tary film which, just like fiction, must necessarily be constructed toward the filmmaker's ends. The comparative premise apart, there are no real surprises, but the case is made effectively — with occasional and, one feels, appropriate hints of anger. Unfortunately, the second of two documentaries on Cowart receives only a fraction of the analytic attention of the first, and it would have been interesting to see Jones' program carried through a little more completely.

Despite its unnecessarily jargon-ridden opening, Johnathan Metzl's re-assessment of critiques of advertising that proceed from gender theory begins with a welcome willingness to complicate the too-simple assumptions made by some of the authors he considers. There follows an interesting tale of the replacement, within a series of pharmaceutical advertisements over time, of images of the authoritative (and male) physician's gaze with images of the pharmaceutical products themselves. Readers will judge for themselves how persuasive Metzl's recruitment of psychoanalytic concepts is in his analysis of this transition, but they can hardly fail to be intrigued.

In one of the book's stronger chapters Marc Cohen and Audrey Shafer succinctly trace a broad history of the emergence and dominance of scientific medicine through visual representations of doctors in painting, photography and, latterly, television. Their thoughtful choice of images, equally thoughtfully discussed, makes their points effectively and injects fresh interest and insight into a conventional historical synopsis.

In summary, *Cultural Sutures* is a slightly baffling mix of the enjoyable and the arcane, a project that perhaps seemed more inevitable to its editor than it does to the uncommitted reader. Lacking a clear role — too patchy for a reference work, yet too laboured for a popular invitation — it may nonetheless encourage others to pay sustained attention to the culturally important and increasingly synergistic relations between medicine and the media.

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Room for a view

The drop attack


Fred Sebastian

The nurse's voice at the other end of the phone contained some urgency. "You'd better come right back to the OR, Dr. Bernstein, the guys need you. We have a situation."

What could it possibly be? It was the last day of work before a much-needed summer holiday, and I had a worse-than-usual backlog of urgent brain tumour cases. The operating room manager had kindly found me some extra time on this particular Friday. So the last surgical patient before my vacation was a lovely 60-year-old lady who had severe headaches and weakness caused by a large brain tumour.

The actual surgery for removal of her rather bloody, delicately located tumour went very well; my residents and I were quite happy with the job. I left the OR for my trainees to close the patient; in our teaching hospital this was the norm. They were both excellent residents — talented doctors and good surgeons who were conscientious to a fault.

I returned to the OR within minutes. It was eerily quiet. Two young students who had been intently observing the surgery were now sitting quietly. The anesthetist avoided my gaze as I passed her. I approached the operating table, and the senior resident explained the situation with a forced calmness. The bone flap we had opened to expose and remove the tumour had been dropped on the floor. It was about the size of a playing card. The junior resident was preparing it with little plates and screws for reattachment to the skull when it slithered out of his hands. This good-natured young man was mortified. He didn't speak. His gaze was fixed on the patient's head.

Fumbles of this kind are an uncommon but well-recognized mistake in surgery; this was my second personal experience with a dropped bone flap in a 20-year career in which I have performed many thousands of surgeries. The senior resident rattled off the therapeutic options in his typically thorough fashion. In the old days we used to "cook" a contaminated bone flap in the autoclave, the same "oven" used to sterilize surgical instruments. But this practice was no longer acceptable to the infection control experts at my hospital. So we decided to fill the skull defect with metal mesh and surgical epoxy, materials made just for such a purpose. Thirty minutes later, final cosmetic touches with a high-speed drill had produced a beautifully contoured skull that was also harder than rock. The residents then closed the scalp. A turban-style head dressing was applied by the junior resident, and the patient immediately awoke in the OR, neurologically intact and speaking well.

I gathered the residents and students

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outside the OR and asked what they thought we should tell the patient's husband and children. First the students got to speak, then the junior, whose voice trembled, and then the senior, in accordance with our teaching practice. We all agreed that, even though this error was unlikely to have negative consequences for the patient, making a full disclosure was the right thing to do. We all knew it. Any reasonable person would want to know there was now a metal and plastic plate in her head where there used to be bone.

Medical error has been a hot topic in the press in the last few years, brought into the spotlight with some infamous and terrible examples. Experts talk of two components of medical mistakes: human fallibility and imperfect systems. This was an example of good old-fashioned human error, the type that will always be with us unless robots do surgery — although even a robot could drop a slippery bone flap.

As we walked down the corridor to the waiting area, the junior resident apologized profusely to me. I knew how awful he must be feeling and tried to take the edge off by telling him that "stuff happens" and that this would not be the worst error in his career. It was somewhat analogous to a good football player dropping a perfect pass in the endzone, I said; he just took his eye off the ball for a moment. I pointed out some differences, too, like the fact that millions of people aren't watching us when we goof. Most importantly, we're dealing with people's health and lives.

I talked with the family while the residents and students watched and listened intently. The patient's husband, daughter and brother were there. I described what happened as plainly and honestly as possible. The family seemed to accept it with equanimity; their main concern was in knowing that the tumour was out and the patient was well. Perhaps they might not have been so placid had she fared badly. I told the same story to the patient herself later that evening, when she was fully alert; she was similarly gracious. She went home the next day in excellent condition, her preoperative weakness and headaches all but a memory.

All workers make errors: this is one of the defining features of being human. Doctors must hope their errors don't produce harm, but whether they do or not, we must acknowledge them, learn from them and disclose them fully to patients. At the same time, patients must accept that we are human. They must try to understand the complexity of what we do, and they must remember that to err is human, and to forgive is … human.

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Photo essay

Afghanistan: in recovery

Peacebuilding and peacekeeping — Canadian style, close up — that's what I witnessed as one of ten Canadian educators invited by the Department of National Defence to Operation Athena in Kabul, Afghanistan. Through their lens, I was impressed by the expertise and generosity of our troops, there as part of the NATO mandate to secure the environment in the capital of Afghanistan's fledgling democracy. Kabul is the most "secure" and "wealthy" place in the country, yet it's difficult to convey the disparity in privilege, safety and opportunity that separates our two countries, especially for women and children. These photographs offer only glimpses of a people struggling to recover from decades of war, still on the brink.

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Lord Strathcona's Horse Reconnaissance Squadron

In the Kabul market. When we stepped off the massive Canadian Forces "Herc" airplane on our arrival in Afhganistan, we were quickly escorted into completely enclosed armoured carriers known as "Bisons" and so saw nothing of Kabul as we hurtled through its dark, rain-soaked streets. Thus I was thrilled the next day to be allowed to "ride sentry" from the manhole of an armoured "Coyote" and to see the congested Kabul cityscape as we made our way through sunny streets like these. However, I was cautioned to be alert with the sad reminder that, months before, Canadian Cpl. Jamie Brendan Murphy had been killed by a man who stepped out of a cluster of people, jumped on a military jeep and detonated a bomb strapped to his body.