and an oxygen saturation probe was clipped onto his finger. He was a rookie, it seemed: only a few fresh track marks in his right arm.

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**Image of the profession**

**The leucotome**

The instrument pictured here was designed by Dr. Kenneth G. McKenziel in the 1940s to bring precision to prefrontal leucotomy, or lobotomy. It is part of the exhibition *Brainwork*, now on view at the Canadian Museum of Health and Medicine in Toronto to mark the 75th anniversary of neurosurgery in this country. McKenzie received the first Canadian appointment in that specialty at the Toronto General Hospital and the University of Toronto in 1923. His contemporary in the field, Wilder Penfield, took up an appointment at the Royal Victoria Hospital and McGill University five years later.

The fact that Egas Moniz, the Portuguese neurosurgeon who introduced frontal leucotomy in 1935, was awarded the Nobel Prize in medicine in 1949 may be jarring to modern sensibilities. Felicity Pope, curator of the Canadian Museum of Health and Medicine, notes: “By today’s standards, lobotomy is seen as a dark episode in neurosurgery’s past. In its heyday ... it met the needs of doctors, patients’ families and asylum superintendents. From the patients’ point of view it was less satisfactory.”

In 1946 McKenzie reported in *CMAJ* improvement or recovery in 23 of 27 consecutive patients who had undergone bilateral frontal lobe leucotomy to treat apparently intractable psychiatric illness, ranging from manic depression to schizophrenia and marked by “pathological fear” manifested as “anxiety, agitation or impulsive behaviour.” By his death in 1964, McKenzie’s view had changed: “the availability of tranquilizing drugs [has] reduced the importance of this drastic, irreversible procedure.” Reporting on a five-year study in which 183 patients who had undergone leucotomy were matched with controls, McKenzie disclosed the unexpected finding that there was no significant difference between the two groups in rates of hospital discharge and concluded that “pre-frontal leukotomy [did] not produce any rate of remission beyond that to be expected without the operation.”

*Brainwork* is on display at the Toronto General Division of The Toronto Hospital, in the College Wing Lobby, 101 College St., Toronto. For information call 416 340-4800 x1899, or email fpope@torhosp.toronto.on.ca

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**References**

**Gut reaction**

Confronted by *gulp*, an exhibition by Toronto artist Sandra Rechico, the viewer is first attracted by her colourful, abstract images only to recoil at the realization of what they are about: the pathology and diagnosis of gastrointestinal disease.

The installation includes a piece called *soot works*, which comprises 100 prints based on radiographic images of barium meals and executed with the use of stencils and candle smoke. In another piece, entitled *Floor Show*, a gallery floor is covered with 1000 square-foot tiles patterned with images of diseased tissue from the gastrointestinal tract.

Gallery visitors might think they are walking on a pattern of surreal petals — until they take a closer look. By then, as the artist intends, “you are too far engaged to turn back.” The challenge is to square these opposing reactions — attraction and revulsion — and to puzzle out why the work is so disturbing. Is it because we view the *content* of art as having something to do with its appropriateness as the locus of beauty? Standards of what is fit matter for art have taken many fascinating turns over the centuries; *Floor Show* was in part inspired by Pompeian floor mosaics from the second century AD, in which leftovers from a feast scattered on a floor became a legitimate subject for design. But perhaps Rechico’s work is disconcerting mainly because it exposes so frankly what is normally hidden, reminding us of our own helplessness before the secret processes of disease.

*gulp* is on display at the Southern Alberta Art Gallery in Lethbridge until April 25.

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**The rookie**

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“Better get restraints on his arms and legs before we bring him around.” There was a murmur of agreement. We had all seen it before, the drug user who comes violently out of his near-death experience.

Naloxone was administered. But Stuart came to like a dazed puppy, scared and confused by the intense surgical lights and the strange faces peering down at him.

“You’re in hospital,” I said. “You were a few minutes from dying.” He laid his head back on the stretcher, considering my words. The restraints were removed.

“Are you left handed?” I asked, finally.

“No, right handed.”

“Who shot you up?” Perhaps, I thought, it was the friend who had run into emergency, his face pale and his body twitching, pleading with us to come check his buddy in the car.

“You don’t need to know.”

“Was it heroin alone?”

“I thought it was just up.”

I didn’t know they were giving me down, too.”

“So, cocaine and heroin?”

“Seems like.”

Over the course of the night I stopped to check on Stuart a few times. His so-called friends disappeared, but his girlfriend arrived to stay by his side. She looked concerned, but not surprised. I got to know a bit about him. He held down a steady job. He was not a regular hard drug user, but neither was this the first time that he had injected heroin.

In the morning, when he was discharged, I wondered if it seemed particularly sweet to him to squint at the sunlight, feel its warmth on his skin and fill his lungs with fresh air. And I couldn’t help but think that fate or luck or some higher power was showing him an open door.

And I remember thinking, “This is your chance, Stuart. Go through.”

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